UNITED NATIONS POPULATION FUND - IRAQ

United Nations Population Fund (UNFPA)

Evaluation
of the 2nd Country Programme 2016 - 2019

Report
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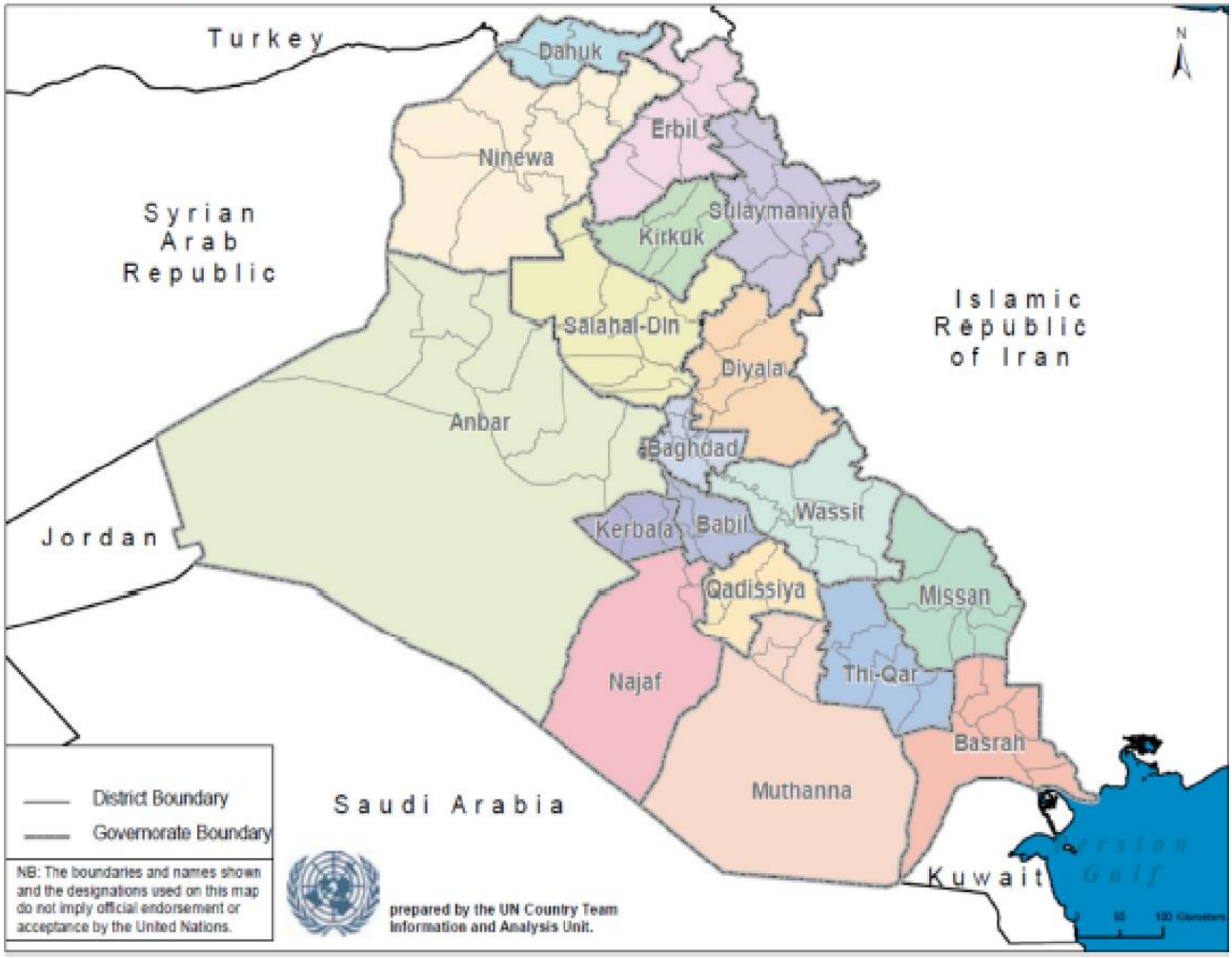
MAP OF IRAQ

Map of Iraq



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DISCLAIMER

This evaluation report was prepared by a team of independent external evaluators. The content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or Member States.

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The evaluation consultants would like to thank the UNFPA Iraq Country Office, particularly M&E Specialist Mr. Alisher Ashurov and Humanitarian Programme Associate Mr. Sahand Mohammed, for coordinating and facilitating the UNFPA Country Programme Evaluation in Iraq. Further thanks are due to the senior management and staff of the UNFPA Iraq Country Office and field offices, who hosted and facilitated visits by the evaluation team, in spite of considerable security and logistical constraints.

The team also owes thanks to staff of UNFPA regional and global offices led by the Regional M&E Adviser Dr. Olugbemiga Adelakin,, other United Nations agencies, government officials at central, regional and governorate levels, implementing partners, beneficiaries, development partners and other stakeholders in Iraq and abroad for generously providing their insights during the evaluation.

Structure of the Iraq Country Programme Evaluation Report

This report comprises an executive summary, six chapters, and annexes and follows the structure recommended in the evaluation handbook issued by the UNFPA Independent Evaluation Office.

Chapter 1, the **Introduction**, provides the background to the evaluation, objectives and scope, the methodology used, including the limitations encountered, and the evaluation process. The **second chapter** describes the Iraq country context including the development challenges it faces in the UNFPA mandated areas. The third chapter refers to the response of the UN system and then leads on to the specific response of UNFPA through its country programme to the national challenges faced by the country in sexual and reproductive health area, population and development and in gender equality. The **fourth chapter** presents the findings for each of the evaluation question specified in the evaluation matrix (which is annexed); the **fifth chapter** discusses conclusions, and the **sixth chapter** concludes with recommendations under strategic and programmatic level, based on the conclusions.

Annexes 1-4 contain the required documents for the CPE: Annex 1 includes the list of documentation consulted, Annex 2 the evaluation Terms of Reference, Annex 3 the list of the persons consulted, and Annex 4 an overview of financial implementation rates of the CP implementing partners.

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ACRONYMS

BEmOC	Basic Emergency Obstetric Care
CEmOC	Complementary Emergency Obstetric Care
CO	Country Office
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CSO	Civil society organisation
DoH	Department of Health at governorate level
DoLSA	Department of Labour and Social Affairs at governorate level
DAC	Development Assistance Committee
ET	Evaluation team
FGD	Focus group discussion
GBV	Gender based violence
GoI	Government of Iraq
HRP	Humanitarian Response Plan
IDP	Internally displaced person
IP	Implementing partner
ISIL	Islamic State of Iraq and the Levant
KII	Key informant interview
MTR	Mid term review
MDG	Millennium Development Goal
MoH	Ministry of Health
MICS	Multiple Indicator Cluster Survey
MoLSA	Ministry of Labour and Social Affairs
MoP	Ministry of Planning
MoY	Ministry of Youth and Sports
NDP	National Development Plan
NGO	Non-governmental organisation
OECD	Organization for Economic Cooperation and Development
RH	Reproductive health
RO	Regional Office
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
ToR	Terms of reference
ToT	Training of trainers
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children Fund

WCC	Women Community Centre
WHO	World Health Organisation

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Annexes 1-5 contain the required documents for the CPE: Annex 1 includes the list of documentation consulted, Annex 2 evaluation Terms of Reference, Annex 3 the list of the persons consulted, and Annex 4 the financial implementation rate of the CP's implementing partners.

KEY DATA ON IRAQ

Table 1: Key facts and figures about Iraq

	DATA	Source
Geographical Location	Middle East Region	
Surface area	437,072 square km	
Population		
Population (inhabitants)	38,433,600 million in 2018	UN World Population Prospects 2019 Revision
Population growth rate	2.28 % in 2019	UN World Population Prospects 2019 Revision
Government of Timor-Leste		
Type	Democratic Republic - Presidential	
Women in parliament	25 % (63 out of 250 seats)	Elections of 2017
Economy		
GDP per capita (PPP US$)	USD 17,952 in 2019	IMF
GDP growth rate	4.8% in 2019	World Bank
Main economic activity	Oil extraction accounts for 95% of GDP	World Bank
Social indicators		
Human Development Index	123 out of 189 countries ranked	HDI report 2019
Under-employment	Unemployed 12.7% (number or percentage); Inactive (or any other figure)366,000	ILO database 2019
Life expectancy at birth	67.5 years men / 72.2 years women	World Population Prospects 2019 Revision
Maternal mortality ratio	104 maternal deaths per 100,000 live births	MICS2018
Under-5 mortality rate	3 deaths per 1,000 live births.	MICS2018
Infant mortality rate	23 deaths per 1,000 live births	MICS2018
Neonatal mortality rate	14 deaths per 1,000 live births	MICS2018
Health expenditure	4.1% of GDP	WHO 2018
Births attended by skilled health personnel	Skilled health personnel assist 95.5% of deliveries, and facility delivery was at 100%	MICS2018
General fertility rate	General fertility rate is 3.6 children per woman, a decline from 5 in 10 years	MICS2018
Adolescent fertility rate (women aged 15-19)	70 per 1000 women	MICS2018
Marital Status (child Marriage rate)	64% % of persons aged 15-49 who are currently married Child Marriage rate before 15 years old: 7.2 Child Marriage rate before 18 years old: 27.9.	MICS2018
Contraceptive prevalence rate (CPR)	CPR of 54.6%, increased from 52.5% in 2011 (years of previous MICS).	MICS2018
Unmet need for family planning (% of women in a relationship unable to access contraceptives)	Unmet need for family planning is 14.3%, increased from 8% in 2011 (years of previous MICS)	MICS2018
People living with HIV, 15-49 years old, percentage	A total of 539 new HIV Iraqi cases were recorded at the INAPC during the period from 2010 to 2019, of which, 486 cases are alive and the rest were dead.	INACP No data available on HIV prevalence
GBV – physical and sexual violence	XX% women aged 15 – 49 years, who have ever-partnered, had experienced physical and/or sexual violence by an intimate partner in their lifetime.	No data

EXECUTIVE SUMMARY

In line with the UNFPA Evaluation Policy, the UNFPA Iraq Country Office (CO) commissioned an independent, external evaluation of its 2nd Country Programme (2016-2019), of which the main field mission took place between June and July 2019. This report presents the findings, conclusions and recommendations of the evaluation.

Purpose and objectives of the Country Programme Evaluation

The **purpose** of the Country Programme Evaluation (CPE) is to demonstrate accountability for humanitarian and development results, support evidence-based decision-making, and to foster learning by contributing good practices and lessons learned to the existing knowledge base. The **overall objectives** of the CPE are: (i) enhancing the accountability of the UNFPA Iraq CO for the relevance and performance of its country programme and (ii) broadening the evidence base for the design of the next Country Programme (CP) cycle. The **specific objectives** of the evaluation are: 1) to assess relevance of the programme and progress in the achievement of outputs against what was planned (effectiveness) in the country programme document (CPD) and/or its action plan (CPAP), as well as efficiency of interventions and sustainability of effects; 2) to assess responsiveness of the Country Office to changes / additional requests from national partners caused by an evolving country context; 3) to assess alignment of CPAP with the UN Development Assistance Framework (UNDAF) and the Humanitarian Response Plans (HRPs) and role of UNFPA country office as an active contributor to the UN coordination mechanisms in the country; 4) to draw key lessons from UNFPA past and current Iraq programme and propose recommendations for future programmes.

Scope of the CPE

The CPE covered the activities implemented and results achieved in all the thematic areas of programming (sexual and reproductive health, adolescents and youth, gender equality and women's empowerment, and population dynamics) during the period from January 2016 to December 2018.

In terms of geographic scope, the evaluation covered all areas in the Kurdistan Region and the Central South Region where UNFPA-supported interventions have been implemented, including areas with a high level of internally displaced persons and refugees in which UNFPA provided humanitarian assistance. The main audience and primary users of this CPE include: the UNFPA Iraq CO; its implementing partners (IPs) - Government institutions and non-governmental organizations (NGOs); the UNFPA Arab States Regional Office; as well as other partners and stakeholders.

The second UNFPA Country Programme 2016-2019 (CP2)

In line with UNFPA's corporate goal, the UNFPA Iraq CP aimed to achieve universal access to sexual and reproductive health and rights through activities designed under four Outcomes and four interlinked outputs: 1) Outcome 1: Sexual and reproductive health - Output1: 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; 2) Outcome 2: Adolescents and youth - Output 2: 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; 3) Outcome 3: Gender equality and women's empowerment - Output 3: 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; 4) Outcome 4: Population dynamics - Output 4: 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 was implemented by UNFPA and a number of IPs from government and civil society organisations. The total CP resources during the first 3 years 2016-2018 amounted to a total of USD 108 million, of which USD 103 million was mobilised from external sources.

Approach and methodology of the CPE

The CPE assessed the performance of the CP according to the following evaluation criteria: Relevance, effectiveness, efficiency, sustainability and coordination. As the CP was implemented in a largely humanitarian context, the evaluation also assessed the coverage and connectedness of UNFPA support during the period under review. These evaluation criteria were translated into 12 evaluation questions

that structured the evaluation matrix, which was the main instrument for data collection and analysis. The evaluation tested the intervention logic underlying the CP, to determine the extent to which the expected results of the CP have been achieved. It adopted a participatory approach that included a diverse range of governmental and non-governmental stakeholders at national and sub-national levels and used mixed methods, to ensure the compilation of well-triangulated data to answer all the evaluation questions. The evaluation relied primarily on qualitative data that was collected first-hand through semi-structured interviews, focus group discussions and observations during field visits. This data was complemented through quantitative and qualitative data obtained from secondary sources of data, such as programme documents and needs assessments. The primary data collection reached a total of 463 individuals in 6 governorates. The evaluation encountered a number of challenges during data collection. Until the end of 2018 the UNFPA Iraq CO did not collect data for the CP outcomes and outputs. Therefore, the evaluation results are based primarily on qualitative information collected through consultations with Government officials, IPs and beneficiaries. In addition, some key staff from other United Nations agencies, federal ministries and donors were not available for interview during the field mission of the evaluation team to Iraq nor remotely during the following weeks. The CO mitigated this by identifying alternative staff to be interviewed by the evaluation team. Due to security reasons, the evaluation team was furthermore not able to visit some locations and some facilities managed by civil society IPs. This was addressed by interviewing all IPs in their offices or remotely.

