ANNEX 6 – EVALUATION MATRIX

<table>
<tr><th colspan="4">RELEVANCE
Q 1: To what extent was the UNFPA country programme (2016 - 2019) and its four Outcomes relevant to the emergent needs of target population(s) and adaptable to the changing humanitarian context in Iraq ? Was UNFPA able to respond and adapt its interventions to the changing humanitarian and development needs?</th></tr>
<tr><th>Assumptions to be assessed</th><th>Indicators</th><th>Sources of Information</th><th>Methods and Tools for data collection</th></tr>
<tr><td>UNFPA country planning documents adequately reflects needs and priorities of the target population groups under UNFPA mandate.
UNFPA plans were relevant and adaptable to changing needs and country context in emergencies as well as transition times.
UNFPA was able to reach out to the population groups ‘most at risk’</td><td>- Needs assessment documents accurately describe needs and priorities of the country and UNFPA target groups.
- Extent to which interventions planned in AWPs accurately reflect interventions identified in CPD / CPAP.
- Geographic locations of programme interventions were identified in country assessment documents.
- IPs and government stakeholders confirm UNFPA timely response and adapted to their needs.</td><td>- CPD, CPAP and AWPs
- UNDAF, HRP, NDP, UNFPA Strategic Plan
- Needs assessment studies
- Stakeholders’ feedback</td><td>o Document’ review (programme documents and related research and surveys)
o KIIs with UNFPA programme staff, government and UN agencies stakeholders.
o KIIs with IPs (Gov’t and NGOs)
o FGD with youth trainees’ and networks
o RH, GBV beneficiary surveys</td></tr>
<tr><td colspan="4">FINDINGS:
During the first years of the 2nd UNFPA Country Programme 2016-2019, UNFPA focussed on responding to the emerging humanitarian needs in the country. UNFPA did so based on the needs identified in the UN Humanitarian Response Plans (HRPs) and the Regional Refugee Response Plan, fields assessments conducted by UNFPA itself and needs identified by the Iraqi authorities at central, regional, governorate and district levels.
The main target group of the humanitarian response led by the UN in Iraq during this period were the millions of Iraqi Internally Displaced Persons (IDPs) and the refugees from Syria, and later the populations of newly liberated areas as well as Iraqi returnees who tried to return to their areas of origin. The UNFPA CP focussed on these vulnerable populations, of which a number of IDPs are marginalised due to their perceived association with ISIL.
The locations for UNFPA CP humanitarian interventions followed the location of the IDP and refugee camps, established by the government in cooperation with UN agencies.
Staff of UN and development agencies interviewed during this evaluation feel that the UNFPA Country Programme was highly relevant, as it focussed on the populations identified by the international community as most vulnerable during the years of crisis. They also feel that UNFPA Iraq Country Office and Implementing Agencies were responsive in that they managed to swiftly adapt their programmes to allow for rapid response to emerging needs.
On the other hand, government officials interviewed stated that while they were grateful for UNFPA’s assistance with catering for IDPs, refugees and returnees, the government would have preferred to see a greater CP emphasis on assisting host populations and other vulnerable populations in the country, such as remote, hard-to-reach and poor populations living away from the urban areas. Government authorities would also like to have seen a continuation of some of the development-oriented activities planned in the Country Programme Actions Plans (CPAP) for 2016-2017 and 2018-2019, many of which were not implemented due UNFPA’s preference to use available resources funding for the humanitarian response.
The evaluation team finds that the CP was relevant in responding to emerging humanitarian priorities as defined by the HRPs.
However, the team questions why the Country Programme Document or at least the Country Programme Action Plans (CPAP) for 2016-2017 and 2018-2019 were not adapted to reflect this main focus on humanitarian response service delivery. Since the documents were not adapted, the outcome and output indicators of the CP Results Framework and the main activities mentioned in the 2 CPAPs give the impression of a CP focussing both on humanitarian interventions and on longer- term development</td></tr>
</table>

work, which was not the case on practise. As a consequence, the CP and CPAP documents do not fully reflect the programme implementation during the years 2016, 2017 and 2018 and do not fully capture the achievements of the Country Programme during this time. This discrepancy was also noticed by newly recruited UNFPA staff coming from other UNFPA Country Offices.

The evaluation team finds that the Iraq Country Programme was in line with the mandate and priorities of UNFPA expressed in its Strategic Plans for 2014-2017 and 2018-2021. However, within the 4 strategic outcome areas, UNFPA Iraq focussed on Outcomes 1 and 3 and within that on service provision for reproductive health and for GBV response, whereas the Outcomes 2 and 4 for youth programming and population dynamics received much less attention and resources. The evaluation team identifies this as a missed opportunity, particularly for the youth response during the humanitarian response through which more adolescents and young persons could have been reached with SRH information, life-skills education and on subjects such as peace building.

The Country Programme was also fully aligned with the United Nations Humanitarian Response Plans (HRPs) and the Regional Refugee Response Plan, and their identification of needs of the populations affected by the humanitarian crisis. In terms of global commitments, the UNFPA CPD and CPAPs reflect the ICPD Plan of Action and the Sustainable Development Goals (SDGs).

Some donor representatives interviewed estimate that UNFPA can and should do more to work on its entire mandate, including the rights-based programming, for example to promote access to knowledge and services for non-married adolescents and young persons and for vulnerable groups such as sexual minorities .

COVERAGE

Q 2: To what extent did UNFPA interventions reach the population groups with the greatest need for reproductive health, gender-based violence services and marginalized youth, in particular, the most vulnerable as defined by HCT?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA ability to identify IPs (government and NGOs) within each of UNFPA mandate' areas. IPs' reach can extend to the geographic areas most in needs particularly unsecure regions. Outreach strategies to target groups is adequate to overcome socio-cultural challenges.	- Evidence of UNFPA services extended to IDPs, refugees in camps and Host communities. - Evidence of UNFPA services reaching identified groups of women, youths and adolescents. - Emergency preparedness response plans and commodities.	- AWPs - Programme reports - Monitoring reports - UNFPA programme staff - IPs (Gov't and NGOs) programme staff - Programme beneficiaries - Emergency Preparedness and Response Plans.	○ Document review ○ KIIs with UNFPA programme staff. ○ KIIs with IPs (Gov't and NGOs). ○ FGD with youth trainees' and networks ○ RH, GBV beneficiary surveys ○ Site visits/observation

FINDINGS:

During 2016-2019, the UNFPA Country Programme in Iraq targeted its humanitarian interventions to the population groups identified as much vulnerable by the UN Humanitarian Country Team (HCT), namely the Internally Displaced Populations and Refugees in the IDPs and refugees.

During the first 3 years (2016-2018) of the current CP, UNFPA supported interventions reached a total of XXX persons in XX camp sites and host populations.

Civil Society IPs were able to support CP activities in insecure areas. In addition, UNFPA contracted field coordinators to enable CP access to hard-to-reach areas and contributed to programme efficiency.

EFFECTIVENESS

Q 3. a: To what extent did the UNFPA programme in Iraq achieve planned programme Outputs and is likely to contribute to programme outcomes in the area of "increased access to and utilization of quality reproductive health, including maternal health services, for the target population in Iraq.

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data Collection

Programme planned Outputs are likely to contribute to UNFPA Outcome for Integrated Reproductive Health. Security situation in the targeted regions does not deteriorate any further...which might lead to increased needs. Government(s) in both regions is supportive of UNFPA mandate in sexual and reproductive health.	- Evidence of achieved Outputs. - Evidence of government(s)' cooperation in RH. - Evidence of services being provided in UNFPA supported centres. - Evidence of service usage in target areas.	- CPAP - AWPs - Progress reports - Annual reports - Monitoring reports - IP reports	o Document' review o KIIs with UNFPA programme staff. o KIIs with relevant IPs (Gov't and NGOs). o KIIs with relevant Gov't stakeholders and UN Agencies o KII with RH centers' management and service staff o RH beneficiary surveys o Site visits/observation

FINDINGS:

Strengths and achievements

According to the UNFPA Annual Reports over 2016, 2017 and 2018) , key achievements of the CP included:

- 76 reproductive health facilities supported (2016-2018).
- 846,239 women supported with antenatal/postnatal care and family planning services (2016-2018).
- 217,438 normal deliveries and 95,636 C-sections supported (2016-2018).
- 1980 RH kits distributed to different levels of health system (in 2016 and 2018).
- 336,283 women reached with awareness raising sessions (2017-2018).
- 2,497 service providers trained on Emergency Obstetric and Neonatal Care as well as other RH topics (2016-2018).
- In 2016 capacity building in the areas of emergency obstetric care, ANC, PNC and FP was provided to 555 health service providers.

The CP achievements are in line with the CP Output "Increased capacity of Ministry of Health, and civil society organizations to deliver integrated quality reproductive health services that meet the needs of vulnerable populations especially those in humanitarian settings." There was capacity building of MoH staff on RH service provision, although most of the capacity building was focussed on government staff working in the RH clinics managed by UNFPA. The capacity of maternity hospitals catering for women from IDP and refugee camps was also strengthened. The target group of the RH supported were in majority women living in camp settings.

The Country Programme (CP) contributed to the development of the following national policy documents:

- The protocol and guideline on Clinical Management of Sexual Assault Survivors, which was endorsed by the Federal Ministry of Health at national level in 2016.
- The updated national Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) Strategy for 2018-2020.
- The new national "Family Planning Strategy" for 2019-2022, on which work started in 2019.

Reproductive Health interventions were effective in delivering RH services and information in UNFPA-targeted locations. In two impact assessments conducted where the beneficiaries were asked on their view of services they received and accessibility, above 90 percent of beneficiaries responded highly satisfied or satisfied.

During the three CP years 2016-2018, UNFPA focussed on supporting the provision of RH services to populations, mainly IDPs and refugees, affected by the humanitarian crises caused by the advance of ISIL forces and the subsequent reconquests by the Iraqi and Kurdish armies. Many stakeholders interviewed during this evaluation mentioned the rapid response by UNFPA to the Mosul liberation between October 2016 and mid-2017 as a main achievement, where UNFPA managed to establish provision of life-saving emergency obstetric care (safe delivery services) and Gender-Based Violence response services within 48 hours of arriving on-site, in close cooperation with WHO, including by establishing emergency obstetric wards adjacent to the emergency hospitals established by WHO. The obstetric operating theatre in Mosul general hospital was reportedly the first operating theatre functional in the city following the Mosul liberation.

Responding to the massive displacement was an immense challenge. UNFPA relied on a camp-centric aid approach and mobilised all its available resources to front-line areas, providing basic services to civilians still located within newly or nearly liberated Mosul neighbourhoods. By May 2017, UNFPA had managed to increase its capacity to provide emergency reproductive health services on front-lines and strengthened referral pathways through 5 maternity hospitals, 14 mobile and static delivery rooms and 35 mobile

and static reproductive health clinics in IDP camps as well as host communities in East and West Mosul. The RH facilities established were supported with personnel, equipment and supplies.

In addition to emergency distribution of RH kits to health facilities, UNFPA, along with agency partners UNICEF and WFP, co-led what is now known as the Rapid Response Mechanism (RRM) consortium where a unified kit of aid items is distributed to the IDPs and similarly vulnerable families during the first 72 hours after eruption of a crisis situation. These RRM kits contain a week-long supply of items essential for a family to tide them over until either the at-risk individuals can reach more sustained aid, or further aid can reach them in-place. Kits contained potable water, food rations, a hygiene kit, and a dignity kit.

An assessment conducted by Médécins Sans Frontières (MSF) in 2017 on the emergency response during the Mosul liberation stated that "UNFPA's response was of a high quality, with UNFPA cited as one of the highest performing WHO partners. Interviewees expressed appreciation for the following aspects of the UNFPA response: they were able to negotiate access effectively; they were operational relatively early in the response compared to other actors; they set up the 'fastest' response for primary health care; and the quality of their programmes was consistently good despite limited funding." The UNFPA Reproductive Health team interviewed during the evaluation identified their emergency preparedness work, including the prepositioning of RH and GBV stocks in the weeks leading up to the liberation of Mosul, as having contributed to UNFPA's rapid response capacity, despite the challenge of UNFPA not allowing for pre-positioning of RH stocks and materials in the region.