Main conclusions of the evaluation

The UNFPA Iraq CP2 for 2016-2018 was highly relevant in responding to emerging humanitarian priorities defined by the United Nations HRPs, and focussed mainly on addressing the needs of populations identified by the international community as most vulnerable, namely IDPs, returnees and refugees in areas affected by conflict and post-conflict situations in Iraq. The CO was highly responsive to changing humanitarian RH and GBV response needs of populations affected, and was able to modify CP support delivery mechanisms in order to increase access to insecure and volatile areas. In 2018, with the humanitarian crisis becoming less acute, the CO shifted the CP focus to facilitate a transition towards a greater development emphasis. UNFPA Iraq has demonstrated added value in the areas of its technical expertise and mandate, which are recognised and appreciated by stakeholders. The CO has added value in engaging in policy dialogue, particularly regarding health and wellbeing for adolescents and youth and to a more limited extent also on sensitive themes such as right of adolescents and young people and unmarried persons to SRHR information and services.

The CP targeted its humanitarian response to populations identified by the UN Humanitarian Country Team (HCT), namely women and girls of reproductive age, GBV survivors and adolescent girls and boys and youth in humanitarian settings - including the marginalised populations comprised of former wives and children of ISIL fighters - particularly those living in camps accessible by the humanitarian community. During the first three CP years (2016-2018), the UNFPA-supported interventions reached a total of six million persons in 83 camp sites and host populations. The bulk of the CP humanitarian support was provided to populations living in camps in the three governorates of the Kurdistan Region of Iraq (KRI), which housed the majority of the IDPs, refugees and returnees, and from which support was also provided to vulnerable populations in neighbouring governorates.

The CP effectively takes into account gender equality and human rights principles. It promotes gender inclusion principles for the development of adolescent girls and young women and men, promoting opportunities and equal treatment for all young people, young women and men. The CP supported the universal access of vulnerable populations living in humanitarian situations to reproductive health information and services, family planning and to the response to GBV and other harmful practices. It furthermore promoted an inclusive approach by generating knowledge on how to include vulnerable groups such as adolescent girls, youth, women and GBV survivors in SRH and GBV programming.

The CP contributed to some degree to strengthening the government's ability to provide RH and GBV services to populations during humanitarian crisis and recovery periods, as well as during the country's transition to a greater development focus. Due to its initial focus on humanitarian service delivery, the CP's capacity strengthening efforts were limited until mid-2018. The manuals and tools developed and rolled-out by the CP were related to the GBV and youth programming, such as the GBV SOPs and Adolescent Girls Toolkit, which were highly appreciated by implementors interviewed for their usefulness

and contribution to standardisation of approaches. The CP did not document the degree of capacity building of government and implementing partners. The shift in focus of the CP in 2018 was demonstrated by moving away from direct support to service provision (including efforts for handing over service delivery to local authorities in stable areas) towards increased emphasis on high-level policy engagement with government and on generation of data for planning and decision making.

UNFPA-led coordination mechanisms contributed to coordination of programme implementation between implementors and with government and other partners and to the development of common approaches and tools and increasing effective usage of resources. UNFPA contributed to the functioning of the UN Country Team and Humanitarian Country Team through its leading of the UN RH working group, the GBV sub-cluster and the Adolescent Girls Taskforce. Stakeholders interviewed found these mechanisms useful as they facilitated exchange of information between implementors as well as identification and addressing of gaps and bottlenecks. The GBV sub-cluster and Adolescent Girls Taskforce furthermore developed tools useful for standardisation of methods used for service delivery and awareness-raising. Coordination with other UN agencies was strong, particularly when funding for interventions was linked.

The UNFPA CP was effective in providing quality RH services to women and girls of reproductive age living in IDP and refugee camps and highly responsive to evolving emergency situations. UNFPA Iraq's rapid RH and GBV response to the Mosul crisis was internationally recognised as a best practice example for provision of RH services in emergency situations: it includes provision of emergency reproductive health services on frontlines and strengthening of referral pathways through maternity hospitals, mobile and static delivery rooms, and mobile and static reproductive health clinics in camps and host communities. The rapid response was facilitated by pre-positioning of emergency in supplies, materials, training of staff in advance and strong cooperation with UN partners and IPs. The CP did not document the contribution by the programme to awareness of, access to and utilisation of RH services amongst targeted populations. From mid-2018 onwards, the CP was effective in shifting the focus of the RH programme towards development-oriented interventions, such as increased engagement and advocacy with government on key policy issues, such the development of a new Family Planning policy. This was successful as the government has established a FP policy working group. Following handover by the CP of RH services to government, health facility staff interviewed stated they noticed a decrease in FP services provided in camps.

The CP was highly effective in providing GBV response services to survivors in humanitarian settings and in hard-to-reach areas, in many of which no GBV response capacity had existed previously. The CP was effective in supporting capacity building of government and civil society staff on GBV prevention and response, as well as in developing and rolling out service delivery norms and tools. These efforts resulted in strengthening the GBV response by government and civil society facilities and in promoting minimum quality standards and standardisation across providers, although these results were not documented by the CP. The CP also contributed to capacity building of government women's authorities at central level, who are now able to coordinate gender and GBV issues, lead policy development and mobilise resources. The CP and GBV sub-cluster support to GBV service mapping, documentation of referral pathways and of vulnerability of GBV survivors and data on survivors contributed to institutionalise the GBV response in Iraq. Despite considerable resources allocated to providing GBV awareness raising and services, the CP did not document their impact on GBV survivors and other women and girls, boys and men in the camps and community attitudes on violence against women and girls, child marriage and women's empowerment. Since mid-2018 the CP focus has shifted away from direct service provision: handover of women's centres to authorities and partners has started as well as support to the replication in other governorates of the model Dohuk GBV survivor centre.

In spite of limited resources being allocated to the youth programme compared to the RH and GBV programme areas, the CP was effective in supporting life skills teaching and SRH and GBV awareness-raising of adolescents and youth in humanitarian settings, as well as through youth volunteer outreach throughout the country. These efforts achieved the objective to provide age- and gender-responsive and inclusive programmes contributing to the protection, health and development of young women, young men, girls and boys within humanitarian settings. The development and roll-out of the Adolescent Girls Tools kit in cooperation with UNICEF contributed to unifying approaches between UN agencies and partners and standardising tools used by government and its partners in Iraq when working with adolescent girls. CP capacity building efforts targeted to government staff on youth issues were limited,

whereas capacity building efforts of civil society organisations focussed on CP IPs. The CP did not document changes in knowledge, skills and attitudes amongst adolescents and youth who attended the youth centres and in attitudes towards young girls attending schools and marrying young, nor document any best practices. From mid-2018 onwards, the UNFPA youth team has shifted its focus to developing a coherent youth programme, with increased emphasis on strengthening cooperation and advocacy on youth issues with central and regional authorities and on developing a national youth agenda.

Population dynamics programming were given a lower priority during the humanitarian crisis in the first CP years, and the CP was therefore not effective in achieving the population dynamics objectives defined in the CP. Generation of data and capacity strengthening efforts of government on population issues were limited. Since late 2018, the CO has revitalised its Population Dynamics programme efforts by resuming advocacy with government on key issues such as the National Population and Housing Survey planned to take place in 2020 and assisting government in preparations for it.

In spite of a highly challenging operational environment and the CP resource needs being extremely high, the **CO performed well in terms of efficiency (including programme management, financial management and corporate compliance) and the Iraq CP became the highest spending worldwide during 2016-2018.** UNFPA Iraq was extremely effective in its resource mobilisation efforts, managing to raise USD 105 million for its 2016-2018 programme, making the Iraq CP the largest resource mobilisation effort globally ever for the organisation. UNFPA's operational set-up allowed for rapid responses and deployment to affected areas and contributed to CP achievements. However, implementation suffered from delays due to political volatility and changing security situations, which required frequent reprogramming of CP activities and budgets. Whereas the CP applied a quality assurance system in its GBV response through the formulation and rolling out of minimum service standards, quality assurance systems across RH and youth programmes were not effective, lacking formalisation and uniform application, which resulted in variations in standards in programme implementation between locations and IPs. In CP monitoring, the CP results framework was only partly able to demonstrate programme results as some CP output and output indicators do not capture the CP's achievements in humanitarian service delivery. The CO teams did not use or update the CP results framework and its CP results tracking tool for monitoring of CP results. The CO established an innovative online programme monitoring system used by CO teams and IPs. However, documentation by the CP of achievements, best practices and lessons learned was not strong. UNFPA leads the network on Protection from Sexual Exploitation and Abuse (PSEA). UNFPA established strong working relations with government counterparts and civil society IPs in key sectors at central and regional level, which led to government commitment to supporting priority CP interventions. Relations with non-IP government agencies were less developed. IPs interviewed found UNFPA a responsive and flexible partner, but observed that UNFPA had not facilitated much information and experience exchange between IPs which is seen as a missed opportunity for IPs to learn from each other and replicate best practice.

Recommendations

At strategic level, the next UNFPA Iraq Country Programme 2021-2025 should focus on youth programming as a cross-cutting issue while ensuring that within the four programme areas also the focus is always on ensuring that systems and services supported reach adolescents and young girls, as well as other highly vulnerable groups.

The current and new CP should continue moving towards an increased focus on resilience, recovery and long-term development objectives. This will include continuing to move away from support to direct service delivery once responsible transition is ensured, and increasing emphasis on systems strengthening in a coordinated manner across programme areas, in combination with advocacy and engagement with government authorities on key issues. UNFPA should ensure that the CP programmes focus on capacity building of IPs, key partners and CO staff in main UNFPA mandate areas through a coordinated approach to systems strengthening. This should be accompanied by an acceleration of the documentation of the achievements, best practices and lessons learned from the current CP as well as knowledge generation, collection and dissemination, so that the CP can use the data and best practices to advocate with government, influence policy development and promote replication where appropriate, and so that other countries can learn from Iraq's example.

UNFPA should further strengthen coordination with IPs, government counterparts, sister UN agencies, academic institutions, civil society organisations, other stakeholders and donors through regular meetings and circulation of regular written updates on programmes and achievements.

At programme level, UNFPA should increase emphasis on strengthening national capacity for SRH, FP, GBV, youth services and population data, while advocating for greater government budget allocation for these programmes.

Furthermore, the CP should strengthen the national capacity for knowledge generation and data analysis in Iraq, particularly regarding population dynamics, as well as the national system for monitoring of country progress on the post-ICPD agenda and performance, including the ICPD-related SDG indicators.

UNFPA should continue to strengthen CP management, quality assurance and monitoring and evaluation, in a way that promotes systematic cooperation between programmes areas and their integration as well as standardisation of approaches between programmes and between implementing partners.

1 INTRODUCTION

In line with the UNFPA Evaluation Policy, the UNFPA Iraq Country Office (CO) commissioned an independent, external evaluation of its 2nd Country Programme (2016-2019), the field visit of which took place in Iraq between June and July 2019. This report presents the findings, conclusions and recommendations of the evaluation.

1.1 Objectives of the Evaluation

The **purpose** of the Country Programme Evaluation (CPE) is to demonstrate accountability for humanitarian and development results, support evidence-based decision-making, and to foster learning by contributing good practices and lessons learned to the existing knowledge base.

The **overall objectives** of the CPE are: (i) enhancing the accountability of the UNFPA Iraq CO for the relevance and performance of its country programme and (ii) broadening the evidence base for the design of the next Country Programme (CP) cycle.

The **specific objectives** of the evaluation are: 1) to assess relevance of the programme and progress in the achievement of outputs against what was planned (effectiveness) in the country programme document (CPD) and/or its action plan (CPAP), as well as efficiency of interventions and sustainability of effects; 2) to assess responsiveness of the Country Office to changes / additional requests from national partners caused by an evolving country context; 3) to assess alignment of CPAP with the UN Development Assistance Framework (UNDAF) and the Humanitarian Response Plans (HRPs) and role of UNFPA country office as an active contributor to the UN coordination mechanisms in the country; 4) to draw key lessons from UNFPA past and current Iraq programme and propose recommendations for future programmes.

1.2 Scope of the evaluation

The CPE covered the activities implemented and results achieved in all the thematic areas of programming (sexual and reproductive health, adolescents and youth, gender equality and women's empowerment, and population dynamics) during the period from January 2016 to December 2018.

In terms of geographic scope, the evaluation covered all areas in the Kurdistan Region (governorates of Duhok, Sulaymaniyah and Erbil) and the Central South Region (governorates of Diyala, Baghdad, Najaf and Ninewa) where UNFPA-supported interventions have been implemented, including areas with a high level of internally displaced persons and refugees in which UNFPA provided humanitarian assistance.

The main audience and primary users of this CPE include: the UNFPA Iraq CO; its implementing partners (IPs) - Government institutions and non-governmental organizations (NGOs); the UNFPA Arab States Regional Office; as well as other partners and stakeholders.

1.3 Evaluation methodology and process

1.3.1 Evaluation criteria and evaluation questions

The CPE examined the following OECD/DAC evaluation criteria: relevance, effectiveness, efficiency and sustainability.[1] In addition, it used the evaluation criterion of coordination to assess cooperation of UNFPA within the UNCT and whether UNFPA interventions promote synergy and avoid duplication. As the

[1] UNFPA Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA Iraq http://www.unfpa.org/admin-resource/how-design-and-conduct-country-programme-evaluation-unfpa ALNAP (2006): Evaluating humanitarian action using the OECD-DAC criteria; an ALNAP guide for humanitarian agencies.

UNFPA Iraq CO has been operating in humanitarian settings, the evaluation also examined the humanitarian-specific evaluation criteria of coverage and connectedness that ALNAP defined.

In addition, the evaluation assessed the integration of human rights and gender equality in the 2nd UNFPA Iraq CP (2016-2019) as part of the effectiveness criterion, using the respective guidance that the United Nations Evaluation Group (UNEG) developed. The evaluation was guided by the UNEG Norms and Standards for Evaluation[2] and the UNEG Ethical Guidelines for Evaluation.[3]

An indicative list of evaluation questions was proposed in the CPE terms of reference (ToR). In the design phase, the evaluation team reviewed the preliminary questions and refined some of them to arrive at a final set of evaluation questions (see Table 2 below, with changes from the evaluation questions defined in the CPE ToR highlighted by underlined text in italics).

Table 2: Proposed Evaluation Questions by Criteria (changes in *italic and underlined*)

EVALUATION QUESTIONS (EQ) followed by the Evaluation Team
Relevance
1) To what extent was the UNFPA Iraq CP (2016 - 2019) relevant to the emergent needs of target population(s) and adapted to the identified humanitarian and development context in Iraq? **2)** Was the UNFPA Iraq CP able to respond and adapt its interventions to the changing humanitarian and development needs? **3)** What is the main added value of UNFPA in the Iraqi context as perceived by national stakeholders?
Coherence
4) To what extent was the UNFPA Iraq CP (2016-2019) 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 for Iraq and the Iraq country chapters of the Regional Refugee & Resilience Response Plans, and the UNFPA mandate, strategy and policies?
Coverage
5) To what extent did UNFPA interventions reach the population groups with the greatest need for reproductive health (RH) and gender-based violence (GBV) services, in particular, the most vulnerable as defined by the Humanitarian Country Team (HCT)?
Effectiveness
6) To what extent did the UNFPA Iraq CP (2016-2019) contribute to an increased access to and utilisation of quality RH services, including maternal health services, for the target population and contribute to the prevention of and response to GBV among the affected population? **7)** To what extent did the implementation of the UNFPA Iraq CP (2016-2019) take into account gender equality and human rights principles?
Efficiency
8) To what extent did the UNFPA Iraq CO make good use of its human, financial and technical resources, as well as of different partnerships, in pursuing the achievement of the expected results articulated in the CP (2016-2019)? **9)** *To what extent was the UNFPA Iraq CO efficient in mobilising resources – human, financial and technical - for a timely response to the emerging humanitarian needs?* **10)** To what extent was the UNFPA Iraq CO able to establish and maintain different partnerships to ensure good use of its comparative strengths in the achievement of the programme outcomes of the CP (2016-2019)?
Connectedness
11) To what extent did humanitarian activities of the UNFPA CO support or contribute to the transitioning towards longer-term (i.e. developmental and/or resilience-related) goals of the affected populations?
Coordination
12) To what extent did the UNFPA Iraq CO contribute to the functioning and consolidation of the UN Country Team (UNCT) and HCT coordination mechanisms *and to national coordination mechanisms*?

[2] UNEG (2011): Integrating Human Rights and Gender Equality in Evaluation. towards UNEG Guidance.

[3] UNEG (2008): UNEG Code of Conduct for Evaluation in the UN System.
UNEG (2017): Norms and Standards for Evaluation.

Based on these questions, an Evaluation Matrix was developed which identifies key assumptions to be tested for each evaluation question and defines associated indicators, sources of information, and relevant methods and tools for data collection. The CPE Evaluation Matrix is included in Annex 6.

1.3.2 Evaluation approach

Intervention logic

The evaluation was premised on the intervention logic underlying the 2nd CP (2016-2019), which was developed by the UNFPA Iraq CO at the start of the CP in 2016 (see figure 1 on the next page). The evaluation team did not make amendments to the intervention logic based on the document review conducted during the development of the evaluation design, approach and methodology. The evaluation assessed the extent to which the expected results articulated in the intervention logic of the CP had been achieved and whether the activities of the UNFPA Iraq CO had contributed to these results, to generate insights about what works (and does not), why and for whom.

Stakeholder participation

The CPE applied an inclusive and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels in the governance of the evaluation through the Evaluation Reference Group (ERG), which provided inputs on the preliminary findings and emerging conclusions following the completion of data collection. The CPE also included a wide variety of partners and stakeholders from Government, civil society, United Nations agencies, international NGOs, donor agencies and local communities at national and sub-national levels in data collection through key informant interviews (KIIs) and focus group discussions (FGDs).

Communication with stakeholders with respect to the evaluation purpose, the criteria applied, and the intended use of the findings was ensured at all stages of the evaluation. The evaluation team made an effort to ensure that both women and men working for IPs of the UNFPA Iraq CO were interviewed and that the beneficiaries consulted included both women and men, and key populations (which in Iraq include adolescents and youth, refugees, IDPs and vulnerable and marginalised groups).

Mixed methods

The CPE adopted a mixed-method approach that combines qualitative and quantitative data. The evaluation primarily used qualitative methods for data collection, including document review, KIIs, FGDs and observations during site visits. Quantitative data was compiled through desk review of documents, websites and online databases to obtain relevant financial data and data on key results indicators.

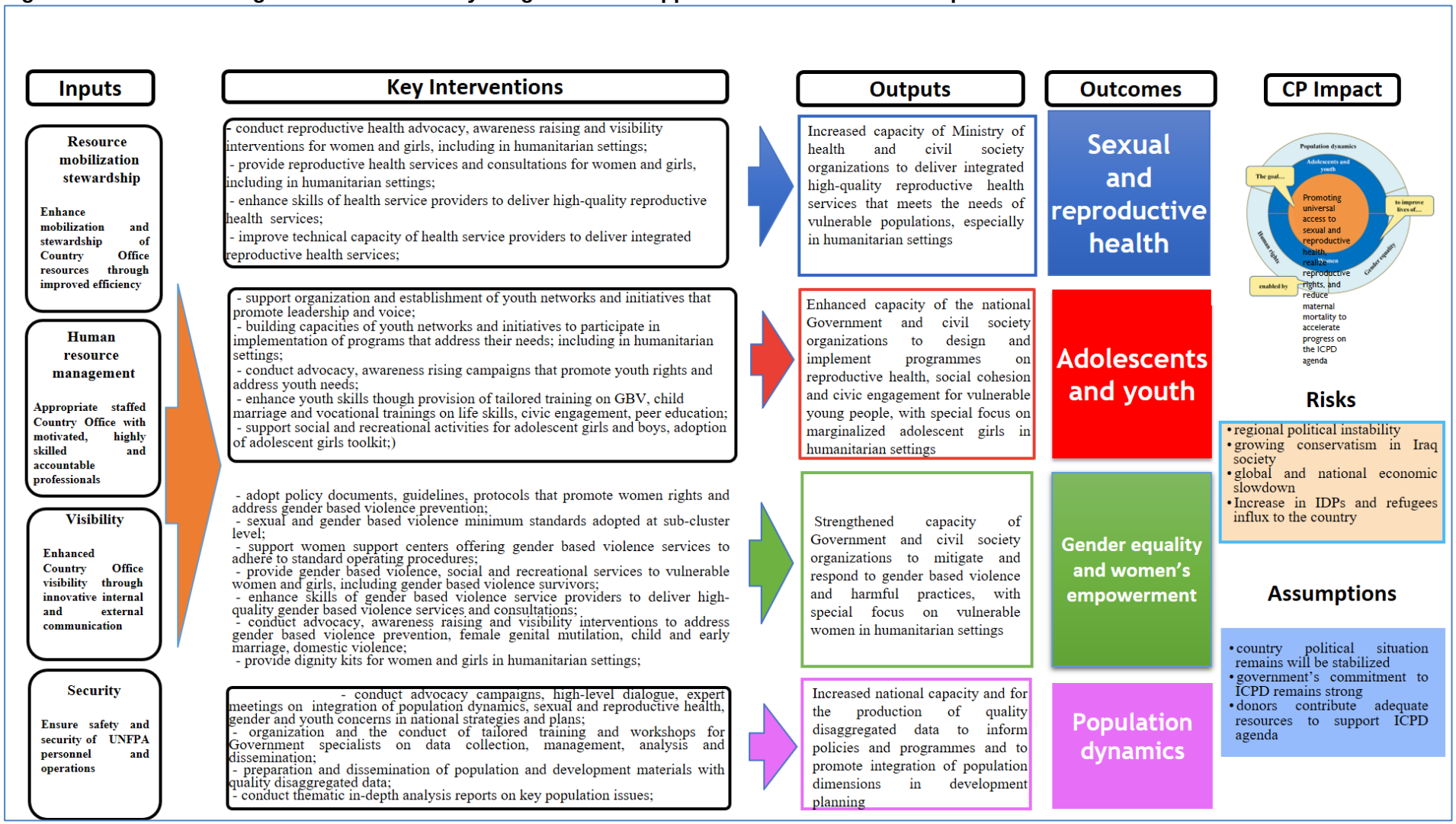
These complementary methods ensured that the evaluation responds to the information needs of the intended users, promotes participation of a broad range of partners and stakeholders, and provides credible information about the benefits for beneficiaries (women and adolescents and youth) through triangulation of collected data.

1.3.3 Methods for data collection and analysis

The CPE used diverse methods to collect both primary and secondary data to answer the evaluation questions. Specifically, the evaluation relied on the following data collection methods:

Document review Secondary data was collected primarily through document review, which covered programme documents and related research reports, including: The UNFPA Iraq Country Programme Document (CPD) (2016-2019); Country Programme Action Plans (CPAPs); UNFPA Iraq CO Annual Reports; IP Annual Work Plans (AWPs); annual budget and expenditures reports; list of Atlas projects; The UNFPA Iraq CO Resource Mobilization Strategy; progress, site visit and monitoring reports; as well as reports, studies and technical strategies and guidelines produced by Government, other United Nations agencies, technical partners, civil society organizations and donors. Additionally, the evaluation used other sources, such as thematic evaluation reports and assessments conducted by other international organisations and donors during the current CP. Annex 1 contains the list of documents consulted in the preparation of this CPE report.

Figure 1: Intervention Logic of the 2nd Country Programme to support the Government of Iraq 2016-2018



Key informant interviews Semi-structured key informant interviews (KIIs) were conducted with UNFPA Iraq CO senior management, programme staff technical and operational staff, as well as with heads and technical staff of IPs - Government institutions and NGOs; senior officials and technical staff of other (non-IP) relevant Government ministries and agencies; relevant United Nations agencies and member organizations of humanitarian cluster working groups; other civil society organisations providing technical assistance in relevant thematic areas of the CP; and donors. Annex 3 contains a list of all stakeholders/institutions consulted.

Focus group discussions Focus group discussions (FGDs) were conducted with several groups of beneficiaries, including: users of RH services; beneficiaries of youth centres; beneficiaries of women's centres; Y-PEER trainers, Y-PEER network members, and young people who participated in trainings on life skills, reproductive health and rights trainings and recreational activities.

Site visits / observations Field visits were conducted to a select number of health facilities (primary and tertiary care), women's centres and youth centres that the UNFPA Iraq CO supported under the current CP. The aim of the site visits was to: 1) conduct KIIs with the managers and/or staff of the health facilities and women's and youth centres, as well as a small number of RH service users at health facilities; 2) conduct FGDs with women and youth beneficiaries who were present in the centres at the time of the field visit; and 3) review/observe the centre's physical facilities, equipment, supplies, staff presence, on-going activities, etc.

At the end of the field mission to collect data, the evaluation team engaged in data validation and analysis, to identify key findings that are firmly grounded in evidence. Once all information and data was collected, a systematic organisation, comparison and synthesis process was undertaken, based on the evaluation matrix. Data analysis was structured according to the evaluation criteria and questions of the CPE. The analysis included an assessment of what answers the data suggested for each of the evaluation questions. In this process, information generated through qualitative and quantitative methods was triangulated to ensure the identification of robust findings.. Data validation involved triangulation of findings from multiple sources – KIIs, FGDs, documents, such as programme reports, studies, national assessments, as well as direct observations at sites visited - as relevant to each evaluation question. In addition, the evaluation sought to validate data through regular exchanges with the evaluation manager at the UNFPA Iraq CO, internal evaluation team meetings, consultations with CO programme staff, and a meeting with the CO staff and members of the ERG to discuss emerging findings and preliminary conclusions at the end of data collection in Iraq.

1.3.4 Selection of the sample of stakeholders and sites

Based on the information in the CPE ToR, the evaluation team completed the stakeholder mapping by identifying direct and indirect partners of UNFPA programming in all thematic areas of the CP (2016-2019). Every effort was made to include key stakeholders as part of the evaluation process - either as sources of data (primary/secondary) or through their representation in the ERG and/or their participation in the debriefing meeting with the CO and the ERG at the end of data collection.

Stakeholders consulted

In view of the evaluation purpose, the evaluation team used a purposive sampling approach for the selection of stakeholders to participate in KIIs and FGDs. The sampling of specific stakeholders was determined on the following basis:

- **UNFPA staff**: UNFPA country team leadership and staff directly involved in programme design, implementation and monitoring and evaluation, as well as operations staff, as relevant to the evaluation questions. Staff was selected to cover the four programme output areas and included staff from the four UNFPA offices visited during the field mission (main office in Baghdad main and field offices in Erbil, Dohuk and Sulaymaniyah).
- **Government officials:** Government counterparts primarily involved UNFPA focal points in ministries and directorates which are directly relevant to the UNFPA mandate and the current programme cycle in both the South-Central and Kurdistan Regions, such as: The Ministry of Planning (MoP), Ministry and Departments of Labour and Social Affairs (MoLSA / DoLSA), Ministry and Departments of Health (MoH / DoH), Ministry of Youth and Culture (MoY), Department(s) of Statistics, the Kurdistan High Council for Women Affairs (HCWA), and the Kurdistan General Directorate for Combating Violence Against Women (GDCVAW) within the Ministry of Interior.