UNFPA's rapid response following the Mosul liberation was internationally recognised and the UNFPA Country Office was commended for this responsiveness by the UN Country Team and the UNFPA Regional for the Arab States in Cairo. The fact that European Union emergency funding provided by ECHO had defined involvement of UNFPA in provision of health services as condition for WHO receiving funding promoted this example of successful inter-agency cooperation.

During and following the Mosul liberation, UNFPA also carried out urgent renovation and revitalisation of key existing government health facility infrastructure destroyed during the crisis, in order to speed up availability of facilities and service provision. According to UNFPA Iraq staff, renovation and revitalisation of destroyed infrastructure is apparently not part of UNFPA's normal intervention (the evaluation team leader questions this as she has seen UNFPA rehabilitating health service infrastructure in Sierra Leone in 2018-2019). However, the revitalisation of infrastructure was key in the Mosul crisis as it resulted in reopening essential facilities to support service provision, and in addition contributed to the sustainability of government structures.

The CP supported the capacity of government and civil society organisations to provide RH services to women of reproductive age, especially ante-natal care (ANC) and Family Planning (FP) through establishment of RH facilities in the affected areas. The majority of the RH services were provided within primary-health care (PHC) clinics established and managed by other development agencies to cater for refugee and IDP populations. In an effort to increase access to RH services for women with restricted movements and women areas where it was not possible to establish static services, the CP deployed mobile RH teams, mobile gynaecological units and mobile delivery units. Furthermore, in the areas which had received large numbers of refugees and IDPs, the CP strengthened the capacity of government Maternity Hospitals through the provision of maternity equipment and furniture, medicines and health / non-health supplies, staff incentives (this includes providing incentives for junior / recently graduated midwives in a maternity hospital in one governorate).

During the field visits of the evaluation team, the team noticed that the structures of the RH sections or buildings were good, although some of the spaces were rather small. The team also noticed the availability of adequate supplies and tools for basic RH interventions, and that privacy was ensured. In a few locations, the follow up mechanism was good the targeted population were provided with the "Women Health Booklet" and follow up cards. The team also noticed that the visibility for UNFPA and donor was good in the RH spaces, ensured mainly through stickers and posters.

Regarding service delivery, in facilities beside the provision of RH services, the CP also supported SRH awareness raising sessions of targeted populations. This was provided mainly by medical doctors and also to some degree through women centres and community mobilizers. Beneficiaries interviewed by the evaluation team expressed their appreciation of the maternal health services received.

For some RH structures supported during the CP, particularly in the central/south area of the country, UNFPA promoted ownership by local authorities, which contributed to government commitment to taking over the structures.

In the area of coordination, CP achievements included the continuous contact by UNFPA with other health stakeholders and actors. Also, the CP established the RH working group - chaired by UNFPA - which contributed to better coordination among RH service providers during and after the Mosul operation and liberation.

Weaknesses and challenges

The CP Output "Increased capacity of Ministry of Health, and civil society organizations to deliver integrated quality reproductive health services that meet the needs of vulnerable populations especially those in humanitarian settings" suggests that the CP contributed to overall capacity building of health workers in government facilities on RH, which was not the case. The capacity building targeted mainly government staff working in the RH clinics managed by UNFPA, and even for them capacity building was limited.

Due to the security situation in Iraq, political/sectarian conflict and high level of corruption, it is highly challenging for any development agencies to undertake any meaningful system strengthening / building efforts. Furthermore, the health system in Iraq is more focussed on curative interventions and less on preventive care, which results in the government is not taking ownership of the preventive aspect of SRH programmes. These external challenges to the CP have likely contributed to a number of weaknesses in the programme implementation.

A weakness of the CP is the fact that not all the five output indicators of the CP results framework are adequately reflected in the programme implementation. The CP was mainly focussed on providing ante-natal and delivery services to IDP and refugee populations, and focussed much less on strengthening family planning services and use or adolescent friendly services, whereas these latter two interventions were included as output indicators in the CP results framework. Beneficiaries of RH facilities interviewed by the evaluation team did not seem to have received much orientation from the RH service providers about family planning.

Another weakness of the CP was the fact that the focus in the RH programme was mainly on preventive and curative interventions provided by facilities, whereas little focus was given to community outreach and to improving male engagement in RH. This is a missed opportunity since in Iraq is that the male populations are not receptive to family planning. Another missed opportunity is the low integration of RH programming with other CP components such as gender equality and GBV prevention and response, and youth programming. An example of this is the work on developing the CMR protocol, which logically should have been implemented under the CP RH programme. Due to RH programme funding constraints this work was undertaken with funding from the gender programme and also under coordination of the gender programme without apparently much input from the UNFPA RH team. As the gender programme does not have strong links with MoH, this resulted in UNFPA supporting the development and implementation of the CMR protocol without strong coordination with MoH, who should own it.

The evaluation team also found that none of the protocols, guidelines and policies on reproductive health planned in the two CPAPs were developed except for the initial work on the development of the Family Planning Strategy, which started in 2019.

In its 2018 annual report, UNFPA states that "among 112 health facilities supported by the agency, 40 were handed over to the government …. and government took responsibility for full support of those health facilities". However, the evaluation team did not manage to confirm the functionality of those handed over facilities. On the contrary, partners interviewed indicated that many RH facilities handed over to the government have since been closed or the quality of the services provided has deteriorated. Stakeholders stated that whenever UNFPA terminates its support, the facilities will either stop functioning or service quality will decline dramatically.

Durability of RH service provision in areas with high vulnerability of IDPs was not well ensured. The CP did not establish mechanisms with stakeholders to encourage them to take ownership of the services in preparation for handover to them. Thus UNFPA is not following guidance of the UN Humanitarian Response Plans which state that agencies would hand over field hospitals, mobile clinics and primary health centres in camps to health authorities through a pre-defined phase-out approach that includes support and capacity building. Facilities were handed over from one partner to another without good orientation to the new partners. It was also not clear to the evaluation team what were the criteria for UNFPA deciding which RH facilities should be closed first. It seems that some RH facilities are still being supported whereas they are located close to local towns or cities, whereas other RH facilities serving highly vulnerable or isolated populations have been closed. DoH staff interviewed in one governorate stated they have noticed a decrease in FP services provided in camps as after handover of the services to government the staff employed there no longer receives incentives to provide FP.

Another weakness of the CP is that institutional and human resource development efforts were limited. The programme only supported limited in-service capacity building on RH/FP provided to service providers. Thus, service providers in RH services supported by the programme depended mainly on their previous field experience rather than being provided by UNFPA and their partners with updated information and new techniques, protocols or guidelines. Another evaluation observation is that the CP criteria for providing staff incentives was not clear; all the physicians and midwives interviewed by the evaluation team received the same incentive regardless of workload. In Domiz 1 Refugee camp in Dohuk governorate, for example, where there are 403 pregnant women and more than 1,000 RH consultations and 25-30 births per month, the health providers are receiving the same incentives as staff working in less overloaded locations.

Stakeholders interviewed also reported that technical communication by UNFPA with IPs is not clear, with IPs not being well oriented or recipient of important messages. This has for example resulted in limited integration by IPs of UNFPA RH - Adolescent & Youth - GBV programming. Stakeholders also reported that communication is mainly taking one way, top-down approach; for example, UNFPA imposed the choice of sub-partner to IPs without adequate consultation.

UNFPA has not implemented a regular system for assessment of technical capacity and efficiency or undertaken initial needs assessments to identify service gaps as well as capacity gaps. The evaluation team also found that the CP has not undertaken any assessment of service use and the impact of the provided services on FP use and acceptability in community. This is again a missed opportunity as documentation of the impact of the RH and FP services supported in vulnerable communities at the scale at which UNFPA has done this in Iraq would be important to learn lessons for work in other areas in Iraq and in other countries. This fact might lead us to think that UNFPA planned its programme on assumption rather than on harmonized approach for assessing the needs, availability of resources, and the impact of its intervention.

During the field visits of the evaluation team, the team noticed that in almost all visited locations, there were shortages of the most needed RH medications and of IUDs. The team also noticed that some equipment donated by the CP to maternity hospitals did not display any stickers stated the donation by UNFPA or the donor. The team also learned from governorate health authorities that UNFPA did not always follow government procedures in donating equipment or supplies, as these were sometimes delivered by UNFPA directly to the government or partner health facilities without passing through the local DoH.

Although provision of RH supplies was crucial in a humanitarian setting while the country was going through a financial crisis, the management by the Country Programme of high value RH kits was inefficient. After the acute emergency situation decreased, UNFPA continued to provide various Reproductive Health kits of medicines and supplies to health facilities supported (most often via the governorate DoH), whereas much of the kits content is not considered by health facility managers as adapted to the country context. Therefore, many kit items were not used and were either returned to DoH medical stores or wasted. All managers of health facilities and DOH staff interviewed stated that they preferred receiving medicines and supplies from UNFPA based on forecasted needs instead of receiving kits, in order to avoid high expense and wastage of unused items. In addition, DoH and health facility management interviewed reported that several times UNFPA provided RH kits or other supplies (condoms) without DoH / facilities having requested them or being able to use the majority of the items provided. Sometimes items received by facilities were close to expiry date. A final weakness is that there has not been any monitoring on appropriate use of the provided RH kits.

In the area of coordination, stakeholders stated that competition over resources and leadership has increased levels of inter-agency competition and has negatively impacted RH coordination, especially among the UN-agencies, except for projects with co-sharing funding mechanisms. Also, during 6 months from late 2018 to early 2019 UNFPA had ceased to effectively coordinate the RH working group. Only when the Health Cluster coordinator raised this matter in the UNCT did UNFPA move to remedy this situation and resume active coordination of the RH working group. However, at the time of the evaluation the RH working had not yet been reactivated.

An external challenge to the CP is the fact that the protocol for Clinical Management of Rape (CMR) developed with support of UNFPA does not take into consideration the current legal context in Iraq.

EFFECTIVENESS

Q 3. b: To what extent did the UNFPA programme in Iraq ***achieve planned programme Outputs*** and ***is likely to contribute to programme outcomes*** in the area of "enhanced mitigation and response to gender based violence and harmful practices, with special focus on vulnerable women and girls in humanitarian settings."

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
Programme planned Outputs are likely to contribute to UNFPA Outcome in the area of women and girls' empowerment, and reproductive rights. Security situation in the targeted regions does not deteriorate any further...which might lead to increased needs. Government(s) in both regions is supportive of UNFPA approach to the	- Evidence of achieved Outputs. - Evidence of government(s)' cooperation in GBV. - Evidence of GBV services being provided in UNFPA supported centres. - Evidence of information dissemination and referral pathways.	- CPAP - AWPs - Progress reports - Annual reports - Monitoring reports - IP reports - Information packets and training modules	○ Document' review ○ KIIs with UNFPA programme staff. ○ KIIs with relevant IPs (Gov't and NGOs). ○ KIIs with relevant Gov't stakeholders and UN Agencies ○ KIIs with GBV centers' management and service staff ○ GBV beneficiary surveys

prevention and response to gender based violence and harmful practices UNFPA is able to reach the groups most in need.	- Evidence of service usage in target areas and service centres.		○ - Site visits / Observation

FINDINGS:

Strengths and achievements

According to the UNFPA Annual Reports over 2016, 2017 and 2018) , key achievements of the CP included:

- Reached around 1.5 million women, girls and community members with awareness raising on various topics including SRH and negative impact of GBV, Protection from Sexual Exploitation and Abuse (PSEA), and child marriage (2016-2018),
- Reached 223,414 vulnerable women and girls with dignity kits (2016-2018).
- Strengthened the GBV response capacity of police and legal institutions through building capacity of 250 security force members and 39 judges on case management and GBV core concept (2016-2018).
- Strengthened capacity of 12,799 services providers and GBV actors on GBV core concept, and GBV case management. (2016-2018).
- Established 108 static women safe spaces in camps and non-camps settings (December 2018).
- 140,293 women and girls subjected to violence were provided with case management services (initial services package) (2018).

The CP achievements are mostly in line with the CP Output "Strengthened capacity of government and civil society institutions to mitigate and respond to gender-based violence and harmful practices with a special focus on vulnerable women in humanitarian settings." There was some CP capacity building of government, although most of the capacity building focussed on civil society and amongst these mainly the organisations who were also implementing partners of UNFPA in Iraq. The focus was mainly on response to GBV, and to a lesser extent on GBV prevention with communities as a whole. The target group were in majority vulnerable women and girls in camp settings.

The Country Programme led / supported the development of national policy documents in coordination with KHCWA and other governmental institutes, such as:

- The amendment of the law for combating violence against women ,
- The National Strategy to Combat Violence against Women 2018-2030 in Iraq ,
- The National Strategy combating violence against women in Kurdistan Region (2017-2027) ,
- Kurdistan National Strategy for the development of women 2016-2026.
- Communication for Behavioural Impact (COMBI) plan on prevention of child marriage in Kurdistan ,
- Protocol and guideline for clinical management of rape (CMR) ,
- Standard Operating Procedures (SOP) for prevention and response to Gender-Based Violence: one SOP for South-Central Iraq and one SOP for Kurdistan ,
- Draft shelter bylaws for all women's shelters,
- Draft National strategy on Female Genital Mutilation (FGM) (to be finalized in 2019),
- Preparations for the next Iraq Women Integrated social and health survey I-WISH planned to be conducted in 2020.

One of the main achievements of the CP was the provision of GBV response services to survivors in humanitarian crises and in hard-to-reach areas, in many of which no GBV response capacity had existed previously. By Dec 2018 the CP had established 108 women safe spaces, with focus on IDPs / refugee settings and host communities where all initial services of case management (psycho-social support (PSS), case management, referral) were provided to survivors from gender-based violence.

The GBV survivor centre established in Dohuk with UNFPA support to provide comprehensive medical, mental health and psychosocial care, now serves as a model for replication in other governorates and has already been replicated in Amriyet al-Fallujah in Anbar governorate. In 2018 UNFPA also supported the Iraq government in the establishment of the first government women's shelter in Baghdad and in the preparation for the establishment of a shelter in Mosul. Discussions are currently ongoing with the Ministry of Labour and Social Affairs to duplicate this prototype across the country. UNFPA furthermore supports 4 additional shelters in Erbil, Sulaymaniyah and Germian in Kurdistan and a shelter in Baghdad, with funding from Canada and the European Regional Development and Protection Programme for the Middle East (RDPP). The CP built capacity of shelter staff in managing the women shelter (including orientations on the international legal framework on women's rights and gender equality, the shelter

objective, shelter, guiding principles and standard operating procedures) and facilitated exchange of experience between the shelters. Furthermore, UNFPA assisted in coordinating the drafting of the shelter bylaws for all Iraq shelters, as co-lead of the shelter working group.

As planned in the CPAP, the CP furthermore supported efforts to prevent GBV and other harmful practices by increasing public awareness on the detrimental effect on families and communities of practices such as GBV, Female Genital Mutilation (FGM), child marriage and honour killings. The CP supported the conducting of multiple awareness raising campaigns by IPs and staff of youth centres, women's centres and by Y-PEER volunteers. For this purpose, the CP developed and published a number of Behaviour Change Communication (BCC) materials. Awareness raising activities were organised in women's centres and through awareness raising training of health service providers, social workers and law enforcement personnel. The CP also supported the capacity development of implementing partners in GBV-case management, Implementation of CMR, Referral pathways, GBV-core concept, PSEA, and child case management.

Staff of several women's centres interviewed during the evaluation mentioned that Y-peer and Adolescent Girls sessions served as strong entrance points for reaching young beneficiaries and increase awareness on GBV and RH. In one IDP camp (Mamarashan) in Dohuk governorate, UNFPA supported an innovative way of community communication by supporting the establishment of a radio station. The station provided the camp management and other organizations operating inside the camp with a channel for directly communication to the camp community about distributions, announcement, and campaigns. Camp management and organisations active in the camp reported the radio station as very useful and lamented the fact that is was closed in early 2018 due to lack of funding.

During the field visit of the evaluation team, and interviews with survivors and direct beneficiaries, it was noted that the beneficiaries were very satisfied with the services provided inside the women spaces. Interviewees reported that the women spaces and the social workers helped to build the capacity of the beneficiaries and contributed in strengthening their auto-esteem and in developing skills and strengths which will serve them even after returning to their original places. IPs interviewed reported that the awareness raising activities had resulted in some men now accepting to attend awareness sessions on various topics and some men in Kurdistan and Anbar requesting psycho-social support for themselves.

Other indicators of the positive impact of the CP on the lives of beneficiaries include that speaking out about gender equality and GBV is now more accepted in the country. Cultural views on the role of women in the community also seems to be changing, which is evidenced by the increase in the proportion of women working outside of their homes and the increase in girls returning to schools.

Under the coordination by UNFPA, the GBV sub-cluster managed to conduct regular service mapping and to develop strong referral pathways for GBV cases among different actors, including government and civil society organisations. Furthermore, the CP supported DCVAW of the Kurdistan Regional Ministry of Interior to launch of the 119 telephone helpline, is a 24-hour call centre to provide confidential support and guidance to survivors of GBV. Callers will be connected with trained social workers as well as legal and psycho-social support counsellors, both female and male. UNFPA trained GDCVAW social workers and phone operators on the helpline procedures and guidelines.

In terms of capacity building, in addition of the training in GBV response of services providers, the CP contributed to strengthening the capacity of the main national institutions coordinating and overseeing work on gender equality, women's empowerment and the fight against GBV and violence against women. Thus, UNFPA supported the capacity building of central level women affairs institutions (the newly established central Women Empowerment Department, the Kurdistan HCWA and DCVAW in management areas such as project management and reporting, financial management and human resource management, and also through supporting the development of programmatic documents such as the internal bylaws. DCVAW were also supported through establishment of a data base on survivor data, report, complains, and case management data.

UNFPA supported advocacy with central and regional government on GBV, including through the commemoration of national days, for which the CP designed national unified themes and developed materials. The CP also supported a number of advocacy meetings, including a meeting with Iraqi Parliamentarians to advocate for women's rights.

Another important achievement of the CP is the strengthening of the coordination of the GBV response in the country, through UNFPA functioning as lead agency of the national gender base violence sub-cluster group, which served as coordination platform among GBV services providers, and through the establishment of GBV working groups, GBV case management working groups, the adolescent girls taskforce, and in 2019 the establishment of 2 shelter working groups, one for Kurdistan and one for the south-central part of the country. Thus, the GBV sub-cluster were able to develop different working groups in almost all Iraq provinces. Stakeholders interviewed found the national level GBV cluster and the governorate level working groups useful for information sharing, standardisation of norms and standards and service mapping. Through the sub-cluster, the CP also supported the development of a referral pathway and facility / service mapping, where all the actors are requested to regularly (monthly or quarterly) provide updates on referral pathways and services mapping.

In order to fulfil guidance from the UN Secretary General, and in line with coordination work undertaken within the GBV sub-cluster, the Iraq network for Protection from Sexual Exploitation and Abuse (PSEA) was established in July 2016 under the auspices of the Resident Coordinator (RC) / Humanitarian Coordinator (HC) with UNFPA as Lead and WHO as co-Lead in order to strengthen the prevention and response to SEA cases amongst humanitarian agencies. The network developed national BCC materials in 4 languages without agency logo and is working closely with the 119 helpline centre for receiving case complaints. The establishment of the network was combined with capacity building on PSEA supported by the CP through its local partners, to build capacity of government, UN agencies, civil society organisations and communities on PSEA, and ensure PSEA mainstreaming among all (humanitarian) coordination clusters. In 2018 UNHCR became co-lead of the network.

In terms of knowledge generation, UNFPA established the Gender Base Violence Information Management System (GBV-IMS), which was one of the targets of the CPAP for 2016-2017. This system for safe and ethical gender-based incident data management is managed by and within UNFPA and registers data from 15 UN and civil society organisations on all case of GBV cases reported in the country. The government is not part of this GBV-IMS system.

The CP has also conducted researches with support of local partners for data collection from the field. UNFPA, in partnership with the GBV sub-cluster and working groups members, conducted a Survivors' Assessment in order to identify the evolving needs of GBV survivors across Iraq. The report, published in 2019, includes a list of recommended actions, including policy action and capacity building of government and local partners, to ensure that survivors receive the care and support that they need and to strengthen the GBV multi-sectoral prevention and response in Iraq. At regional level, UNFPA and UNICEF are currently conducting a joint comprehensive research of child marriage, addressing quantitative data and also some qualitative analysis on factor affecting child marriages. This study conducted in Iraq and neighbouring countries will be finalized later in 2019. In Sulaymaniyah UNFPA is also conducting a GBV needs and service availability assessment, which is due to be published later in 2019.

Weaknesses and challenges

The CP did not focus on some aspects of the CP output "Strengthened capacity of government and civil society institutions to mitigate and respond to gender-based violence and harmful practices with a special focus on vulnerable women amongst men in humanitarian settings." The CP focussed on service provision, particularly GBV response services, and on awareness raising targeted to women and girls attending in-service sessions in the women's centres. The CP gave less attention to GBV prevention through awareness raising and behaviour change communication targeted towards the men and boys and the wider community, such as community leaders, religious leaders, youth clubs, sports clubs, etc. Also there was very limited focus on other harmful practices which are prevalent in Iraq, particularly amongst displaced populations, such as child marriage, honour killing, FGM, etc. A number of stakeholders interviewed questioned the impact on behaviour change of the awareness raising activities supported by the CP.

One of the weaknesses of the gender empowerment and women's equality programme in Iraq during 2016-2018 was that it focused nearly entirely on gender-based violence, and more specifically mainly on the response to GBV amongst IDPs and refugee populations through linking with women survivors and other women and girls in the community through women centres. UNFPA put little focus on and support for GBV prevention in the wider community in IDP / refugee sites (reaching out to men, community leaders and host communities) and on preventing other harmful practices, such as child marriage, FGM and honour killings. Particularly the subject of honour killing was hardly addressed in the CP.

The conservative community and cultural norms in Iraq represent considerable external challenges to working on promoting women's equality and empowerment and to raise awareness about the reproductive health and rights of young girls, about marital rape, child marriage etc. In such an environment, it is very important for the CP to reach out to men and boys and to community leaders in the awareness raising on GBV and harmful practices. However, interviews by the evaluation with stakeholders and beneficiaries indicate that the engagement of men and boys in the CP was weak and not very developed nor systematic. Some beneficiaries interviewed stated that their husbands threaten them that once the families return to their places of origin, the women will no longer be able to seek help of women spaces. Some camp managers mentioned that men and religious leaders approached them complaining that women spaces are destroying the culture and have a negative impact on women and girls. Lack of male and community-wide engagement hampers the effectiveness of the programme and limits the impact and sustainability of the awareness raising and empowerment of women and girls.

The lack of unified Behaviour Change Communication (IEC) materials represents another CP weakness. The evaluation team found no evidence of efforts by the CP to ensure consistency and minimum quality standards in the development of and use of BCC materials nor any efforts to ensure the maximum use of materials produced. Each implementing partner developed their own BBC materials, which resulted different partners using different materials with different BCC message contents on the same subject, such as the indoors awareness raising in the women centres or the community outreach. Also, once BCC materials were produced by one partner, there was no follow up by the UNFPA team to ensure that the materials were sufficiently disseminated by UNFPA and partners.