- **Implementing partners:** a desk review of UNFPA programme documents provided the basis for identifying and selecting a sample of UNFPA IPs. Selection of IPs was determined based on the following criteria by order of priority: a) IPs that implemented the largest amount of investments and who received UNFPA funding for three consecutive years; b) IPs that were involved in the implementation of projects covering more than one of the UNFPA programme output areas; and c) IPs that implemented projects relevant to one of the programme output areas only. The final selection of IPs targeted for data collection in the field comprised governmental and non-governmental IPs working in all four programme output areas in locations in both the South-Central and Kurdistan Regions. This included IPs delivering both humanitarian and development assistance, as well as a few former IPs due to the evolving context in Iraq.
- **Programme beneficiaries:** In light of the sensitive nature of the services provided to women and adolescents and youth through the UNFPA CP and also considering confidentiality issues and the very large numbers of beneficiaries served by the programme, the IPs managing women's centres were contacted to identify women beneficiaries who would be willing to participate in an FGD held by the evaluation team. The evaluation team held FGDs with groups of 10 to 15 young women in each women's centre to collect their feedback on the services they had been receiving through the centre. Similarly, relevant IPs were contacted to identify youth beneficiaries and invite groups of adolescents and youth, as well as Y-Peer and network members to participate in FGDs. As for users of RH services, during the visits to RH clinics the women who were at the clinic were asked about their impressions of the services they received in an exit interview.
- **United Nations agencies:** The evaluation conducted interviews with representatives of United Nations agencies that are active in similar sectors as UNFPA, such as UNICEF, WHO, UNHCR and UNOCHA. These KIIs had a specific focus on the United Nations system-wide coordination mechanisms and specifically targeted focal points active in the Health cluster, GBV sub-cluster and Protection cluster of the humanitarian architecture in Iraq.
- **Donors**: Donor agencies supporting the current UNFPA CP in Iraq.

By the end of the evaluation, the evaluation team had managed to interview a total of 463 persons, of which 309 women and 154 man (see table 3 below). These included representatives in seven ministries at central and regional levels, four high-level governorate departments, 15 civil society organisations, five United Nations agencies, four humanitarian coordination clusters, two donor agencies and one academic institution. This sample included 15 out of the 17 IPs under the 2nd UNFPA CP (2016-2019) for Iraq, including Government institutions, NGOs and international and national organizations. This also included a total of 233 beneficiaries of UNFPA supported RH clinics, and youth and women's centres.

Table 3: Overview of institutions and persons consulted during the evaluation

INSTITUTIONS INTERVIEWED	Nr of persons interviewed	Women	Men
UNFPA	33	10	23
Central and governorates government and public agencies	33	13	20
Camp authorities	8	6	2
Civil society Implementing Partners	26	13	13
Academic institutions	1	1	0
UN agencies	8	3	5
Donors	2	2	0
Health providers and health facility managers	14	13	1
Staff in women's centres	16	15	1
Staff in youth centres	41	25	16
Youth Y-PEER volunteers	48	33	15
Beneficiaries in health centres	7	7	0
Beneficiaries in women's centres	19	19	0
Beneficiaries (adolescents and children) ofyouth and women's centres	207	149	58
Total number of persons interviewed	**463**	**309**	**154**

See Annex 3 for a list of the stakeholders/institutions consulted during this evaluation.

Sites visited

In parallel, the evaluation team identified the specific geographic locations and facilities/centres to be visited during the field visits. The selection of sites focused on the South-Central and Kurdistan Region and included IDP and refugee camps with the highest concentration of population, RH facilities, women centres and youth recreational centres supported by the UNFPA Iraq CO.

The geographic coverage of the data collection for this evaluation was extensive. In the two regions of South-Central and Kurdistan, the evaluation reached all seven governorates where the UNFPA CP is active: the evaluation team visited the governorates of Dohuk, Ninewa, Erbil, Sulaymaniyah and Baghdad, and covered the governorates of Anbar and Kirkuk through interviews with agencies working there.

1.3.5 Evaluation process

The evaluation process entailed five phases: 1) preparatory; 2) design; 3) field; 4) reporting; and 5) facilitation of use and dissemination.

Preparatory Phase (undertaken by the UNFPA Iraq CO)
In the preparatory phase, the UNFPA Iraq CO appointed an Evaluation Manager who would be responsible for the management of the CPE with support and guidance from the Regional M&E Adviser at the UNFPA Arab States Regional Office. Under the leadership of the Evaluation Manager, the UNFPA Iraq CO undertook the following activities: drafting the ToR for the CPE with support from the Regional M&E Adviser and approval of the ToR by the UNFPA Evaluation Office; orientation of key national Government counterparts about the evaluation process; compiling documentation on the CP and the country context; selection of evaluation team members, pre-qualification by the UNFPA Evaluation Office and recruitment of the evaluation team; and establishment of the ERG.

Design Phase
This phase included: desk review of all relevant documents provided by the CPE team; development of the CPE Design Report by the CPE team; UNFPA CO and ERG providing comments on the Design Report and its annexes; finalisation of the report addressing all comments received; clearance of the design report by the Regional M&E Advisor and CO Approval.

Field Phase
The evaluation team was deployed to Iraq for 3 calendar weeks in June-July 2019 to conduct interviews and further desk reviews to answer the evaluation questions. At the end of the field phase, the CPE team facilitated a validation workshop to present to key stakeholders - main government counterparts and implementing partners - the preliminary findings and recommendations of the evaluation in an effort to validate it.

Reporting Phase
During this phase, the evaluation team continued the analytical work initiated during the field phase and prepared a first draft of the evaluation report, taking into account comments made by the CO at the field phase debriefing meetings. The draft report was submitted to UNFPA Iraq, the evaluation reference group and UNFPA ASRO and the reference group for their comments. The final report was developed taking into account comments received. The Report will be cleared by the CO and the draft EQA will be submitted from the Regional Office to EO for finalisation. The quality of the report will be assessed based on the criteria set out in the CPE Guidance.

Facilitation of Use and Dissemination (undertaken by the UNFPA Iraq CO)
The CO management will provide a management response to the evaluation recommendations. ASRO will quality assure the response. The final response will be uploaded in the corporate tracking system within six weeks of CPE submission. The CO will be responsible for periodically updating the status of implementing the management response. The CO senior management will be responsible for ensuring that the lessons and evidence emerging from the CPE informs the design of the 3rd CP. A dissemination strategy will be in place to share findings and lessons internally within UNFPA and externally. The evaluation and the management response will be posted on the CO website within six weeks of CPE submission.

1.3.6 Limitations and risks

The 2nd UNFPA CP for Iraq (2016-2019) was implemented in a humanitarian country context and therefore programming was primarily focused on reaching vulnerable populations (IDPs and refugees) in crisis-affected areas and little attention was paid to data collection and performance measurement with regard to the outputs and outcomes of the CP. Up until the end of 2018, the UNFPA Iraq CO did not collect data for the output and outcome indicators defined in the CPD to measure quantifiable changes at output and outcome levels. The CPE is therefore based primarily on qualitative information collected from Government counterparts and IPs and presents anecdotal evidence of results achieved. Given the lack of systematic monitoring data at results level, the evaluation primarily assessed the achievement of the CP outputs, and, where possible, gauged the likelihood of achieving some results at the outcome level, based on the available evidence. While the data and information compiled by this evaluation provide some useful illustrations of changes at the beneficiary level, they are not statistically representative for the entire population of beneficiaries under the UNFPA CP.

The 2nd UNFPA CP (2016-2019) for Iraq addressed the needs of multiple groups, involved cooperation with numerous governmental and non-governmental IPs and targeted large numbers of beneficiaries in a wide geographic area spread across seven governorates in Iraq. The stakeholder sampling for data collection focused on recipients of UNFPA support (i.e. implementing partners) as well as on beneficiaries (i.e. women and adolescents and youth). In spite of the precarious security situation, this evaluation still managed to consult with large groups of beneficiaries – particularly beneficiaries of the women's and youth centres - as listed above.

A limitation was that a number of staff from UNFPA, other United Nations agencies, federal ministries and donors were travelling or on leave during the data collection phase in Iraq, or could not be physically reached due to security reasons, and therefore were not available for an interview either during the field visits or remotely after the field visits. The CO addressed this by proposing alternative consultees. In addition, the evaluation team was not able to visit some facilities managed by civil society IPs and interview them in their offices or other locations, either due to security restrictions preventing access to their facilities (DARY and UIMS), lack of time (ZHO) or because IP contracts with these organisations had been terminated (WAHA, Islamic Relief). The CO addressed this by organising for the evaluation team to interview these IPs in their offices or remotely. As mentioned in above, the evaluation team also requested that the number of IPs and beneficiaries to be interviewed be increased, and with the facilitation by the CO managed to consult a large number of IPs and beneficiaries.

Finally, the security situation limited the evaluation team's ability to access some locations for data collection during the field phase. In particular, only a very short visit was possible to the Ninewa governorate (limited to east Mosul) and to Anbar governorate and no visits were authorised to the Kirkuk governorate. The evaluation team was able to visit most of the other areas, as planned, including multiple locations in Baghdad, Erbil, Dohuk and Sulaymaniyah governorates; and with the help of UNFPA programme staff at the CO, the evaluation team was able to interview IPs working in Anbar and Kirkuk at another location.

2 COUNTRY CONTEXT

2.1 Development challenges and national strategies

The Republic of Iraq is an upper middle-income country[4] in the Middle East, bordered by Turkey to the north, Iran to the east, Kuwait to the southeast, Saudi Arabia to the south, Jordan to the southwest and Syria to the west. Since the fall of the Saddam Hussein regime in 2003, Iraq has undergone a prolonged period of internal political and social instability that has led to significant insecurity and displacement of populations. The violence and political instability at national and sub-national levels in the years leading up to 2011 led to over 1.6 million internally displaced people, and a further 2 million Iraqis seeking refuge outside Iraq.[5] The commencement of the conflict in Syria in 2011 exacerbated instability within Iraq, with armed groups representing Shia and Sunni factions in increasing conflict with each other. In 2014, Sunni insurgents belonging to the Islamic State of Iraq and Syria (ISIL) staged successful attacks on large areas of Iraq, seizing control of major cities such as Mosul, Fallujah and Tikrit. Military responses to ISIL by the Iraqi army and Kurdistan army resulted in the progressive liberation of territory from ISIL control through from 2015 onwards, with the Iraqi Prime Minister declaring final victory over ISIL in December 2017.[6]

After years of dictatorship, sanctions and three major conflicts, Iraq is achieving many notable gains. In the past years, extreme poverty has been dramatically reduced, and child malnutrition, infant and early childhood mortality all decreased significantly[7]. Additionally, elections have been held successfully and key legislation including decentralization of authority to governorates was passed. The country economic growth rate has steadily increased, yet extreme poverty is widespread in rural areas and a number of governorates. “Poverty, vulnerability and inequality is predominantly young and female.”[8] The UNDAF 2015 – 2019 document identifies the most vulnerable people in Iraq as follows:

- Women with limited labour market participation and low capacity to participate in decision making processes;
- Children deprived of family income, nutrition, health, education, protection or water and sanitation;
- Youth with high unemployment and low enrolment rates in education especially in rural areas;
- IDPs, refugees and hosts communities affected by the impact of protracted displacement.

Iraq’s institutions have suffered from the attrition effects of conflict, challenging their ability to formulate policies, design programmes and deliver services, including in the areas of population, gender and reproductive health. While the capacity of statistical institutions has recently improved, Iraq has limited capacity to provide up-to-date and disaggregated data for evidence-based policymaking. With the demographic changes in Iraq over the past two years, there is a need to revisit national and sectoral strategies that were designed based on the 2012 Iraqi Household Socio-Economic survey.

In 2018, the Iraqi government set out its medium and long-term strategic development priorities in its “Iraq Vision 2030” that is aligned with the global 2030 Agenda for Sustainable Development and SDGs and defines the elements and the strategic reforms to establish a new social contract for peace.[9] The Vision prioritises human development including health, good governance and safe society, economic diversification, and sustainable environment. These are being implemented through various plans and strategies, including the new Iraq National Development Plan (NDP) for 2018 – 2022 and the Iraq governmental programme. The NDP defines Iraq’s commitment to growth which seeks reconciliation, stabilisation and prosperity, based on civilizational heritage and balanced values, and where all share in the opportunities to build an interdependent and mutually reinforcing society.[10] It is guided by a set of sectoral policies and strategies which correspond to UN priorities, including decreasing poverty levels;

[4] World Bank categorisation - http://www.worldbank.org/en/country/iraq

[5] UNFPA Iraq (2011): Iraq Country Programme Action Plan 2011-2014

[6] https://www.bbc.com/news/world-middle-east-42291985

[7] UN Iraq (2015): United Nations Development Assistance Framework (UNDAF), Iraq 2015-2019.

[8] Ibid.

[9] https://sustainabledevelopment.un.org/content/documents/22769Iraq_VNR_Messages_final_English.pdf

[10] Republic of Iraq, Ministry of Planning (2018): Iraq National Development Plan 2018-2022. June 2018.

strengthening education and health service delivery; and promoting the empowerment and participation of women and youth.

2.2 Emergencies and humanitarian responses

With the ongoing conflict in Syria and the deterioration of the security situation in Iraq since 2013 with forced ethnic and sectarian displacements, the United Nations system declared the humanitarian situation in Iraq in 2014 as a level three emergency. Since then, further attacks on civilians and massive population displacements occurred as a result of the occupation of large parts of the country by ISIL and the subsequent reconquest by the Iraqi and Kurdish forces. From early 2014 to late 2015, 3.2 million people were forced to flee their homes, in addition to 1.1 million people already displaced from earlier sectarian violence in 2006-2008. A total of 6 million persons were displaced during the conflict against ISIL between 2014 and 2017.