Stakeholders interviewed mentioned the lack of clear procedures between the UNFPA programme and the GBV sub-cluster regarding GBV case management for minors. A number of times, UNFPA Implementing Partners referred a minor case to GBV actors, but then the GBV actor returned the minor survivor to the UNFPA partner because of the survivor being a minor.

The evaluation team also noticed that whereas during the first years of the CP, dignity kits were used by UNFPA's partners as entry point for GBV awareness raising. Thus the women's centres distributed the dignity kits to women after attending awareness sessions, based on specific criteria. However later in the programme women's centres and partners started using dignity kits as part of emergency response to women and girls, given to any women or girl perceived as being in need of the content of the kit, independent on whether they had attended an awareness raising session. This was for example the case in April 2019 when UNFPA supported the distribution of 568 dignity kits through partners in the flood-affected areas of Diyala and Salahuddin, and in Sulaymaniyah in November 2017 where UNFPA deployed one gynaecology mobile clinic, distributed medicines and reproductive health kits as well as dignity kits to more than 500 women and girls in the Darbandixan area most affected by the earthquake, where maternity wards were damaged and are no longer operational.

The evaluation team learned that since early 2018 UNFPA has been terminating support to a number of initiatives previously funded through the gender programme, such as women's centres in various locations and the community radio station in one IDP camp. Staff of the Fallujah survivor centre reported that the reduction by the CP of support to the centre has resulted in the social worker staff being reduced from two to one, with the only worker remaining a women, which hampers the centres capacity to adequate manage male survivors.

UNFPA has reportedly initiated dialogue with government on handing over a number of women's spaces to local government authorities. However, government reportedly has so far not accepted to take over responsibility for the centres due to lack of resources and staff and lack of staff capacity. This may result in UNFPA closing additional women's centres without ensuring a responsible transition for these important structures. Partners interviewed by the evaluation team stated that during the various cluster coordination meetings UNFPA generally only shared information on their intention to close or handover women's centres or the radio station after UNFPA had taken the closure / handover decision and generally only very shortly before the closure or handover (e.g. one week in advance). This lack of lengthy handover preparation and timely consultation with partners is a missed opportunity as other partners may have resources available or be able to help in preventing many women spaces to be closed. The final decisions or specific dates for closing were also not communicated with the relevant implementing partners in time, which also caused considerable uncertainly for the implementing partners and their employees.

According to the CPAP 2016-2017 and CPAP 2018-2019 , UNFPA planned to support the integration of RH/GBV and mental health services at health facilities to include mental health support for SGBV cases (staff training, developing protocols, and educational materials). However, during the field visits of the evaluation team, this integration seemed poor. Many partners, stakeholders, and also beneficiaries interviewed identified the lack of mental health services as an important gap.

As part of the integration of GBV and RH, the Clinical Management of Rape (CMR) protocol was developed by UN agencies with partners and endorsed by government. However, the challenges here are in the implementation of the protocol, as some elements of the protocol are not in line with the current law in Iraq, for ex. on mandatory reporting of rape cases. Also the CP has always not been effective in making sure that the right health service providers were trained in the use of the CMP protocol. Instead, UNFPA left it up to DOH and health facility managers to identify the individuals to be trained, which resulted in person being sent to the trainings who are not always the ones who receive the survivors or who directly manage the cases in the health facilities and hospitals. The evaluation team learned that other UN agencies and partners communicate more clearly with health authorities on the type of individuals who should be targeted for trainings, and thus are more effective in ensuring that only these and not others benefit from the specific trainings.

Another CP weakness is that the current GBV-IMS system is managed by UNFPA in a parallel way without clear links with or inclusion of government, which should manage or at least own it. Also, not all partners of UNFPA or partners active in the area of GBV are members of the system. Also at the same time, the CP is supporting government in the development of a separate database which is not part of the GBV-IMS. Furthermore, the GBV-IMS has been used more as a data storing mechanism rather than being used for data analysis, and analytical results were not always shared with partners. The evaluation team also found that some of the GBV-IMS members were reporting to the database without having a clear understanding of the purpose of the database, and final destination of their shared data. A general challenge in the field of GBV case reporting is that the majority of GBV cases in the country go unreported.

Women's centre staff interviewed reported that it was a challenge for the programme that the centres do not have resources to organise or facilitate livelihood support or follow-up on livelihood capacity building for the centre's clients.

Staff of some women's centres also stated that they reported that they did not receive any monitoring visits from DoLSA.
The legal environment in Iraq still represents an important external challenge for the promotion of gender equality. The Iraq constitution and laws still allow and condone practices such as marital rape, child marriage, polygamy, etc.).

EFFECTIVENESS

Q 3. c: To what extent did the UNFPA programme in Iraq **achieve planned programme Outputs** and is likely to contribute to programme outcomes in the area of "improved outreach to vulnerable young people with programmes on reproductive health, social cohesion and civic engagement."

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA interventions with vulnerable youth is likely to result in enhanced mobilization and engagement of youth within communities. Government(s) in both regions is supportive of youth rights and inclusion within national plans. Outreach to youth includes support for their future engagement within communities.	- Evidence of achieved Outputs. - Evidence of functional youth centres - Evidence of government(s)' policies for youth development. - ToT youth trainers and trainees. - Youth networks - Training packets.	- CPAP - AWPs - Progress reports - Annual reports - Monitoring reports - IP reports - ToT and training modules - Youth - Youth national policies	○ Document' review ○ KIIs with UNFPA programme staff. ○ KIIs with relevant IPs (Gov't and NGOs). ○ KIIs with relevant Gov't stakeholders ○ KIIs with youth centers' management and staff ○ FGDs with trained youths ○ Site visits / Observation

FINDINGS:

Strengths and achievements

According to the UNFPA Annual Reports over 2016, 2017 and 2018) , the main achievements of the CP included:

- Strengthened youth awareness of 278,858 boys and girls from IDP and refugee populations about child and forced marriage, youth communication, STDs, SRH, peace building and other youth-related topics, through indoor awareness activities and 123,969 youth through outreach activities (2016, 2017, 2018),
- Supported capacity building of 12,763 youth on vocational skills (2017).
- Provided technical support to Ministry of Planning - Central Statistics Office and Kurdistan Region Statistics Office - in designing and preparing for a National Adolescent and Youth Survey that will cover 11,850 households and 54,000 adolescents and young girls and boys aged 10-30 years (2018).
- Supported the establishment of two Youth Advisory Boards in Najaf and Diyala Governorates in collaboration with the Ministry of Youth and Sports (2018).

The CP achievements are partially in line with the CP Output "Enhanced capacity of national government and civil society organizations to design and implement programmes on reproductive health, social cohesion and civic engagement for vulnerable young people, with special focus on marginalized adolescent girls in humanitarian settings." There was limited capacity building of civil society organisations, focussing on the organisations who were the implementing partners of UNFPA in Iraq. The target group were in majority adolescent girls and boys in camp settings, with no visible focus on vulnerable young people.

The Country Programme led / supported the development of national policy documents in cooperation with government and partners:

- Revised, finalized and launched the National Youth Strategy for 2016-2026 with its associated 5-year action plan for youth and sports 2018-2022,
- Developed the national youth volunteer strategy (ADD FULL TITLE, YEAR AND PUBLISHING INSTITUTION),
- Developed and rolled out Adolescent Girls toolkit together with UNICEF,
- Supported preparations for the National Adolescent and Youth Survey.

During the humanitarian crisis in 2016-2017, the main focus of the youth programme was on supporting life skills training and awareness raising of adolescents and young persons on SRH, GBV and other harmful practices such as child marriage and forced marriage. For this purpose, the CP supported the establishment of 19 youth centres managed by civil society IPs in refugee and IDP camps in Kurdistan and supported youth centres in host populations in the north and south-central parts of the country. In

order to increase the access of young people to youth centres and spaces managed by MoLSA, the CP supported the rehabilitation of some government buildings in south-central, and supported government to conduct youth awareness sessions in the north.

UNFPA supported life-skills based education through MoLSA and civil society IPs in schools, universities and youth spaces. In south-central, rather than establishing specific youth centres, the programme used women spaces managed by UNFPA IPs to reach adolescent girls for awareness raising on SRH and GBV, and for GBV response programming. The programme also supported some vocational skills training. UNFPA also co-funded the establishment of an arts centre adjacent to the youth centre in Domiz 1 refugee camp, where children, adolescents and young people can undertake arts and music activities.

UNFPA also supported awareness raising of adolescents and young people through the Y-PEER network, established by UNFPA in 2009. The CP supported Y-PEER activities in all 18 governorates in the country implemented by Y-PEER volunteers. Activities included awareness raising of young persons about health and SRH, GBV prevention, life skills, participation in social changes and civic engagement. Methods used included individual peer education sessions, interactive theatre, online campaigns, attending sport events, meetings and public events, and advocacy with decision makers. Y-PEER volunteers are male and female, and targeted both female and male adolescents and young persons, thus strengthening male engagement. Some IPs supported the establishment of local Y-Peer networks, such as in Dohuk through Harikar. Whereas the CP did not allocate much funding for supporting Y-PEER activities, UNFPA staff in the south-central actively supported efforts by Y-PEER to mobilise resources from other partners.

The CP has increasingly supported work to strengthen Youth Peace & Security: it supported the training of 4.000 youth in Central-South on reconciliation and negotiation skills, with financial support from the German government. This included training youth leaders in transformational leadership, to prepare them to lead trust-building activities in their own communities to overcome conflict and foster social cohesion and resilience as part of Iraq's recovery and development effort. This programme is to be expanded to Kurdistan in 2019.

Adolescents and young people beneficiaries interviewed by the evaluation team reported high satisfaction with the services they had received, including awareness raising and life-skill education. They also reported that they had been empowered by the information received and their participation in the activities, and this had a positive impact on their status in their homes and communities. For example, they now understood that they have a right to go to school and not to marry young; that they should not accept sexual harassment; that they have the power to participate in their communities to support young adolescent girls and their partners; the power to express their opinion and to report on SGBV issues, etc. Adolescents interviewed reported that attendance of the youth centres has impacted their lives as they gained positive energy and had opportunities to express themselves, and discuss their issues about home and school; that some of them were had developed their skills in areas such as music, painting and handicraft and others had benefited from vocational training. Young adolescent girls also reported that whereas previously they thought it was preferable to marry at a young age, they had changed their minds and since then decided to focus on finishing school. Some girls also reported that since having attended the youth centres, their families and the camp community has become more accepting of them moving about in the camp without being accompanied by adults and without them being harassed by men and boys.

The evaluation team was impressed with the youth centres visited in a number of IDP and refugee camps, and can see that they are a useful way to work with adolescents and youth and make a real difference in the lives of adolescents and youth living in the camp areas who have been through so much in the past years.

One of the main tools used for the awareness raising of adolescents on SRH was the Adolescent Girls toolkit. Many stakeholders interviewed mentioned the development and roll-out of the Adolescent Girls Tools kit as a major achievement of the UNFPA youth programme. This toolkit – in Arabic, Kurdish and English - was developed jointly with UNICEF with funding from Norway. It provides tools for teaching SHR and life skills to adolescent girls, as well as tools for teachers. The toolkit contributed to unifying approaches between UNICEF, UNFPA and other partners and standardise tools used by government and its partners in Iraq when working with adolescent girls. There is international interest in the toolkit which partners in other countries reportedly interested in using the kit in their countries.

The CP supported the roll-out of the Adolescent Gils toolkit by strengthening the capacity of service providers working with youth, such as youth workers, NGOs, and government entities in the use of the Adolescent Girls toolkit. The toolkit had special sessions for parents (mothers) which contributed to closing the gap between young girls and mothers, and helped them to build better relations, which also changed the mothers' view on child marriage, girls' empowerment, and on the importance of communication with young girls.

Since the arrival of the international youth specialist, the UNFPA youth team is focussing on developing a coherent youth programme, with focus on supporting life skills training, youth participation and knowledge generation, while strengthening cooperation and advocacy with central and regional authorities on youth issues and to develop a national youth agenda. UNFPA supported the secondment of youth advisors to 4 governorates. The establishment of the two Youth Advisory Boards in two governorates in

Central-South is also an effort to promote youth participation and empowerment. The board members consist of young persons who will advise government on youth programming needs, policy development and on needs for resource allocations in government annual plans.

The CP has also been working with the central Ministry of Youth and Sports on the introduction of Civic Values and Life Skills (CVLS) Education within the education system in a systematic and sustainable manner, to allow for a better preparation of youths' future. The CP focussed on strengthening the institutional and staff capacities of the Ministries of Education (MOE), MOLSA and MoY to deliver quality formal and non-formal education through the promotion of CVLS and to integrate CVLS education in the Vocational Training Centres (VTC) operating under MOLSA and the Vocational Education Schools (VES) of MoE.

In the absence of a youth cluster or youth working group in the country, youth coordination has been conducted through the adolescent girl task force, which was established by UNFPA and UNICEF in May 2016. To coordinate the development of the Adolescent Girls Toolkit. Development partners are currently considering to establish a large adolescents and youth working group which would also cover adolescent boys and young people of both sexes.

In terms of knowledge management, UNFPA is coordinating and supporting the Adolescent and Youth Survey, which is currently being conducted by the federal government and the Kurdistan Regional Government through the Central Statistics Organisation and the Kurdistan Regional Statistics Organisation, in consultation with ministries such as MoLSA and the Ministry of Youth and Culture. Data collection is currently on-going and results are expected to come out later this year. The youth survey is expected to provide important data for evidence-based programming for adolescents and youth in the country and is also being used as a tool for UNFPA and partners to advocate with government on the importance of taking into considerations the needs of adolescents and youth in the development of the country.

Weaknesses and challenges

In spite of the CP Output being defined as "Enhanced capacity of national government and civil society organizations to design and implement programmes on reproductive health, social cohesion and civic engagement for vulnerable young people, with special focus on marginalized adolescent girls in humanitarian settings", there was no capacity building of government on designing or implementing youth programmes. The CP capacity building of civil society organisations on the management and implementation of youth centres in humanitarian settings was limited to the organisations implementing the youth centres funded by UNFPA. The evaluation team could find no evidence on focus on marginalised adolescent girls. Programming focused mainly on SRH and life-skills education, with little emphasis on social cohesion and civil engagement.

During first years of the current CP which corresponded with the period of humanitarian crisis in Iraq, UNFPA prioritized programming and fundraising for RH and GBV service delivery. As a consequence, UNFPA dedicated less focus and resources to Adolescent & Youth programming during that time. Little donor support was received for youth programming, and the youth programme activities that took place during these initial years were mainly funded from GBV and RH funding. The fact that the UNFPA Country Office lacked an international youth specialist during 2016-2017 maybe both a consequence of and a contributing factor to this situation.

UNFPA staff interviewed stated that the fact that donors were less interested in youth programming during the humanitarian response, contributed to the lesser focus by UNFPA on this area of the UNFPA mandate. However, if the UNFPA programme areas had worked in a more integrated fashion, the UNFPA team and their IPs would have made sure that youth programming was always linked to or integrated into any programme intervention and into any funding proposal submitted to donors. There was no reason not to focus on adolescents and young people within the RH programme and within the GBV response activities.

The lack of UNFPA youth programme staff, programmatic leadership and adequate funding affected the quality and quantity of the CP youth programming. During the first years of this CP, the UNFPA Youth programme was mainly implemented through small project activities focussing on service provision and was not a coherent programme with a vision. During 2016-2018 the CP engagement with government on youth issues was very limited, and consequently the CP was not able to increase the policy priority on adolescents, especially on very young adolescent girls, in national development policies and programmes.

The evaluation team observed that engagement by UNFPA with the Kurdish Ministry of Youth was minimal, which is surprising in view of the fact that the Country Programme Action Plans state that the Ministry of Youth "will coordinate adolescent and youth programmes". Another weakness is that the focus within the Adolescent & Girls Task Force is mostly on GBV prevention & response, rather than on other aspects affecting Adolescents and Girls, such as SRH and life skills, empowerment, etc.

The capacity of line Ministries charged with youth programming is still weak in programme management, financial management and understanding of and application of internationals standards. Over the past years, UNFPA and other UN agencies have focussed their cooperation and coordination mainly on one government authority, namely the Ministry of Labour and Social Affairs. In Kurdistan, UNFPA only started engaging with the Regional Ministry of Youth and Culture in early 2019 on the Adolescent and Youth Survey.

There are no clear coordination mechanisms in the country for adolescent and youth programming. Within the UN coordination system, several clusters touch upon youth activities, including the RH working group, the protection cluster (with sub-clusters for child protection and for youth protection, the education cluster, etc.). Consequently, there is little coherence between the various IPs implementing activities targeting adolescents and youth in the IDP and refugee camps.

Involvement of relevant government authorities in the coordination and management of youth centres managed by IPs in camp settings is minimal. An exception to this Dohuk governorate, where - as an exit strategy and development mechanism – UNFPA and its IP Harikar decided to place Department of Youth (DoY) focal points in youth centres.

Recently, the CP has started to close a number of youth centres previously supported by UNFPA. The evaluation team could not find evidence that the closure decisions were based on criteria of vulnerability, as some youth centres in camps located close to larger population centres have remained open, whereas others youth centres in in camps in more remote locations were closed. The opening hours of youth centres visited (only open until 3.00 p.m.) do not seem to facilitate the access of adolescents and youth on school days.

Stakeholders interviewed questioned the capacity of the IPs used in the CP, particularly to work with youth in challenging settings (e.g. ultra-conservative communities) and suggested that the CP should allocate additional focus on this area. In terms of the content of awareness raising with youth, stakeholders interviewed expressed the view that young people are now less interested in participating in sessions on SRH, and give priority to learning skills which they can use to obtain or create work.

The CP youth programme was mainly implemented through a number of international NGOs and MoLSA, whereas the Y-PEER network was not much used, in spite of 1 out of 3 CP output indicators focussing on working with and through Y-PEER. UNFPA programme staff from all programme areas seemed not know about the usefulness of Y-PEER network for reaching adolescents and young people and consequently, the Y-PEER network has been under-used in this CP. This is a lost opportunity: not only would implementing through Y-PEER provide an opportunity to strengthen this national youth network established by UNFPA, but supporting Y-PEER activities also contributes to ensuring their continuity and sustainability by increasing their ability to retain key staff and capacity. It is also a lost opportunity in that working through Y-PEER is a cheap and sustainable medium for peer education and community awareness campaigns, compared to working through a national or international NGO.

As a consequence of the limited funding which Y-PEER has obtained so far for supporting its activities in Iraq, the network has had to make an even greater appeal on the voluntarism of its members, not only to give their time for free to conducting Y-PEER activities but also to pay out of their own pocket for expenses such as transport, hospitality, etc. This has also resulted in the Y-PEER carrying out their activities mainly in / around major cities and not being able to reach more remote areas and populations, and in no training of new peer educations having taken place for 2 years now, which will result in attrition of Y-PEER volunteers. It was also suggested to the evaluation team that not all UNFPA programme staff was equally supportive in facilitating and supporting Y-PEER's application to other partners for funding opportunities.

External challenges affecting the implementation of the CP, is the fact that the Iraqi Government does not allocate adequate budgets for adolescent and youth programming and has not yet started to implement the National Youth Strategy. Another challenge is the considerable variation in level of government support to youth centres between regions and districts in the country.

EFFECTIVENESS

Q 3. d: To what extent did the UNFPA programme in Iraq ***achieve planned programme Outputs*** and ***is likely to contribute to programme outcomes*** in the area of "increased national capacity for the production of quality disaggregated data to inform policies and programmes."

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA technical assistance to national governments is likely to result in policies and plans informed and supported by relevant research in population dynamics and areas within the UNFPA mandate. Interest in population dynamics and national planning is effective within a humanitarian country context.	Evidence of technical support for research planning Evidence of government(s) interest and cooperation National plans in UNFPA mandate areas	- AWPs - Progress reports - Annual reports - Monitoring reports - IP reports - Research plans - Relevant government stakeholders - UN research reports (MICS…)	○ Document' review ○ KIIs with UNFPA programme staff. ○ KIIs with relevant Gov't ministries and directorates.

Security concerns impeded research in high risk areas.			

FINDINGS:

Strengths and achievements

According to the UNFPA Annual Reports over 2016, 2017 and 2018) , the main achievements of the CP included:

- Facilitation of Iraqi government delegations to attend a number of international meetings and conferences (2016),
- Facilitation of 4 humanitarian crisis assessments conducted by government which reflect SRH, GBV and youth issues (2016),
- Assistance to the UN system to profile IDPS, refugees and host communities in Kurdistan ensuring reflection of GBV and RH issues (2016),
- Support to a survey integrating indicators on youth in conflict, GBV and FGM in Kurdistan (2016),
- Support to a demographic survey in Kurdistan (2017),
- Support to preparations for the National Adolescent and Youth Survey (2019),
- Support to preparations for the National Population and Housing Survey (2018 and 2019) planned to take place in 2020,

The CP achievements are somewhat in line with the CP Output "Increased national capacity for the production and dissemination of quality disaggregated data to inform policies and programmes and to promote the integration of population dimensions in development planning." The CP supported some limited capacity building of the CSO and KRSO, mainly in teaching techniques through Training of Trainers courses in preparation for the Youth Survey.

The Country Programme led / supported the development of national policy documents in cooperation with government and partners:

- National Adolescent and Youth Survey (ongoing in 2019),

Amongst the CP achievements is the support provided to the preparations for the National Adolescent and Youth Survey, which is currently being conducted by CSO and KRSO. Preparations included consultation by UNFPA with various national and regional Ministries and partners on the survey content, target group, indicators etc. and funding of training of 200 enumerators on data collection. The CP also supported preparations for the second Iraq Women Integrated Social and Health Survey (I-WISH) which was initially planned for 2016 but delayed due to lack of funding. The I-WISH will include a module on costing the GBV response.

Under leadership of the Prime Minister, the Federal and Regional Governments commenced preparations for National Housing & Population Census planned to take place in 2020. National commitment to the census is high: since early the start of 2019 the federal government has issued a ministerial decree in early 2019 on the organisation of the census, established a Supreme Council for Population to oversee the exercise, and allocated USD 40 million from the State budget to contribute to funding the census. UNFPA is providing technical assistance to the government in conducting the census to ensure that the latest electronic technologies are used to allow for speedy data entry and analysis. In June 2019, UNFPA supported a study tour of Iraqi government officials to Egypt to learn about the recent electronic census ("e-census") conducted there in 2017, using new technologies such as census mapping.

The CP cooperated closely with IOM to support KRSO in conducting the Kurdistan Demographic Survey in 2017. The survey was useful in providing demographic data on the inhabitants of Kurdistan, and innovative in that it documented the population's disability status.

The CP also supported some capacity of a limited number of officials from CSO, KRSO and the Ministry of Planning in use and analysis of population data, and supported them to attend courses and seminars abroad, such meetings on Demographic Dividend and the tracking of the ICPD-related SDGs.

UNFPA CO staff made some efforts to integrate population issues into national and regional policies. However, the NDP 2018-2020 does not address any issues of population dynamics and demographic dividend, and the NDP objectives do not include the promotion of SRH and family planning.

Working relationships between the CSO and KRSO are reportedly excellent, which facilitated the organisation of large data collection initiatives.

Weaknesses and challenges

The main focus of the CP Output "Increased national capacity for the production and dissemination of quality disaggregated data to inform policies and programmes and to promote the integration of population dimensions in development planning" was not achieved as the CP supported very little capacity strengthening for the production and dissemination of data, nor did UNFPA and its IPs produced much data during the CP period.