By early 2016, the UN categorised 10 million out of the total Iraqi population of 36 million as people in need, including 3.2 million IDPs, 250,000 refugees, 3.2 million host communities and 3 million other hard-to-reach persons.[11] By early 2018, the number of persons in need had reduced to 8.7 million according to UN estimates.[12] More than 90 percent of internally displaced persons live within host communities, particularly within the Kurdistan Region, which has seen a population increase of 30 per cent over the last two years.[13] By early 2019 the UN reported that the total number of persons in need had reduced to 6.7 million, including 500,000 IDPs living in camps, 1,5 million IDPs living outside of camps, 4 million returnees and 390,000 vulnerable host communities.[14]

The humanitarian response in Iraq was impressive: by early 2016 a total of 188 humanitarian agencies were active in Iraq, which had reduced to 94 by early 2019. By the end of 2018, 2.9 million people out of 3.4 million people (85 per cent) targeted by humanitarian partners were reached with some form of humanitarian assistance. Of this 2.9 million, 1.4 million were women and girls and 1.3 million were children.[15] While more than 4 million people have now returned to their communities, approximately 1.8 million people remain displaced, and over half of all internally displaced persons (IDPs) have been displaced for three or more years. The prolonged nature of their displacement has led to increased vulnerabilities among IDPs; in 11 districts, displaced persons are facing a very high severity of needs. Approximately 11 per cent of 4 million returnees are in locations where living conditions are precarious.[16]

During the ISIL occupation, trauma was widespread, making protection one of the most important aspects of the crisis and its aftermath. Horrific violence, mass executions, systematic rape, and torture were used against communities in areas controlled by ISIL. About 3 million people were estimated to live under ISIL control. Gender-based violence (GBV) including sexual violence and forced marriages, was widespread, used as a weapon of war, with devastating consequences. UNFPA and other humanitarian agencies have been providing much needed assistance to survivors with GBV response services. A challenge is that thousands of Iraqi women and children with perceived ties to IS – many of whom still live in IDP camps – are being stigmatised and punished. A 2018 report by Amnesty International has revealed that, in camps for displaced persons across Iraq, these women and children are denied food, water and health care; blocked from obtaining the civil documents they need to work and move freely; are subjected to sexual harassment, rape and sexual exploitation; and are prevented from returning home.[17]

[11] UN (2015): Humanitarian Response Plan, Iraq, 2016. December 2015.
[12] UN (2018): Humanitarian Response Plan, Iraq, 2018. February 2018.
[13] UNHCR (2018): Iraq Factsheet, March 2018.
[14] UN (2019): Humanitarian Response Plan, Iraq, 2019. February 2019.
[15] UNHCR (2018): Iraq Factsheet, March 2018.
[16] UN (2019): Humanitarian Response Plan, Iraq, 2019. February 2019.
[17] Amnesty International (2018): The condemned: women and children isolated, trapped and exploited in Iraq.

2.3 Population dynamics

Iraq's population is still growing at a faster rate than many other countries in the region, increasing from 10 million in 1970 to around 35 million in 2014 and it is expected to increase fourfold by 2050 if current growth remains unchanged.[18] This rapid growth is fuelled by a high total fertility rate - estimated in 2018 at 3.6 -, a low contraceptive prevalence rate (modern methods) at 36.1 percent [19] and a relatively high life expectancy at birth 67.6 years for males and 70.9 for females.[20] The general adolescent birth rate (age-specific fertility rate for women age 15-19 years) for Iraq was estimated at 70 per 1,000 women in 2018, with some regional variations (Kurdistan 40 and South-Central Region 77). The unmet need for family planning amongst women aged 15-49 is estimated at 14.3 in 2018, with regional variations (Kurdistan 8.0 and South-Central Region 15.7).[21] Comparing the 2018 MICS results with the figures quoted in the 2015 UNDAF document seems to indicate that fertility rates are falling and that modern contraceptive use is increasing in Iraq. The majority of the population of Iraq (69.9 percent) lives in urban areas.[22]

Recent population data are not available in Iraq. The last Population Census was undertaken in 1997, over 22 years ago, and did not cover the Kurdistan region, which was last part of a census in 1987. Preparations undertaken since then to organise a new census were cancelled for political reasons. The Iraqi federal government is committed to organising a new Population and Housing Census in 2020.

2.4 Sexual and Reproductive Health and Rights

Poor quality of available data in Iraq also affects data on health status and reproductive and sexual health. This has resulted in the government and development agencies having to plan and implement programmes based on unreliable data. For example, while UNFPA in its CPAP of 2018-2019 (REF), mentions that between 1990 and 2013 the maternal mortality ratio (MMR) reduced from 117 to 35.7 per 100,000 live births, a report produced by UNFPA, WHO and UNICEF identifies the MMR as 50 per 100,000 live births in 2015[23]. On the other hand, the recent 2018 MICS of Iraq identifies the maternal mortality rate as 104 per 100,000 live births[24]. In any case, overall there is consensus that the Millennium Development Goal (MDG) target for the reduction of maternal mortality in Iraq was not achieved by 2015. Figures on intramural deliveries also vary considerably: MoH estimated in 2014 that 87% of women delivered with skilled births attendants and 77.7% of them in health care institutions[25].

The Iraqi health sector is impacted by the continued challenges. In January 2019, the mid-term review of the RMNCAH Strategy highlighted the following obstacles affecting the health system: the unstable security situation in Iraq and associated military operations in some governorates, in addition to poor resource allocation to support full implementation of planned activities.[26] The Iraq National Health Policy states that Iraq also suffers from poor capacity of health care facilities, especially at the district level; maldistribution of health care personnel; stock-out of essential medicines; and weak collaboration between public and private health care sectors.[27] Due to the historically curative- and hospital-oriented health system in Iraq, there is less emphasis on providing preventive health services and the need for

[18] UN Iraq (2015): UNDAF, Iraq 2015-2019.

[19] Iraq Central Statistics Office, Kurdistan Region Statistics Office,
Ministry of Health UNICEF (2019): Iraq Multiple Indicator Cluster Survey (MICS), 2018.

[20] UN Iraq (2015): UNDAF Iraq 2015-2019.

[21] Iraq MICS 2018.

[22] UN Iraq (2015): UNDAF Iraq 2015-2019.

[23] WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division (2015): Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Maternal Mortality Estimation Inter-Agency Group.

[24] Iraq MICS 2018.

[25] Iraq Ministry of Health (2014): Iraq National Health Policy 2014-2023, p. 7.

[26] http://www.emro.who.int/irq/iraq-news/midterm-review-of-iraqs-national-reproductive-maternal-newborn-child-and-adolescent-health-strategy-20162020.html

[27] Iraq Ministry of Health (2014): Iraq National Health Policy 2014-2023.

reproductive health services has been underestimated.[28] Family planning services, for example, are offered in "less than 5% of primary health care centres and family commodities are rarely available except through private pharmacies at a high cost".[29] Among 2,632 primary health care centres in 2014, only 37 centres deliver family planning.[30]

Despite some positive trends in maternal health, the 2015 Millennium Development Goal (MDG) target was not achieved. Recent conflict-related access issues contributed to reversing or stalling some of the progress previously achieved. During the occupation of large areas of Iraq by ISIL, millions of Iraqi women, girls, boys and men did not have access to reproductive health services as most maternity wards and hospitals were destroyed or closed, while the facilities that remained open were not easily accessible. Population movements, the lack of adequate health professionals and structural damage to facilities have contributed to the decreased capacity of the central and regional governments to deliver timely and high-quality services, and has put significant strain on existing social services, including reproductive health services. The Emergency Obstetric and Neonatal Care (EmONC) assessment carried out by Ministry of Health in 2014 with UNFPA support revealed that in 2013 none of the 87 surveyed health centres with at least one delivery in the past year had performed all seven signal functions during the last three months to quality as a Basic EmONC facility. Of all the 136 surveyed hospitals with at least one delivery in the past year, only one in five performed all nine signal functions and could qualify as a Comprehensive EmONC (CEmONC) facility. Applying WHO's standards to Iraq's projected population of 35.1 million as per the 2013 estimate, at least 351 EmONC facilities would be required.[31]

In 2017, the Ministry of Health in collaboration with WHO, UNICEF, and UNFPA launched the updated national Reproductive, Maternal, New-born, Child and Adolescent Health Strategy (2018-2020) [32]. The MoH in collaboration with UNFPA is currently in the early phases of developing a new national Family Planning Strategy for 2019-2022.

2.5 Adolescents and youth

Iraq is at a demographic turning point, with 60 percent of the population under the age of 25, it has one of the most 'youthful' populations in the world.[33] Young people's access to formal education and health services, including sexual and reproductive health services, is negatively affected by the years of conflict and displacement. One in three young persons in the age group 15-29 is illiterate, with a marked gender difference between young women and young men (36.2 percent and 22.4 percent, respectively).[34]

The low level of political and civic participation by young people hinders them from contributing to the development in Iraq. Young people are not adequately represented in planning and development processes and not afforded space for dialogue and engagement with the Government. However, the Government has clearly indicated its interest in engaging with young people and involving them in the development processes within Iraq.

In 2016 the government worked with partners to review the National Youth Strategy, update and publish it.[35] Development partners such as UN organisations have started pushing the youth agenda and supporting youth participation and empowerment activities. However, data on youth is still scarce in the country. Therefore in 2018 UNFPA supported preparations for conducting the Adolescent and Youth Survey in 2019.

[28] Iraq MoH (2014): Iraq National Health Policy 2014-2023.

[29] Ibid.

[30] Ibid.

[31] Iraq Ministry of Health (2014): Iraq Emergency Obstetric and Neonatal Care (EmONC) Needs Assessment: National Report 2014.

[32] http://www.emro.who.int/irq/iraq-news/launch-of-national-reproductive-maternal-newborn-child-and-adolescent-health-strategy-2018-2020-in-iraq.html

[33] UNFPA Iraq (2015): UNFPA Iraq Country Programme 2016-2019.

[34] UNFPA Iraq (2015): UNFPA Iraq Country Programme 2016-2019.

[35] Iraq Ministry of Youth and Sport (2016). National Youth Strategy, 2016-2026.

2.6 Gender equality and women's empowerment

Years of repression, economic sanctions and armed conflicts has led to deterioration in the lives of women in Iraq. These conditions are often exacerbated by misconceptions of traditions, cultural and social values and a lack of awareness of women's rights and potential. The 2014 Human Development Report (HDR) ranks Iraq 120 out of 187 countries, with a gender inequality index estimated at 0.54, whereas the 2018 HDR report ranks Iraq 120 out of 187 countries for women empowerment.[36] The employment gender gap in Iraq is quite large: in Iraqi Kurdistan women in the work force represent barely 15% of the women of working age – compared to 70% among males. Between 78% and 93% of women aged 25 to 64 years are housewives or doing housework.[37]

In addition to the Gender-Based Violence (GBV) experienced by Iraqi women and girls during the conflict, they are subject to domestic violence, "honour" killings, early and forced marriages and human trafficking. Domestic violence is common, with 46 percent of currently married women exposed to at least one form of spousal violence. Iraq has one of the highest child marriage rates in the region. Although the legal age of marriage is 18 years for both men and women, the recent MICS of 2018 shows that among women aged 20-49 years old in Iraq, 24.8 percent were married before the age of 18, and 6 percent before the age of 15 in Iraq.[38] Child marriage is more prevalent in the south, with 20.9 percent of women aged 20-49 in Kurdistan declaring to have been married before the age of 18, compared to 25.7 percent in south central Iraq.[39] In Iraq, child marriage is a practice that in many communities is culturally, religiously and socially accepted and this is exacerbated amongst refugee and IDP populations.[40] Anecdotal evidence suggests that child marriage has increased over the past years as a negative coping mechanism to the conflict situation. This is a worrying trend, as child marriage compromises the development of girls and often results in school dropouts, early pregnancy and social isolation, with little education and poor vocational training reinforcing the gendered nature of poverty. UNFPA has commissioned a study on child marriage in Iraq and other countries in the region, to be published later in 2019.

Female Genital Mutilation is also a challenge in Iraq: the national average of women aged 15-49 years who have experienced some form of female genital mutilation is 7.4%, despite the fact that the practice is criminalized.[41] The majority of cases (37.5%) occur in the Kurdistan region. According to the Iraq MICS 2018, FGM has declined in the past 14 years: by 2018 only 1% of girls aged 0-14 years had undergone FGM, most of them in the Kurdistan region.

Conflict and displacement have acutely increased the vulnerability of women and put them at higher risk of violence, including sexual exploitation. Out of the 6.7 million people who needed some form of humanitarian assistance by early 2019, 3.3 million were female (women and girls) and 3.3 million were children. The UN estimated that 13 percent of all IDP and returnee households are headed by females and they are at heightened risk of GBV.[42] Female-headed households are particularly vulnerable due to their precarious economic and social situation. As IDPs start to return to their place of origin, they require infrastructural and service support to the girls and women among them in the areas of reproductive health, GBV case management and psycho-social counselling. However, the cities that experience IDP returns are characterized by large scale damage of infrastructure, lack of RH and GBV response services, with existing service structures being overwhelmed.[43] Standardized protocols for GBV services, including reporting and case management, have been developed but have not yet been implemented everywhere and by all relevant agencies.

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[36] UNDP (2015): Human Development report 2014.
UNDP (2019): Human Development report 2018.

[37] KRSO, UNFPA, IOM (2018): Demographic Survey, Kurdistan Region of Iraq. July 2018.

[38] Iraq MICS 2018.

[39] Ibid.

[40] Kurdistan Regional Government and UNFPA (2017): Behavioral Change Campaign for Reducing Child Marriage in Kurdistan Region, Iraq; "Securing My Future", July 2016 – October 2017. Communication for Behavioral Impact COMBI plan.