It is clear that UNFPA Iraq and HQ did not see the area of population and development as priority during the first three programme years 2016-2018, when all the focus was on supporting RH and GBV responses to populations affected by humanitarian crisis.

Allocation of funding and staff to UNFPA population dynamics programme area was very limited and was further cut as government and donors shifted funding to the humanitarian response. As a result, in 2016 UNFPA had to cancel supporting a few south-to-south initiatives which government had valued, which caused discontent amongst government partners. The only surveys that took place were those funding through other programme areas.

Stakeholders interviewed mentioned the weakness of the UNFPA CO in consulting partners before taking decisions on the subject of capacity strengthening efforts. Thus, UNFPA decided that CSO and KRSO staff would be receive a Training of Trainers course, whereas the national partners would have preferred for their staff to be trained in data entry and analysis.

Government and partner staff interviewed also question the desirability of conducting an expensive survey such as I-WISH-2 costing USD 700,000, whereas a similar population survey - MICS - was conducted in 2018 and resources required to conduct the important Population & Housing census planned for 2020 have not yet all been mobilised.

A major weakness of the CP identified by the evaluation team is the insufficient data analysis and documentation of best practices by UNFPA and partners in all programme areas.

The CP was affected by many external challenges. Over the past years, there was little commitment of government to conducting a population census and other large surveys. This has now thankfully changed. A major challenge in Iraq is the absence of reliable data at central, regional and district levels on population and the demographic dividend, in combination with a lack of demographers and specialists in large surveys, and a lack in capacity in data analysis. Any data generated in Iraq during the emergency phase of the past years has mainly come from development agencies and civil society.

In addition, the political instability has made it difficult to reach agreement on conducting nation-wide surveys, whereas access to some geographic areas is restricted for security reasons, which makes hampers conducting surveys there.

EFFECTIVENESS

Q 3. e: To what extent did the UNFPA programme in Iraq ***achieve planned programme Outputs*** and ***is likely to contribute to programme outcomes*** in the area of "Enhanced capacity of government and civil society organizations to design programmes and deliver quality services that meet the needs of vulnerable populations."

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA support to implementing partners – government and NGOs- is likely to result in improved capacity and enhanced quality of services. UNFPA programme extended direct and indirect capacity building to partners Capacity was institutionalized within partners' operations and integrated	- Evidence of formal and informal trainings provided - application of technical, financial and project management trainings. - Improved performance of IPs - Improved quality of services in RH, GBV and youth centers - Training materials	- Annual reports - Monitoring reports - Implementing partners	○ Document' review ○ KIIs with UNFPA programme staff. ○ KIIs with relevant IPs (Gov't and NGOs). ○ KIIs with management and trained staff of RH, GBV and youth centers ○ Site visits / Observation

FINDINGS:

Capacity development was one of the programme delivery mechanisms defined in the CP. IN the implementation, the CP put emphasis on individual capacity building of service providers, such as health workers and women centre staff, and to some degree of decision makers and policy makers at governorate, regional and central level. The CP contributed to systems strengthening through procurement of equipment and supplies, and to a lesser degree to development of internal policies, procedures and tools. The enabling environment was strengthened through contribution by the CP to some national strategies and policies and legislative frameworks.

IP capacity building focussed on strengthening programme management, monitoring and reporting skills of staff, and to a lesser extent on strengthening technical capacity. Some exceptions here included the capacity building on the application of the CMR protocol and on the use of the GBV Standard Operating Procedures. South-south cooperation (experience exchange visits to other countries in the region or other parts of the world outside of the West; bringing expertise from other countries) when it occurred was much appreciated by Iraqi partners, but at times was cancelled during lack of funding.

From 2017 onwards, Humanitarian Response Plans state that agencies would hand over field hospitals, mobile clinics and primary health centres in camps to health authorities through a pre-defined phase-out approach that includes support and capacity building. The evaluation team however found no evidence of such a phased handover approach with consistent capacity building by the CP of governorate DOHs and local authorities to prepare them for taking over RH facilities in camps or for organising outreach to

camp sites from government facilities in host communities. Similarly, there was no system for capacity building of and adequate handover to civil society organisations and other counterparts to prepare them in advance for handover of CP interventions.

The evaluation team observed that in most cases there was no adequate planning for responsible transition and handover to counterparts or local institutions. Stakeholders interviewed expressed the opinion that the CP did not apply adequate planning for responsible transition and handover to counterparts or local institutions. Capacity strengthening efforts supported by the CP were mostly conducted on an ad-hoc basis instead of through a coherent systematic approach using an institutional development plan.

Furthermore, resources allocated in the CP to capacity building of IPs were insufficient. This was a particular challenge when IPs such as TAJDID and QANDIL were requested to sub-contract smaller local NGOs or CBOs. Also, when government staff was invited to participate in training, UNFPA often did not provide or impose guidelines on which staff should be targeted for the training. As a result, at times, the same managerial staff tended to participate in trainings instead of the service providers targeted. This was for example reportedly the case for the training of health workers on the CMR protocol.

EFFECTIVENESS

Q 4: What is the main UNFPA **added value** in the country context as perceived by national stakeholders?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA comparative strength is contributing value added to national stakeholders National government(s) are interested in investing UNFPA value added in humanitarian and development contexts	- Commitment of government and IPs to implement UNFPA programmes and achieve its mandate - Increased handover of UNFPA supported centres to government institutions.	- Annual reports - Monitoring reports - Implementing partners - Government(s) stakeholders	○ Document' review ○ KIIs with UNFPA programme staff. ○ KIIs with relevant IPs (Gov't and NGOs). ○ KIIs with relevant government(s) stakeholders ○ Site visits / Observation

FINDINGS:

National stakeholders interviewed know UNFPA's technical mandate in the area of reproductive health, gender and the fight against harmful practices. They appreciate UNFPA's technical and programmatic expertise and the technical support provided by the CP to partners in these areas. Some also recognised that until recently UNFPA was one of the few agencies advocating for adolescents and youth.

UNFPA as a UN agency should have the focus and capacity to continue to advocate on the areas in its mandate so that national policies and strategies are revised where required. The CO should also work with government to build capacity in its mandate areas.

Since a few years, more UN agencies and partners have started to implement programmes on gender-based violence response and prevention and on adolescent and youth health programming. Some UN agencies such as UNICEF have created units in their HQ and in field offices for GBV and adolescent development programming. It is therefore crucial that the UNFPA CO reflects on and continues to demonstrate on its comparative advantage compared to these other agencies, while maintaining an inclusive approach to the coordination of these areas.

Over the past decades and until recently, UNFPA Country Programmes largely focussed on working in development contexts by supporting programmes through advocacy and policy development, capacity strengthening and knowledge generation at upstream level, in combination with supporting some piloting of service delivery approaches at peripheral level. However, since a few years, including following the crisis in Syria and Syrian refugees moving to various neighbouring countries, UNFPA has started moving into front-line service delivery in humanitarian settings, an area which is not traditionally a strength of UNFPA and for which UNFPA did not have the capacity in terms of human resources, procurement procedures and operational procedures, unlike other UN agencies such as UNHCR and UNICEF.

UNFPA has now recognised humanitarian interventions as an important way to ensure essential service provision to vulnerable populations and also as a way to mobilise resources from external sources. UNFPA has established a Humanitarian Department at HQ, recruited Humanitarian Advisers to Regional Offices and established regional humanitarian hubs in locations such as Amman and Nairobi. A humanitarian dashboard has now been added to the UNFPA website, which "highlights the needs of women, girls and young people in humanitarian settings, and reveals how UNFPA is mobilizing to meet these needs." The dashboard can be searched by country.

If UNFPA wishes to continue down this path, it needs to ensure that it further strengthens its capacity to ensure quality humanitarian interventions while at the same time ensuring a strong link with resilience building and post-conflict programming. This will include development of standard operating procedures for humanitarian interventions and training all UNFPA and IP staff in using them.

Gender Equality and Human Rights Principles

Q 5: To what extent did the implementation of the UNFPA programme in Iraq **take into account gender equality and human rights principles**?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA programme design and implementation integrates gender equality and human rights principles. UNFPA monitoring of IPs includes requirements for application of gender equality and human rights principles	- Evidence of UNFPA and IPs commitment and application of gender equality and human rights principles in the implementation of programme interventions. - Evidence of services to target populations which are gender responsive	- Implementing partners - UNFPA staff	○ Document review ○ KIIs with UNFPA staff ○ KIIs with implementing partners (Gov't and NGOs) ○ KIIs with centres' management and staff ○ Site visits / observation

FINDINGS:

Gender equality

All UNFPA programme activities in Iraq have a direct link to women and girls as they focus on reproductive health and family planning, GBV and other harmful practices and on population interventions, which are supposed to improve the health status of girls and women, decrease early marriage, early pregnancies and school drop-outs amongst girls, decrease violence against women and girls and thus all contribute to increasing girls' and women's empowerment and participation, which contributes to gender equality. To some degree, the CP also worked with the central and regional authorities to strengthen capacity of institutions spearheading efforts to further women's empowerment and gender equality in Iraq and contributed to developing national policy documents to this effect.

Human Rights

By supporting the provision of SRH services to vulnerable women in the country and the strengthening of quality SRH services to vulnerable and marginalised populations, the CP supported the rights-based approach of universal access to primary health care and safe deliveries. Similarly, by supporting the provision of GBV and youth interventions for vulnerable and marginalised populations, the CP contributed to the right of populations to access such services. UNFPA Iraq has furthermore supported the Government to review, document and report on various human rights related commitments.

So far the CP has not yet included disability into its programming, unlike other UN agencies, such as for example IOM, who have developed a disability inclusion strategy.

EFFICIENCY

Q 6: To what extent was UNFPA **efficient in mobilizing resources** –human, financial and technical- and securing partnerships for a timely response to the emergent humanitarian needs?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA resource mobilization has leveraged appropriate resources to support implementation of country programme document. UNFPA was effective in mobilizing human and technical resources to address emergency needs.	- Resource mobilization strategy - Leveraged resources appropriate to planned programme outputs - Evidence of effective implementation of programme plans	- UNFPA (including finance / administrative departments) - UNFPA CO staff - Financial records - Annual reports	○ Document review including financial records ○ Interview with UNFPA staff

FINDINGS:

In terms of the content of the supported interventions, the Country Programme is considered to provide "Value for Money". Through the strengthening of provision of sexual and reproductive health services and GBV response services to vulnerable populations in Iraq and through the promotion of family planning, UNFPA contributed to reducing maternal mortality and morbidity, decreasing fertility and increasing contraceptive coverage, and decreasing psychosocial trauma of GBV survivors. The programme also contributed to some extent to increasing the coverage of family planning amongst IDPs and refugees.

It is not possible to calculate the exact Value for Money of the programme results, because the CP Results Framework does not include any cost-effectiveness indicator, such as the cost per Couple Years Protection or beneficiary satisfaction of the provided support.

It is however possible to estimate some aspects of cost-effectiveness of the Country Programme using the criteria known as the 4 "E-s": economy, efficiency, effectiveness and equity.

Economy

The programme contributed to economies of scale through its involvement in the international procurement by UNFPA of reproductive health products (including contraceptives), thus contributing to achieving low prices for reproductive health products in conformity with UNFPA quality standards.

However, most of the contraceptives and reproductive health supplies provided to health facilities were provided in the shape of UNFPA kits. Health facilities and health authorities were only able to a part of the kit items, which represents a considerable inefficiency for the programme. DoH were also not able to fully use some other ad-hoc donations made by UNFPA which resulted in inefficiency.

Efficiency

Funds:

The government and UNFPA have so far managed to implement the programme for the budgeted costs in the work plan. Efforts were also made to economize programme costs by holding meetings and workshops in existing agency premises, and by compacting the number of meeting days and increase use of remote meeting technology (video calls). The use of field coordinators enabled CP access to hard-to-reach areas and contributed to programme efficiency.