[41] Iraq MICS 2018.

[42] UN Iraq (2019): Humanitarian Response Plan, 2019.

[43] UNFPA Iraq (2017): The Assessment of the needs of and the services provided to Gender–Based Violence Survivors in Iraq.

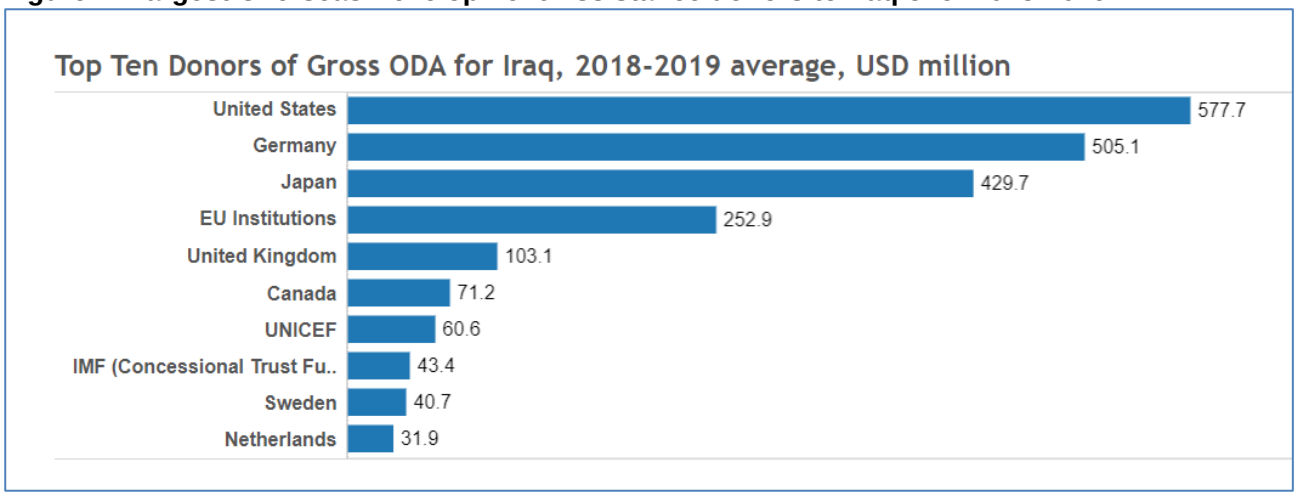
Whereas previous governments did not always support women's empowerment (for example the previous federal government abolished the Ministry of Women's Affairs[44]), both the current Iraqi central government and the Kurdistan Regional Government recently established entities that lead the government's efforts to promote gender equality and women's empowerment: the central Women's Empowerment Council and the Kurdistan Regional Government High Council of Women's Affairs. These institutions as well as other government agencies, with support from development partners, have achieved progress in advancing gender equality in Iraq, such as the drafting of the national law for women protection by central government, the opening of the first governmental women protection shelter in Baghdad, the launching of the 119 hotline in Kurdistan for responding to violence complaints, the rollout of Standard Operating Procedures for GBV cases in both Kurdistan and south-central Iraq, and the development of the Clinical Management of Rape protocol.

2.7 The role of external assistance

Despite extensive oil resources (fifth largest global reserves[45]) the last 15 years has been characterized by ongoing conflict and enormous instability, most recently with the influx of Syrian refugees and the huge internal displacements from the ISIL-related conflict. During the height of the humanitarian crisis, international development partners such as the United States Government and the European Union and its member states provided considerable funding to support the Iraqi government and its partners in the humanitarian response. Most of the support was channelled through the UN system and its partners to support the implementation of the Humanitarian Response Plans (HRP).

In 2017 Iraq was number 10 among countries in the world receiving Overseas Development Assistance (ODA): that year it received 2,907 million USD in net disbursements, amounting to 2% of the total worldwide ODA provided that year.[46] In 2018 Iraq received 2,300 million USD. Figure 2 below provides an overview of the top ten of ODA donors during 2018-2019, with the largest being the USA, Germany and Japan.

Figure 2: Largest Overseas Development Assistance donors to Iraq over 2018-2019



Source: OECD DAC data

More recently, following the defeat of ISIL, the Iraq context has been characterised by decreasing availability of international funding, since Iraq is considered a middle-income country, which makes many donors reluctant to provide funding to the country during the upcoming post humanitarian emergency period. Furthermore, funding available to the Kurdistan Regional Government decreased as a result of its disputes with the Federal Government of Iraq. External sources of funding for humanitarian assistance

[44] Republic of Iraq, Ministry of Planning (2018): Iraq National Development Plan 2018-2022. June 2018.
[45] OPEC Share of World Crude Oil Reserves, OPEC, 2015.
[46] OECD (2020): Development aid at a glance; statistics by region; 1. Developing Countries. 2019 edition.

to Iraq have declined significantly over the past three years as donors have started to shift their focus to reconstruction instead of basic needs.[47]

Nevertheless, the World Bank stated in late 2018 that its Iraq portfolio currently comprises of ten projects worth a total of USD 1.86 billion, which includes funding for large infrastructure reconstruction and scaling up social protection interventions.[48] Japan recently decided a new assistance package for Iraq amounting to USD 63 million. With this package, the total amount of Japan's assistance to the Iraq people affected by the crisis reaches USD 500 million.[49] In 2018 Australia confirmed a three-year AUD 100 million Humanitarian and Stabilisation package for Iraq.[50] Section 4.5 includes an overview of the main external donors of the UNFPA Iraq CP, of which Canada, the European Union and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) are the largest.

[47] UN Iraq (2015): UNDAF, Iraq 2015-2019.

[48] World Bank (2018): Working for the people of Iraq. World Bank Iraq Operations, September 2018.

[49] https://iraq.unfpa.org/en/news/people-japan-stand-women-iraq-us-13-million-contribution-unfpa

[50] https://iraq.unfpa.org/en/news/australia-commits-three-more-years-support-unfpa-interventions-iraq

3 UNFPA / UNITED NATIONS RESPONSE AND COUNTRY PROGRAMME STRATEGIES

3.1 Strategic response of the United Nations and UNFPA in Iraq

United Nations Strategic Frameworks

The United Nations strategy for Iraq is set out in the United Nations Development Assistance Framework (UNDAF) 2015-2019 [51], the Humanitarian Response Plans (HRPs) for Iraq for the years 2016, 2017, 2018 and 2019 and the Regional Refugee Response Plans for the same years.[52]

The UNDAF 2015-2019 promoted national cohesion in Iraq based on 2 priorities:

- A- Improving performance and responsiveness of targeted national and sub-national institutions,
- B- Addressing acute vulnerability and participation gaps.

UNDAF outputs include:

- A.1 Targeted government institutions capacity strengthened for accountability, transparency, and provision of equitable and high-quality services,
- A.2 Government capacity at national and sub-national levels enhanced for evidence-based decision-making,
- B.1 Strengthened resilience through enhanced government and community disaster risk management capacities,
- B.2 Economic and livelihood opportunities increased for women and youth in both public and private sectors,
- B.3 Increased inclusion of women and minority groups in decision-making processes on development issues at national and sub-national levels,
- B.4 Capacity of civil society strengthened to promote behaviour change through raising awareness of social rights and issues amongst the vulnerable population and to advocate for government accountability, transparency and provision of equitable and high-quality services.

UNFPA Strategic Plan

The previous UNFPA global Strategic Plan for 2014-2017 informed the development of the UNFPA Iraq CP in 2015.[53] The 2014-2017 Strategic Plan set out a vision for the changes in the lives of women, adolescents, and youth that UNFPA sought to bring about. Sexual and Reproductive Health (SRH) and reproductive rights were placed squarely at the centre of the work of the organization. This strategic direction – colloquially known as the "bull's eye" – is depicted in figure 3 below.

The bull's eye defined the goal of UNFPA: the achievement of universal access to sexual and reproductive health, the realisation of reproductive rights, and the reduction in maternal mortality. The work of the organisation was centred on attaining this goal, particularly through an enhanced focus on family planning, maternal health, and HIV/AIDS. Women, adolescents and youth were the key beneficiaries of UNFPA work. The organisation prioritised the most vulnerable and marginalized, particularly adolescent girls and also indigenous people, ethnic minorities, migrants, sex workers, persons living with HIV, and persons with disabilities. UNFPA would work to improve their health and their ability

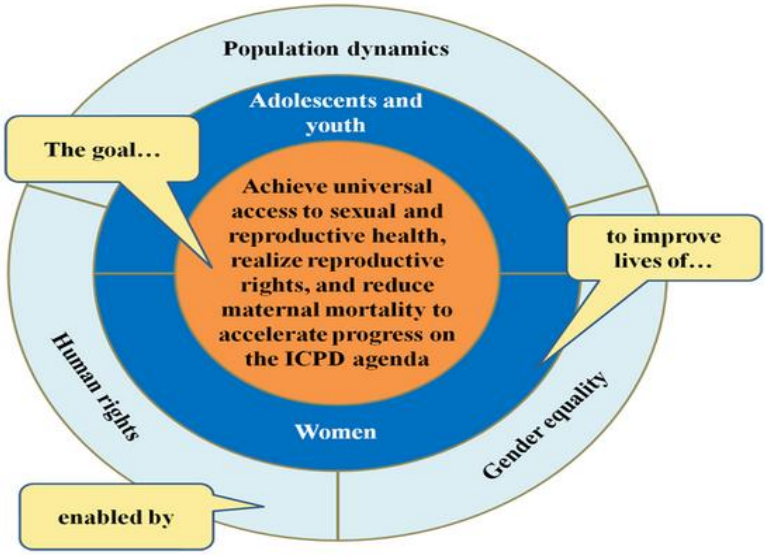
[51] UN Iraq (2015): UNDAF Iraq 2015-2019.

[52] UN (2015): Humanitarian Response Plan, Iraq, 2016. December 2015.
UN (2017): Humanitarian Response Plan, Iraq, 2017. February 2017.
UN (2018): Humanitarian Response Plan, Iraq, 2018. February 2018.
UN (2019): Humanitarian Response Plan, Iraq, 2019. February 2019.
UN (2016): Regional Refugee Response Plan 2016-2017.
UN (2017): Regional Refugee Response Plan 2017-2018.
UN (2018): Regional Refugee Response Plan 2018-2019.

[53] UNFPA (2014): UNFPA Strategic Plan, 2014-2017.

to participate in the decision-making process on the issues that affect their lives, whether those decisions are made at the individual, family, community, or country levels. The outer ring of the bull's eye contains the key factors that enabled the attainment of the goal. Respect for "**human rights**" was a principle that underpinned all of the Fund's work. A human rights-based approach can be seen in how UNFPA operates, such as in the emphasis on ensuring that family planning services are free of coercion or that HIV/AIDS interventions are stigma-free.

Figure 3: Bulls Eye for the UNFPA Strategic Plan for 2014-2017



The promotion of "**gender equality**" was another central principle of the Fund's work, being both a key programmatic area for UNFPA and a cross-cutting approach that influenced all interventions. For example, the focus on gender equality manifests in an emphasis on ensuring that SRH services are provided in a gender-responsive manner, and in promoting the collection and use of disaggregated data to enable identification of the specific needs of women and girls. The third element of the outer ring – **population dynamics** – concerns the support provided to the preparation and analysis of censuses and other population-based surveys which are a critical means of ensuring that women, adolescents, and youth are at the centre of sustainable development policies, and that programmes have the evidence needed to improve SRH services. Helping national stakeholders understand and plan for the implications of emerging population issues such as migration, urbanization and ageing for the SRH needs of women, adolescents and youth is a key area for UNFPA.

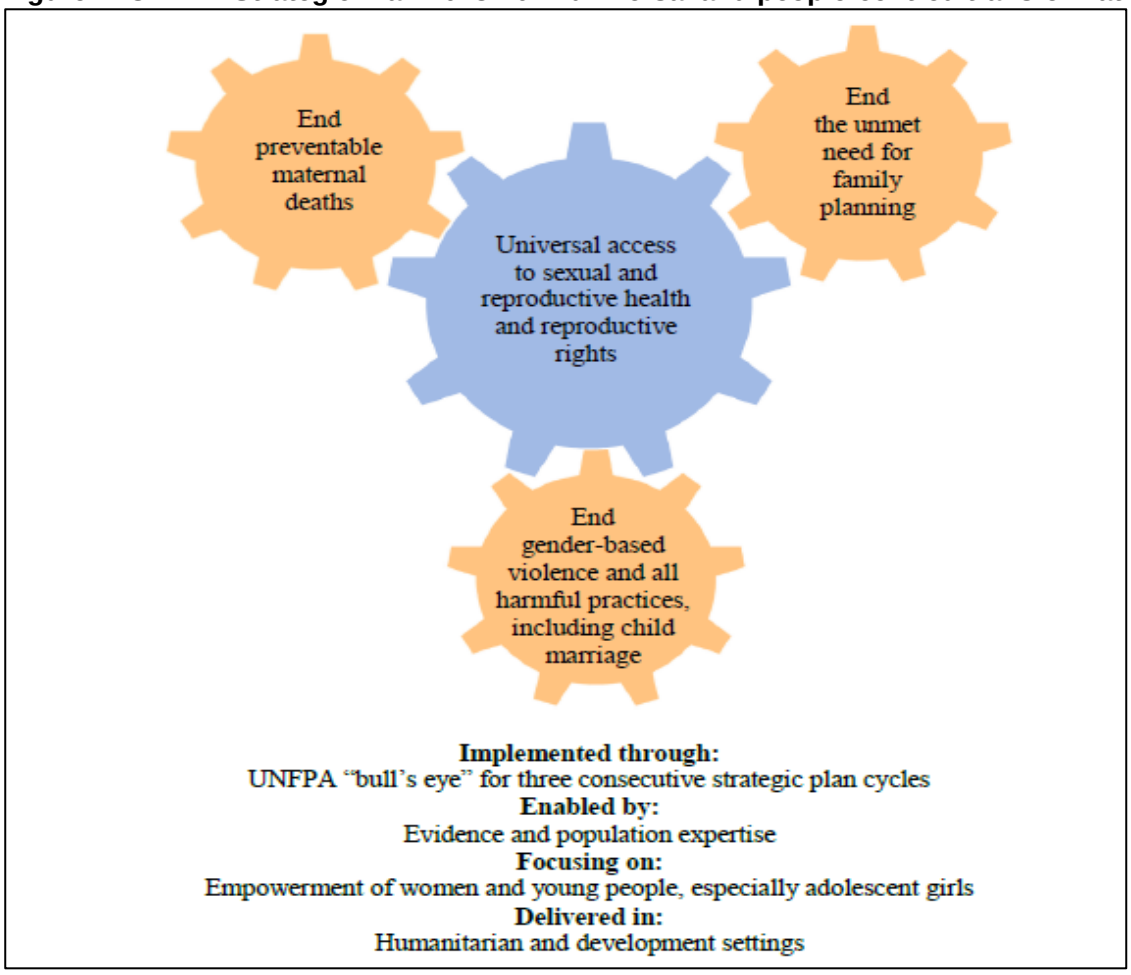
To achieve the goal of the bull's eye, the UNFPA Strategic Plan 2014 – 2017 identified four strategic outcomes:

- ***Outcome 1:*** Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.
- ***Outcome 2:*** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services.
- ***Outcome 3:*** Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth
- ***Outcome 4:*** Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

In accordance with UNFPA policy, these four strategic outcomes have been adopted into the Iraq Country Programme as the four CP outcomes.