In terms of execution of funds, the UNFPA country programme in Iraq reached average financial execution rates in the order of 89% over the period from January 2016 to December 2018, as shown in the table below. Execution rates execution rates varied greatly, from 33% for some IPs in some years to 99% for other IPs in other years.

Administrative costs

The evaluation does not have enough elements to assess if the level of CP administrative costs indicate efficiency. It is clear that operating a programme in a country like Iraq, where several government systems operate at the same time, creates additional operating and administrative costs. In addition, the security situation generates considerable additional costs

Timeliness: the Iraqi Government and UNFPA are committed to implementing the programme and achieving all the goals in a timely manner. The prepositioning of supplies for upcoming humanitarian emergencies allowed for rapid response.

On the other hand, due to the political volatility and security situation in many areas of CP operations, planned activities often had to be delayed and reprogrammed. In addition, the quarterly disbursement system for IPs and recently also the quarterly workplan mechanism led to numerous delays in IPs receiving programme funding which therefore affected programme efficiency. Late communication by UNFPA to IPs on events and decisions taken resulted in ineffective planning by IPs.

Government and CSO IPs interviewed expressed the opinion that in general UNFPA procurement procedures were lengthy.

Expertise

Overall UNFPA managed to engage adequate in-house and external expertise for the CP. Government partners interviewed mentioned that procedures for UNFPA to source national and international consultants was sometimes lengthy.

Effectiveness

The programme supports the demand for and the use of sexual and reproductive health interventions which are internationally recognised to be effective.

However, the CP efforts to reduce programme costs by limiting staff movement reduces the quality of programme supervision, monitoring and quality assurance and increases the risk of inappropriate use of resources. This in turn has an effect on the programme effectiveness.

Equity

UNFPA is supporting equity of access to essential services by facilitating the geographic and financial access by vulnerable and marginalised groups such as women and girls and young people living in IDP and refugee camps to essential reproductive health and GBV response and prevention services.

Resource mobilisation

Resource mobilisation by UNFPA Iraq has been impressive, particularly in areas of GBV and RH response in humanitarian settings. Since the start of the CP in January 2016, UNFPA Iraq managed to mobilise a total of USD 105 million from external donor sources. With this, the UNFPA Country Programme Iraq became the largest UNFPA programme globally. The largest external partners of the UNFPA CP in Iraq are Canada, the European Union and United Nations Office for the Coordination of Humanitarian Affairs (OCHA).

As of 1 February 2019, UNFPA had only received 29 percent (USD 6.4 million) out of the USD 22 million required during 2019 for its humanitarian interventions in Iraq targeting 700,000 individuals through reproductive health services and 400,000 persons with the gender-based violence.

Most of the above-mentioned partners provide project-related support to the CP, which means that funding is earmarked for specific UNFPA programme activities. A large part of the external funding is confirmed annually by partners, which represents a challenge to multi-annual programme and operational planning.

A positive development is that UNFPA Iraq managed to secure multiannual funding (3 years) to the UNFPA Country Programme budget from the Australian Embassy. This funding modality is a type of budget support in that it provides non-earmarked general funding to the CP, which UNFPA Iraq can use where it sees fit.

In November 2018, the UNFPA CO developed a draft RM strategy for 2018-2020. It is unclear whether this document has not been finalised and is being used by senior management and staff.

UNFPA Iraq also produced quarterly updates, which are used as donor briefings, where the evaluation team remarked that to be useful to donors, the updates should focus on programme achievements instead of on donor visits.

The evaluation team observed that the understanding of CO staff on donor policies and procedures is insufficient. CO staff do not understand the difference between funding modalities (budget support, programme support, project support). This was also noticed by donor partners and resulted in CO staff not following correct donor procedures. For example, once funding was secured by the Sida Sweden to the CO, UNFPA CO staff continued to contact the Swedish Embassy staff in Stockholm to follow up on the Sida funding instead of contacting the relevant Sida staff in Stockholm. Also, CO staff contacted the Australian Embassy with requests for project funding, whereas Australia provides budget funding to the UNFPA CP, which UNFPA can use flexibly to respond to any needs, and therefore the Australian Embassy will not take into account additional project funding.

Donors informed the evaluation that overall they have a good impression of UNFPA programme and its achievements, and feel that UNFPA is doing an adequate job in moving towards resilience and reconstruction after the humanitarian phase. It has been appreciated that UNFPA CO staff have involved Embassy staff in programme coordination mechanisms, such as the technical working groups on gender, and that CO staff regularly invited donor officials to join monitoring visits to UNFPA programmes.

EFFICIENCY

Q 7: To what extent was UNFPA efficient in **establishing different partnerships** to ensure good use of its comparative strengths in the achievement of the programme outcomes? Did UNFPA financial support to IPs enable an efficient and timely delivery of services and support to the target populations?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA was effective in instituting partnerships with IPs –gov't & NGOs as needed to implement programme plans. UNFPA implementing partners received planned support and resources to the level foreseen and in a timely manner. Programme strategic approaches, business model, administrative and financial procedures and mix of implementation	- Number and kinds of IPs - Planned resources were received to the foreseen level in AWPs - The resources were received in a timely manner.	- AWPs - Financial records - UNFPA (including finance / administrative departments) - Implementing partners	○ Document review including financial records ○ KIIs with UNFPA CO admin and finance staff ○ KIIs with implementing partners (Gov't and NGOs)

modalities fostered achievement of programme' outputs.			

FINDINGS:

In terms of UNFPA's partnerships with government, UNFPA maintained strong working relationships with a number of Ministries at central, regional and governorate level. Staff from these institutions found UNFPA to be a responsive partner. UNFPA participated in and supported annual planning process of a number of government partners, such as Kurdistan High Council of Women's Affairs.

UNFPA partnerships with government focused on those government institutions and departments within them which are Implementing Partners of UNFPA. As a result, partnerships with a few Ministries were weak or non-existent and opportunities for engagement and advocacy with government were missed. Furthermore, UNFPA tended to leave the liaison with government officials to the UNFPA focal points for the specific government IPs, whereas UNFPA senior management liaised less with government. Government staff interviewed felt that leaving liaison – particularly with senior government officials - to junior UNFPA staff was not always the best way to strengthen relations with government. During the interviews several officials observed that since his arrival 6 months earlier the new Deputy Representative had not yet paid courtesy calls to senior government officials.

A weakness of the CP youth programme was its weak engagement with the Regional Ministry of Health in KRI, which was a missed opportunity. Even if the CP decided not to make this ministry an IP, the UNFPA and IP staff should still have actively involved the MoY officials at regional and governorate level in programme planning, implementation and monitoring.

Another weakness observed by the evaluation team is the fact that in KRI locations outside of Erbil, UNFPA programme staff from Erbil or Baghdad rarely visits IP offices. When field visits take place, UNFPA staff generally go straight to the activity sites, often to accompany donor representatives, and rarely make courtesy calls to camp management. Thus, opportunities for strengthening partnerships and learning about what's going on the ground are lost.

Government officials mentioned that UNFPA generally does not consult local authorities in the selection of IPs or in decisions of terminating support to certain interventions. The limited engagement by UNFPA with government authorities in the establishment and management of women's and youth centres has resulted in limited ownership by the government of these initiatives, which is now hampering handover discussions.

In terms of UNFPA's partnership with civil society organisations, UNFPA focusses mainly on its civil society implementing partners, most of whom are national or international NGOs. Collaboration with local and international NGOs is essential as NGOs have capacity for service delivery. In addition, some of them are able to access insecure areas even when UN agencies cannot.

During the past years, UNFPA's civil society IPs have done an excellent job in running programmes and providing essential services in very difficult circumstances, including insecure situations and hard-to-reach areas. This is much appreciated by UNFPA staff and other stakeholders.

The CP IPs generally appreciate UNFPA as a cooperative, flexible and responsive partner, prepared to listen to technical suggestions and requests when IPs make them. All UNFPA programme staff are IP focal points and liaise regularly with IPs on programme planning and monitoring. IPs reported that UNFPA contributed to capacity building of local IPs in term of policies development, programme management, narrative / programmatic and financial reporting, and data collection and some level of documentation and communication products.

IP staff interviewed also informed the evaluation team that during the past years UNFPA staff generally liaised with IP staff on individual basis rather than meeting with IPs as a group per programme area or meeting with all CP IPs together. UNFPA did little to promote links or exchange of experience between IPs working in the same programme area or in same location. There was very limited exchange of experience with organisations internationally, nor sharing by UNFPA staff on developments in programme area within Iraq or abroad. This was a missed opportunity for the CP implementing partners to learn from each other, replicate best practise, form stronger links and also to motivate IP staff. The new senior management has made some changes in this respect and has reportedly organised some meetings with IPs as a group.

IP staff interviewed mentioned that contact with UNFPA was generally limited to discussing workplans and activity implementation, and that there was not much engagement by UNFPA with their partners for strategic level discussions on programme objectives, strategies and long-term vision. Also, IPs expressed the opinion that decision making by UNFPA was generally unidirectional, with limited consultation with IPs on decisions such as whether or not to adopt or maintain certain interventions in the workplan and on closure of facilities and handover processes. This resulted in some IPs considering that UNFPA does not treat them as equal partners but mainly as sub-contractors, with UNFPA taking all the decisions.

Some IPs interviewed pointed out that there does not seem to be a clear system for information sharing by UNFPA with IPs and stakeholders, including with central and local government. A few IP staff mentioned their confusion about who was their focal point within UNFPA. IPs also reported that some UNFPA programme staff communicate in a rather direct and directive way with them.

Interestingly UNFPA has opted to contract some larger NGOs to implement programme activities through smaller local organisations. This is the case for TAJDID, which is an umbrella implementing partner for UNFPA in the South-Central region. Similarly, QANDIL has been contracted to support local NGOs in Kurdistan and South Central was all as some government partners. Both organisations have supported some capacity building in monitoring and financial management capacity of their sub-contracting agencies. TAJDID and QANDIL have not been requested to provide any technical capacity building of their subcontractors. Some stakeholders interviewed expressed their concern about the technical capacity of some of the smaller civil society IPs of the UNFPA CP.

During the interviews, stakeholders suggested that UNFPA should increase consultation with IPs and promote engagement of IPs with each other to harness opportunities for cross-fertilisation and learning from each other. They also suggested that the CP should maximise opportunities for ownership by local and central authorities of CP initiative by constant contact by UNFPA and IPs with authorities, inviting them for visits, sharing information and reports, involving them in annual planning processes and important decisions, etc.

Partnerships by UNFPA with other UN agencies were strong in some aspects, particularly on interventions which were jointly funded or implemented. Examples of this is the cooperation with WHO on the sharing of PHC and RH clinics and with UNICEF in the Adolescent Girls Taskforce.

However, the general style of the previous UNFPA senior leadership seemed to be to work alone. This contributed to the impression of competition amongst UN agencies for resources, rather than strengthening cooperation to deliver interventions together.

CONNECTEDNESS

Q 8: Resilience – Sustainability: To what extent did UNFPA humanitarian activities support or contribute to the transitioning towards longer-term (i.e., developmental and/or resilience-related) goals of the affected populations?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA is implementing its programme through 5 modes of engagement UNFPA has introduced development initiatives alongside service delivery.	- Evidence of developmental activities alongside humanitarian assistance - Evidence of gradual phasing out from service delivery	- AWPs - CPAPs - Progress reports - Annual reports - Monitoring reports	○ Document' review ○ KIIs with UNFPA programme staff. ○ KIIs with relevant government(s) stakeholders

FINDINGS:

Documentation and knowledge management

Documentation of programme interventions for advocacy and policy development is a way to increase the sustainability of programme efforts. Unfortunately, documentation by UNFPA, Government of Iraq and IPs of interventions supported through the CP, of success stories, lessons learned and best practices has generally been very limited. This is a lost opportunity as a number of interventions supported by UNFPA in Iraq were mentioned by stakeholders interviewed as examples of best practise and it would be useful to document these while the main actors are still around.

In addition, documentation of best practices and development of guidelines is important to guide programme implementation and ensure quality and standardisation of implementation between the various Implementing partners. Apart from the Standard Operating Procedures (SOPs) developed for GBV case management by non-medical facilities, which by the way are very basic and do not describe all the aspects of GBV response, no other guidelines were introduced or developed by UNFPA:

An exception here is the documentation of the rapid response approaches used by UNFPA and partners during the Mosul liberation: in 2018 produced an excellent 6-page summary of the RH response in Mosul as part of a worldwide effort by UNFPA HQ to document emergency RH responsiveness in several countries. Furthermore, UNFPA Iraq hired a consultant who is currently conducting a more comprehensive study on all areas of the response, including GBV.

Where documentation of CP interventions took place, the products were mainly "traditional" reports not necessarily useful for influencing policy. No policy briefs – 2-page summaries of issues for advocacy with government and main stakeholders were produced for influencing policies in Iraq on any major subjects. Thus, the link between

production of strategic information and influencing policy development has not been strong in the current Country Programme. We know from other evaluations that piloting / testing of new approaches without documentation does not generate any lasting impact.

It is not too late yet to document lessons learned, best practice and success stories to showcase the results and merits of the CP and of UNFPA. This documentation should be undertaken rapidly as institutional memories of counterparts and beneficiaries are short in view of the high rotation of staff and movement of beneficiaries. By strengthening the documentation of its best practices and lessons learned, UNFPA can better contribute to the development of national policies and guidelines on important issues, and build the knowledge base that will allow UNFPA to demonstrate impact and guide the replicability and expansion of good practices in the country and abroad.

Sustainability

Capacity development normally contributes in two ways to sustainability of interventions supported: it contributes to institutional sustainability by strengthening the capacity of counterpart organisations to plan, manage and monitor key interventions; and it contributes to financial sustainability by strengthening the capacity of counterpart organisations and partners to mobilise resources and to advocate with government for increased resources for priority interventions.

The evaluators consider that during the first 3 years 2016-2018, the Iraq Country Programme focussed on service delivery with some degree of capacity building. This strengthened the capacity of some of the civil society IPs to establish, manage, monitor and report on humanitarian interventions in the area of RH, GBV and adolescents & youth. This increased capacity and visibility will assist these IPs to sustain their programmes, and apply for and obtain funding from other sources. It also increased the capacity of some IPs to organise campaigns and advocate with local, regional and national government for increased political attention and domestic resource allocation to their areas of focus.

The abrupt stop of support and lack of advance planning did not allow for adequate phase-out and hand-over to counterparts of some youth and women spaces. This contributed to a stop in service provision to vulnerable populations and to the loss of staff and physical capacity (premises) that had been built using CP resources. The provision of incentives to government staff for working in CP-supported facilities was also controversial. Whereas it motivated government staff such as health workers to provide FP to clients, it created inequalities between staff working in departments supported by the CP and other staff working in other departments. Also it was reported that since the phase out of the incentives, staff motivation to provide FP services has fallen.

To some extent CP interventions strengthened the capacity of central and regional government departments responsible for overseeing the thematic areas of UNFPA's mandate, particularly on GBV and other harmful practices, as well as the capacity of governorate level departments in providing emergency assistance in the areas of RH and GBV to populations in humanitarian settings. This has contributed to improved emergency preparedness in Iraq in the area of SRHR and GBV.

The CP interventions therefore contributed to some degree to increasing the sustainability of some of the interventions supported and therefore augmented partner resilience to risks (such as recurrence of emergencies, decrease in funding from UNFPA, etc).

Behaviour and social change communication contributed to raising demand for key interventions – particularly for GBV response and psycho-social support - amongst the populations affected by the humanitarian crisis, which will contribute to indicating to government and civil society the importance of providing these services and of ensuring their quality.

Lobbying and advocacy by UNFPA with government authorities contributed to building political buy-in of government for RH and GBV services and increasing commitment to support the scale up of key interventions using its own resources. This has contributed to the financial sustainability of interventions. These efforts will need to be maintained to ensure that government will indeed adopt the supported interventions as key priorities and support their scale up.

During the past year, the CP started its transition towards resilience and recovery related programming, in that efforts for handing over service delivery in stable locations to local authorities are being undertaken and the programme started turning its focus towards longer-term developmental goals. Again, assisting government and national partners in the development of policies, protocols, procedures and tools will be crucial for a middle-income country such as Iraq. Increased focus on south-south cooperation

The next step here will be for the CP to assist the government to develop their own standard operating procedures and tools for RH and GBV emergency preparedness, and to advocate for increased domestic resource allocation for this purpose.

Investment in capacity building of local government and civil society partners is important for improving the quality of interventions, strengthening resilience, building national ownership and ensuring the sustainability of interventions, particularly now that the CP move towards a more developmental approach. Therefore, the CP will need to allocate adequate financial and human resources for capacity building activities. When supporting training of staff of government institutions, UNFPA should impose rules to

ensure that the staff targeted by the training are the ones participating in the training. Building capacity of civil society organisations, including Y-PEER, will also ensure that they will lobby with government on key priorities.

COORDINATION – VALUE ADDED

Q 9: To what extent was the UNFPA programme in Iraq aligned with and contributing to the priorities of the wider humanitarian and development system as set out in the UNDAF, successive Iraq Humanitarian Response Plans and the Regional Refugee Response Plan, and the UNFPA mandate and policies?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA programme is aligned with and contributes to the UNDAF. UNFPA programme is aligned with identified priorities of Iraq Humanitarian Response Plans and the Regional Refugee Response Plan. UNFPA programme in Iraq is aligned with the UNFPA strategic plan	- UNFPA programme addresses some of the needs identified in humanitarian and refugees' response plans. - Matching priorities of UNFPA CPD with a number of UNDAF outcome areas - UNFPA programme in Iraq adopt UNFPA strategic plan in humanitarian settings	- Humanitarian response plans - Regional Refugee Response Plans - UNFPA strategic plan - UNFPA Iraq CPD - UN Agencies	○ Document review ○ KIIs with UNFPA management ○ KII with relevant UN agencies

FINDINGS:

See above section on relevance on alignment of UNFPA CP with UNDAF and Humanitarian Response Plans.

UNFPA programmes and interventions are aligned to government policies and strategies in Iraq. Through leading and participating in various humanitarian assistance coordination mechanism UNFPA has worked to harmonise its interventions with other partners and thus avoid duplication in emergency response interventions. Engagement by UNFPA in some coordination mechanisms can be strengthened.

Government staff would have preferred for the CP over the past years to not have had as main focus the provision of humanitarian assistance.

COORDINATION – VALUE ADDED

Q10: To what extent has the country office contributed to the functioning and consolidation of UNCT and HCT coordination mechanisms?

Assumptions to be assessed	Indicators	Sources of Information	Methods and Tools for data collection
UNFPA is participating / leading coordination working groups in its thematic areas of interest.	- Evidence of active participation in UN working groups - Evidence of the leading role played by UNFPA in working groups relevant to its mandate - Potential for involvement in joint programme activities with other relevant UN Agencies	- Minutes of GBV sub-working groups at national and governorate level - Minutes of protection working groups - Relevant UN agencies.	○ Document review ○ KIIs with UNFPA management and staff ○ KIIs with other UN agencies relevant staff

FINDINGS:

The evaluation team observed that UNFPA contributed to the functioning of the UN Country Team (UNCT) and Humanitarian Country Team (HCT) coordination mechanisms through its attendance of meetings and contributions to data collection and development of reports etc.

UNFPA was Lead of the Reproductive Health Working Group and of the GBV sub-Cluster. Stakeholders interviewed generally found the RH working group, which is a sub-group of the UN Health Cluster, a useful mechanism for coordinating RH interventions and exchanging information on gaps in service provision and stocks of medicines and supplies. Challenges were reported in the participation by actors in this group. For example, reporting to the group by partners not funded by UNFPA was irregular. The central RH working group in Erbil reportedly worked well until late 2018, when a change in UNFPA RH programme staff resulted in a gap in UNFPA leadership. In spite of this issue being raised by the UN Health Cluster and at the UNCT, the RH working group has not resumed its regular meetings. A challenge here has been the availability of RH staff as they had to combine the leading of the RH working group with other tasks.

The GBV sub-cluster contributed to coordination of GBV programming in humanitarian settings, particularly of service provision to IDPs and refugees living in camp settings and also the development of common standards and procedures for GBV response. This is important, as many actors have now become involved in GBV programming. UNFPA has the mandate to lead on GBV interventions within the UN family and has recruited a full-time GBV sub-cluster coordinator, which has facilitated availability for engaging in the coordination of the sub-cluster. Stakeholders appreciated the expertise of UNFPA in this area and the technical contributions made by UNFPA to the activities of the Cluster. The service mapping, referral pathways and Standard Operating Procedures were all found to be useful. RH sub-working groups were created in several governorates in Kurdistan. These were also found to be useful, although the ones not led by UNFPA such as in Dohuk where an international NGO was nominated as lead) were found not to meet regularly.

UNFPA has also been leading the PSEA network, with a full-time coordinator recruited for this. Network members interviewed by the evaluation team stressed the importance and visibility of this network in the country and the need for a highly proactive and inclusive approach.

Stakeholders interviewed expressed the opinion that UNFPA Iraq's style of leadership of joint initiatives, including the GBV sub-cluster and PSEA network, tended to be uni-directional and not inclusive and collaborative. Key informants mentioned the example of UNFPA insisting to be Lead of the PSEA network and appearing not to be willing to relinquish ownership to co-leads. At times UNFPA was seen as representing only its own agency when liaising with external parties rather than acting as representative of a multi-agency effort. Stakeholders interviewed also remarked that UNFPA's leadership style was often reactive rather than proactive, and gave examples of pilot activities and initiatives led by UNFPA, which partners were willing to participate and in which donors had expressed interest, but which UNFPA did not follow up on after the initial phase ended. The way in which UNFPA has handled handovers and closures of women's and youth spaces is another illustration here: rather than consulting with partners in a timely manner to explore options for future cooperation and funding to ensure that key structures catering for highly vulnerable populations could be kept open even if no longer funded or managed by UNFPA, UNFPA tended to take decisions first without consultation and then to communicate these decisions very late.

On an Individual level, UNFPA has generally cooperated well with other UN agencies in the programming and management of interventions, particularly for interventions that were part of a joint project or where funding was linked. Furthermore, the operations team of UNFPA also coordinated closely with other UN agencies in the sharing of resources (transport, supplies, etc.). UNFPA participated in the UN Business Operations working group (BOS) and its sub-groups such as the logistics cluster. Attendance by UNFPA of UNCT meetings is reportedly not always regular and UNFPA does not always communicate to the UNCT on who are in charge during absence of the Representative and Deputy Representative. Stakeholders interviewed appreciate the willingness of the new UNFPA Representative to cooperate and share information with other UN agencies.

Stakeholders interviewed recommended that UNFPA should strengthen joint UN programming, to ensure complementarity. This approach could for example be used to move into the Basra region. Informants also suggested that the UNFPA senior management should take responsibility for the coordination of the groups which it leads and ensure there are no gaps. Coordination efforts should not depend on the availability and motivation of individual UNFPA staff members. Coordination should also be inclusive and proactive. A way in which to assure this would be to have the lead function rotate between members and to allocate some tasks to other members or co-leads. It was also recommended that leadership of the GBV sub-cluster and PSEA network should be highly proactive, working to strengthen relationships between members and synergies between agencies and programme efforts, and working to maximise opportunities for joint working and resource mobilisation. Lastly, it was suggested that UNFPA should systematically invite other UN agencies when it organised meetings with government and civil society on programmatic issues. For coordination positions, UNFPA should provide staff with both programmatic / technical background and coordination ability and experience. Furthermore, the coordination tasks should be included into UNFPA staff job descriptions of UNFPA staff and performance of coordination tasks should be part of performance monitoring by UNFPA superiors.