In 2018 UNFPA published its new Strategic Plan 2018 – 2021.[54] The current SP has as goal to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality."

Figure 4: UNFPA Strategic Plan 2018-2021 universal and people-centred transformative results



Additionally, in accordance with the strategic direction of UNFPA and in line with General Assembly resolution 70/1 on the 2030 Agenda for Sustainable Development, the UNFPA Strategic Plan 2018-2021 will seek to ensure that "no one will be left behind and that the furthest behind will be reached first."

In the period leading up to 2030, UNFPA will organise its work around three transformative and people-centred results:

a) an end to preventable maternal deaths;
b) an end to the unmet need for family planning; and
c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.

3.2 Previous Country Programme 2011-2015

The first UNFPA Country Programme for Iraq 2011-2015 (CP1) made contributions to improving sexual and reproductive health; integrating life skills into vocational centres and civic engagement for young people in national programmes; establishing structures for gender equality and empowerment of women; and making disaggregated population data available for decision-making.

[54] UNFPA (2018): UNFPA Strategic Plan 2018-2021.

The programme supported the MoH to develop the Reproductive Health Strategy 2013-2017, family planning guidelines, youth-friendly health services guidelines and revision of curricula for midwifery training. The programme also increased skills of hundreds of health workers in areas related to RH and family planning and facilitated RH services to 176,000 refugee and internally displaced women through RH facilities that were supported with personnel, equipment and supplies. The programme also supported the development of the National Youth Strategy, developed life skills manuals, integrated life skills education into vocation centres and trained peer educators who in turn reached over 5,500 young people. The programme improved the policy environment and technical capacity for gender equality and women's empowerment at national level through formulating national and sub-national policies, strategies and action plans, supported advocacy activities; enhanced capacity of gender-based violence service providers, medical professionals and uniformed personnel and reached over 330,000 displaced and refugee women with a range of GBV services through women's centres in camps and host communities. The programme supported the formulation of the national population policy and the establishment of the population commission; made population data available through five national surveys and supported the registration of populations in humanitarian situations. The programme also supported the capacity building of national and sub-national statistics organisations.

Lessons learned from the 2011-2015 CP include: a) focus on preparedness plan for GBV and RH services in the event of crisis escalation; b) strengthening capacity of maternity centres and the referrals from women's centres located in the camps to maternity centres / delivery rooms and tertiary maternity hospitals; strengthening and supporting the capacity of health providers through a monitoring system for better accountability and quality of service standards; targeting additional vulnerable people through Y-PEER and other youth networks; recognising and supporting the role of NGOs in filling the service-delivery gap in humanitarian contexts, and ensuring standardisation of their services, particularly in GBV services; addressing host community needs alongside those of the displaced; and strengthening the national referral system and state institutions who provide support for GBV survivors.

3.3 The current Country Programme 2016-2019

General focus of the CP

The second UNFPA Country Programme Document (CPD) 2016 - 2019 (CP2) defines the UNFPA response to the country context in Iraq.[55] The development of the CPD benefitted from the lessons learned through the implementation of the first CP (2011-2015), and was also guided by analytical studies and assessments and multi-sectoral consultations with the Government of Iraq (GoI), civil society and other United Nations agencies. The CPD was aligned with the National Development Plan (2013-2017), UNDAF (2015-2019), the UNFPA Strategic Plan (2014–2017), and the 2015 Iraq Humanitarian Response Plan.

The CP2 2016-2019 situated itself in the Iraq humanitarian context to provide targeted support to internally displaced persons, host communities and refugees, while deliberately seeking to build linkages between the short and medium-term humanitarian context and the development context through resilience and preparedness strategies. Specific areas of CP2 focus articulated in the CPD include:

- Focus on RH/GBV service preparedness plans in the event of escalation of the crisis;
- Capacity strengthening of maternity centres, referrals from camp clinics to outside maternity centres and to tertiary RH facilities;
- Strengthening/supporting capacity of health providers through accountability and quality of care standards;
- Targeting young vulnerable people;
- Recognising and supporting the role of non-governmental organizations (NGO) in filling humanitarian service delivery gaps, and standardising their services, particularly for GBV;
- Addressing host community needs;
- Strengthening referral systems and state institutions to support to GBV survivors.

The CP2 was implemented through two Country Programme Action Plans (CPAP). The first CPAP (2016-2017) focused heavily on the humanitarian context to provide targeted support to internally displaced persons, host communities and refugees. The second CPAP (2018-2019) currently underway is still

[55] UNFPA (2015): UNFPA Iraq Country Programme 2016-2019.

heavily leaning towards humanitarian service delivery but is expected to build linkages with the development context through strategies of recovery and resilience.

In line with UNFPA's corporate goal, the Iraq CP aims at achieving universal access to sexual and reproductive health and rights through activities designed under four outcomes and four outputs:

- ***Outcome 1: Sexual and reproductive health -*** Output1: 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.
- ***Outcome 2: Adolescents and youth -*** Output 2: 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.
- ***Outcome 3: Gender equality and women's empowerment -*** Output 3: 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.
- ***Outcome 4: Population dynamics -*** Output 4: 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.

For each of the four CP outcome areas and relevant outputs, the CPAP documents have articulated specific strategies and a list of indicative activities designed to achieve the relevant output.

The UNFPA programme interventions delivered the majority of its interventions at a subnational governorate level, both in the Kurdistan Region (governorates of Duhok, Sulaymaniyah, Erbil) and in the South-Central Region (governorates of Diyala, Baghdad, Kerbala, Anbar, Najaf, Ninewa).

Intervention Logic

Figure 1 in Section 1.3 represents an overview of the intervention logic of the current CP (CP2) – developed by the UNFPA CO in 2016 - with its underlying risks and assumptions.

Due to the humanitarian situation, the United Nations declared Iraq in 2014 as a level three emergency. Therefore, the UNFPA CP is being delivered through the full five modes of engagement with service delivery featuring prominently to reach the most vulnerable populations, especially refugees and IDPs with reproductive health and gender-based violence services.

In the second CPAP 2018-2019, with the acute emergency winding down, capacity development, knowledge management, advocacy, policy dialogue and advice as well as partnerships and coordination, including South-South and triangular cooperation, were expected to be more prominent.

Financial structure of the CP

The Country Programme Document for the programme cycle 2016 – 2019 indicated a total UNFPA resources need of USD 40.9 million, with USD 6.4 million (16%) provided from regular resources and USD 34.5 million (84%) to be mobilised through co-financing modalities and or other external resources.

However, seemingly due to the deteriorating emergency humanitarian context of the country and UNFPA's ability to leverage resources in support of its programmes in Iraq, the Country Programme Action Plans (CPAPs) budgeted for a higher level of resources than originally planned in the CPD.

Table 4: CP Indicative Resources by Outcome Area (2016 – 2019) in USD million

Budget per Strategic Plan Outcome Areas	Regular Resources	Other resources	Total (USD mln.)
Outcome 1: Sexual & Reproductive Health	2.5	10	**12.5**
Outcome 2: Adolescent and Youth	0.5	6.5	**7.0**
Outcome 3: Gender equality and women empowerment	0.7	15	**15.7**
Outcome 4: Population Dynamics	1.8	3	**4.8**
Programme Coordination & Assistance	0.9	--	**0.9**
Total in USD million	**6.4**	**34.5**	**40.9**

Source: UNFPA Iraq (2015): Country Programme Document 2016-2019

Table 5 below shows that the indicative resources estimated in the two CPAPs to achieve the planned programme resources were estimated at a total of USD 73.1 million for the four-year programming period instead of the USD 40.9 million estimated in the CPD (shown in table 4). Of this, UNFPA estimated to need USD 53.1 million for the period January 2016 to December 2018.

Table 5: CPAP Indicative Resources by Outcome Area (2016 – 2019) in USD million

Budget per Strategic Plan Outcome Areas	Regular Resources: R / Other resources: O							
	2016		2017		2018		2019	
	R	O	R	O	R	O	R	O
Outcome 1: Sexual & Reproductive Health	0.6	4.0	0.6	3.0	0.10	12.0	0.10	8.0
Outcome 2: Adolescent and Youth	0.2	1.5	0.3	1.5	0.2	2.0	0.2	2.0
Outcome 3: Gender Equality and women empowerment	0.2	6.0	0.2	5.0	0.1	12.0	0.1	8.0
Outcome 4: Population Dynamics	0.2	0.5	0.3	0.7	0.45	0.10	0.45	0.10
Programme Coordination & Assistance	0.15	--	0.15	--	0.15	--	0.15	--
Total in USD million	**1.35**	**12**	**1.55**	**10.2**	**1.0**	**27**	**1.0**	**19**
Total by Year in USD million	**13.35**		**11.75**		**28**		**20**	

Source: UNFPA Iraq (2016): Country Programme Action Plan for 2016-2017. And
UNFPA Iraq (2018): Country Programme Action Plan for 2018-2019.

Section 4.5 of this report includes an analysis of the CP expenditure and implementation rate until 31 December 2018.

4 EVALUATION FINDINGS (RESPONSES TO EVALUATION QUESTIONS)

This chapter summarises the main findings of the UNFPA Iraq Country Programme Evaluation.

4.1 Relevance

Relevance to needs of the CP target population

EQ 1) To what extent was the UNFPA Iraq CP (2016 - 2019) relevant to the emergent needs of target population(s) and adapted to the identified humanitarian and development context in Iraq?

FINDINGS SUMMARY

The 2nd UNFPA (2016-2019) in Iraq was based on a clear understanding of the needs of populations affected by humanitarian crisis and took into account national policies and strategies of Iraq in the areas of maternal and reproductive health, youth and GBV and women's empowerment. Interventions focused mainly on addressing the needs of IDPs, returnees and refugees, as articulated in consecutive Humanitarian Response Plans and the national chapters for Iraq in the Regional Refugee & Resilience Plans (3RPs) for the Syria crisis.

While UNFPA has sought to base all interventions on needs assessments and research among affected populations over the course of the humanitarian response, activities implemented in the early period of the response were not informed by reliable data. Although data availability for programming improved over time, the evaluation did not find evidence that interventions in the areas of SRH and adolescents and youth have been systematically informed by timely, comprehensive and iterative needs assessments. Only interventions in the area of GBV and women's empowerment have been consistently based on data from surveys and needs assessments, such as a GBV service mapping, GBV survivor assessments and incident reporting in the Gender Based Violence Information Management System (GBV-IMS), Government-led humanitarian crisis assessments and situation analyses carried out by the Government and partners in preparation for the development of a national policy to combat violence against women. No evidence of standalone or joint needs assessments in the area of population dynamics was found as UNFPA implemented nearly no activities in the framework of the CP due to the focus on delivering humanitarian assistance.

In the period 2016-2018, the 2nd UNFPA CP (2016-2019) in Iraq largely focused on responding to the emerging humanitarian needs in the country, which were identified in the annual United Nations Humanitarian Needs Overviews (HNOs) and Humanitarian Response Plans (HRPs) as well as in the national chapters on Iraq in the annual Regional Refugee & Resilience Plans (3RPs) for the Syria crisis, developed by the United Nations system in Iraq and to which UNFPA regularly contributed data. The humanitarian needs presented in the HRPs and 3RPs were identified through meetings of the Humanitarian Country Team (HCT) and the humanitarian cluster system, as well as fields assessments conducted by the UNFPA Iraq CO and IPs, in consultation with Government authorities at central, regional, governorate and district levels. UNFPA CP programming was informed by these assessments.

The main target group of the humanitarian response led by the United Nations in Iraq during the period covered by this evaluation were the millions of internally displaced persons (IDPs) and the refugees from Syria, which were later joined by the populations of newly liberated areas, as well as returnees who tried to return to their places of origin within Iraq. The 2nd UNFPA CP (2016-2019) in Iraq focused on these populations as they were identified as being the most vulnerable and affected by the humanitarian crises. UNFPA support also included some of the most marginalized groups of IDPs due to their perceived association with ISIL. Staff of United Nations agencies and other development partners interviewed for this evaluation noted that the UNFPA CP was highly relevant because it focused on the populations that the international community identified as most vulnerable during the humanitarian crises.

Sexual and Reproductive Health (SRH): The UNFPA Iraq CO advanced the provision of reproductive health (RH) services identified in the HRPs and RRRPs, by supporting the delivery of integrated reproductive health services to women and girls of child-bearing age in IDP and refugee camps, providing

emergency reproductive health services in acute crisis settings, and supporting referral services in local maternity hospitals catering for the needs of IDPs, refugees and host populations. The interventions in the areas of SRH were in line with the updated national Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) Strategy for 2018-2020 and the Iraqi national protocol and guideline on Clinical Management of Sexual Assault Survivors of 2016. As during the reporting period the main focus of the CP was on the humanitarian response the rapid assessment for humanitarian needs were mainly undertaken under the cluster approach with UN common initiative. UNFPA was an active contributor to annual Multi-Cluster Needs Assessments (MCNA) surveys, as well as to the development of Humanitarian Needs Overviews (HNO) and Humanitarian Response Plans (HRP), including through to the health cluster which identified reproductive health needs, target groups and priority areas. These documents were updated every year to reflect the newly emerged humanitarian needs, situation development on the ground and Government and UN agreements related to humanitarian responses.

Adolescents and Youth: The UNFPA Iraq CO supported life skills training and awareness-raising on SRH, GBV and other harmful practices among adolescents and youth living in IDP and refugee camps identified in the HRPs and RRRPs through youth centres in these camps, as well as awareness-raising with adolescents and youth in camps and host communities across the country by Y-PEER volunteers. In view of socio-cultural sensitivities to SRH issues, UNFPA-supported interventions focused on the social and cultural engagement of young people and youth empowerment, in combination with awareness-raising about life-skills, gender, child/early marriage and GBV. To inform youth programming and policy in 2016-2019, UNFPA relied on the data from HNO and HRP which were updated each year. Data on SRH and GBV were used for designing interventions in youth centres for girls and young people. The assessment was conducted for the CPAP development in 2016 and 2018 also facilitated the setting of set targets for the youth programme. In 2016, UNFPA conducted 72 consultations with 1,365 youth age 15-29 years to assess their situation across Iraq. This includes development and humanitarian needs of youth that resulted in the development of the National Youth Strategy and the 5-year National Plan of Action for the Federal Ministry of Youth and Sports. In 2019, the UNFPA Iraq CO supported the Adolescent and Youth Survey, which is expected to inform CP interventions starting in 2020.

Gender Equality and Women's Empowerment: The UNFPA Iraq CO promoted the provision of response services for women and girl survivors of GBV, as identified in the HRPs and 3RPs, by supporting women centres in IDP and refugee camps and specialised GBV survivor centres and women's shelters in selected host communities, and raising awareness on GBV and other harmful practices in IDP and refugee camps through women centres, youth centres and community campaigns. The CO furthermore supported capacity development of women's authorities at central level in Kurdistan and the South-Central Region. The interventions under the CP were informed by evidence from the Iraq Woman Integrated Social and Health Survey (I-Wish) that the CO conducted in 2016 and aligned with the Iraq National Strategy to Combat Violence against Women 2018-2030, the Kurdistan Region National Strategy combating violence against women in Kurdistan Region 2017-2027 and the Kurdistan National Strategy for the Development of Women 2016-2026, and the 2016 Communication for Behavioural Impact (COMBI) Plan on Prevention of Child Marriage in Kurdistan. The GBV and women's empowerment activities of the CP were also informed by the service mapping coordinated by the GBV sub-cluster and data from the Gender Based Violence Information Management System (GBV-IMS) and the GBV survivors assessments conducted by the UNFPA Iraq CO in 2016 and 2018. The survivors assessments documented treatment pathways chosen by survivors and the barriers they face, as well as strengths and weaknesses of GBV response efforts in Iraq, including the women centres supported by UNFPA. The UNFPA Iraq CO further conducted a GBV needs and service availability assessment in Sulaymaniyah in 2019. At the regional level, UNFPA and UNICEF conducted a joint comprehensive research of child marriage in 2019, which included a chapter on Iraq.

Population Dynamics: In the framework of the CP (2016-2019), the UNFPA Iraq CO supported a limited number of studies and assessments to inform programming for outputs on SRH, adolescents and youth and GBV and women's empowerment, most of them from 2018/2019 onwards. Due to the CO's focus on supporting humanitarian service provision during the period 2015-2017, all UNFPA staff were reassigned to humanitarian response interventions and the majority of programme funding reallocated to support humanitarian response interventions. In spite of these limitations, in 2017 the UNFPA Iraq CO managed to support the Kurdistan Regional Government in conducting a demographic survey in Kurdistan. In 2019, the UNFPA Iraq CO supported the national Government to start preparations for the national Population and Housing Census, scheduled to take place in 2020.

In sum, the evaluation finds that the support of UNFPA was relevant and responded to emerging humanitarian priorities defined in the HRPs and the 3RPs. Over the course of the CP period (2016-2019) the humanitarian response of UNFPA in the areas of SRH, adolescents and youth and gender equality and women's empowerment has been informed by needs assessments among IDPs and refugees. UNFPA used all data sources and planning tools available within the common UN cluster approach (such as MCNA, HNO/HRP, and the IOM Displacement Tracking Matrix) in the planning of its priority interventions for humanitarian response. Some stakeholders observed that these estimates could have been based on more reliable data. However it is sometimes difficult to predict the precise course of situation during the rapid emergency response which occurred in Iraq.

A challenge was that the CO did not use the Country Programme Document (CPD), CP results framework and CP Action Plans (CPAPs) as basis for programme implementation and management. Instead, the CO team planned CP implementation based on the annual HRPs and on programme Annual Work Plans developed by UNFPA staff with IPs. The CPE team questions why UNFPA Iraq did not adapt the CPD or at least the CPAPs for 2016-2017 and 2018-2019 to better reflect the CP's main focus on humanitarian response service delivery. Instead, the outcome and output indicators of the CP Results Framework and the main activities defined in the 2 CPAPs give the impression of a CP focussing both on humanitarian interventions and on longer-term development work. As a consequence, the CP and CPAP documents do not fully reflect the actual focus of programme implementation during the years 2016, 2017 and 2018 and do not fully capture the CP achievements during this period.

Responsiveness to changing humanitarian and development needs

EQ 2) Was the UNFPA Iraq CO able to respond and adapt its interventions to the changing humanitarian and development needs?

FINDINGS SUMMARY

The UNFPA Iraq Country Office (CO) was highly responsive to the emerging and changing humanitarian RH and GBV response needs of internally displaced, returnee and refugee populations in areas affected by conflict and post-conflict situations in Iraq.

In 2018, with the humanitarian crisis becoming less acute, the CO changed the CP focus towards the transition to development.

During the period of the CP, Iraq experienced rapidly evolving humanitarian crises, with frequent changes in the geographic areas affected by conflict and in Government control over territory due to military operations, which led to high levels of insecurity and population movements in various directions. This resulted in a continuously changing environment for the implementation of the CP.

The evaluation finds that in 2016-2018 the UNFPA Iraq CO and its IPs were able to quickly adapt their programmes to ensure a rapid response to emerging humanitarian needs in the areas of the country with a large influx of new IDPs, returnees or refugees. These were areas in which UNFPA was already present at the start of the CP, particularly in Kurdistan, and which were accessible to operations of the United Nations from a security point of view. In addition, the CP also expanded its operations to areas liberated from ISIL, such as Mosul and its surroundings in the north-western part of the country and around Falluja and other cities in the south-central part. The UNFPA Iraq CO was able to establish different service delivery modalities to ensure availability of lifesaving services in accordance to the changing realities and security situation on the ground. For example, when during the Mosul military operations health facilities were destroyed and not accessible and RH services were therefore not accessible, UNFPA deployed 15 mobile RH teams, six mobile gynaecological units and nine mobile delivery units. In addition to, UNFPA joined with WHO to establish maternity departments in two field hospitals with a total of 40 beds admission capacity.

The interviewed UN and government stakeholders expressed their high appreciation for the capacity of the UNFPA Iraq CO and its IPs to rapidly respond to changing humanitarian needs in the areas of RH and GBV. However, some interviewed Government authorities regretted that due to the shift of the CP's focus to the humanitarian response, the CP was not able to (continue to) support some of the development-oriented activities planned in the Country Programme Actions Plans (CPAP) for 2016-2017 and 2018-2019, such as trainings in population dynamics which had been initially planned in the CP.

Towards the second half of 2018, as the military operations against ISIL ended and the security situation in the country stabilised, and with the arrival of the new senior CO leadership, the UNFPA Iraq CO shifted its focus towards supporting recovery and resilience building and the implementation of more development-oriented interventions.

Added value

EQ 3) What is the main added value of UNFPA in the Iraqi context as perceived by national stakeholders?

FINDINGS SUMMARY
UNFPA Iraq has demonstrated added value in the areas of its technical expertise and mandate, which is recognised and appreciated by national stakeholders in Iraq. UNFPA is furthermore recognised as champion for reproductive health and rights and for the fight against gender-based violence and other harmful practices.

National stakeholders interviewed all 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.

Among the interviewed stakeholders, including government officials, civil society partners, UN agencies and donors, UNFPA's technical expertise and mandate are well recognised and appreciated. This is particularly the case in the area of sexual and reproductive health - especially for adolescents and youth - and family planning, gender issues, GBV and population dynamics, focussing on populations living in humanitarian settings in Iraq. UNFPA has been able to bring these topics to the national agenda, despite the cultural sensitivities and taboos around these topics. UNFPA-supported interventions in the areas of maternal health and reproductive health for vulnerable populations are well accepted. Several partners interviewed mentioned that they had been impressed by UNFPA's capacity to provide lifesaving maternal health services on the frontline. Other partners observed that until recently UNFPA was one of the few agencies advocating for health and wellbeing for adolescents and youth. Several partner agencies have used UNFPA expertise to develop their strategies, programmes and projects, such as government ministries and CSO implementation partners. UNFPA is also seen as a leading agency in the procurement and provision of reproductive health products, including contraceptives.

UNFPA has developed an international collection of information, knowledge and lessons learned, which has been partially shared with the Government of Iraq and regional authorities throughout the current programming cycle. Several examples cited in this report acknowledge the usefulness of the South-South cooperation strategy for various programming 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. This may affect UNFPA's efforts to coordinate GBV and young people health programming.

4.2 Coherence

EQ 4) To what extent was the UNFPA Iraq CP (2016-2019) aligned with and contributing to the priorities of the wider humanitarian and development system as set out in the UNDAF, successive Humanitarian Response Plans for Iraq and Iraq country chapters of the Regional Refugee & Resilience Plans, and the UNFPA mandate, strategies and policies?

FINDINGS SUMMARY
The UNFPA CP (2016-2019) in Iraq was entirely aligned with and contributing to the United Nations system-wide priorities for humanitarian response, defined in the HRPs and Iraq country chapters in the 3RPs for the Syria crisis, as well as the development priorities outlined in the United Nations Development Assistance Framework (UNDAF) 2015-2019 for Iraq. The CP was also in line with the mandate and priorities of UNFPA expressed in its global Strategic Plans for 2014-2017 and 2018-2021.

The support provided by the UNFPA Iraq CO under the CP (2016-2019) was fully aligned with the United Nations HRPs and the 3RPs for Iraq, and the prioritization of RH and GBV protection needs of IDPs, refugees and returnees, which these plans identified as the affected populations most in need of assistance (see section 4.1 above). In addition, the humanitarian action undertaken by UNFPA has been aligned with broader humanitarian priorities and commitments. During its initial years, the CP contributed to three key actions of the global Compact for Young People in Humanitarian Action to which UNFPA is a signatory, namely the programming for and capacity building of young people in humanitarian settings and resource allocation. Later the CP also initiated efforts to strengthen action on the other key actions of the Compact, which are the participation of young people and the generation of data on young people. UNFPA Iraq furthermore made efforts to implement the New Way of Working by increasing close cooperation with other UN agencies in the humanitarian response.

In terms of alignment to the United Nations Development Assistance Framework (UNDAF) for Iraq[56], the evaluation finds that the CPt was fully aligned with the framework. The CPD makes explicit reference to the results of the UNDAF and links them to the expected results of the CP, as illustrated in Table 6 below.

Table 6: Alignment of the 2nd CP Outputs to the UNDAF

Intervention area.	Output of the 2nd UNFPA Country Programme	UNDAF Results
Outcome 1: Sexual and reproductive health -	Output1: 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.	Contributes to the UNDAF outcome "Targeted government institution capacities strengthened for accountability, transparency, and provision of equitable and quality services."
Outcome 2: Adolescents and youth	Output 2: 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.	Contributes to the UNDAF outcome "Increased inclusion of women and minority groups in decision- making processes on development issues at national mid subnational levels."
Outcome 3: Gender equality and women's empowerment	Output 3: 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.	Contributes to the UNDAF outcome "Increased inclusion of women and minority groups in decision-making processes on development issues at national and subnational levels.
Outcome 4: Population dynamics	Output 4: 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.	Contributes to the UNDAF outcome "Government capacity at national and subnational levels enhanced for evidence-based decision making."

At the same time, the UNDAF has a number of targets to whose achievement the 2nd UNFPA CP (2016-2019) in Iraq directly contributed, such as targets related to access to reproductive health and family planning services, the use of sex- and age-disaggregated statistics in policy-making at governorate level, the proportion of women and men who tolerate violence against women, the proportion of girls married before the ages of 15 and 18, as well as the adolescent fertility rate.

In addition, the CP targeted the populations considered most vulnerable in the UNDAF, notably women, adolescent girls and youth, in particular in IDP and refugee communities within and outside camps, as they are largely excluded from decision-making processes, at high risk of violence and harmful practices, such as child and forced marriage, and lack access to SRH services and information, as well as education and employment.

As the UNDAF document was developed in 2015, it mainly had a development focus, similar to the UNFPA CPD. However, programming of the United Nations system in Iraq during the period 2016-2018 focused almost exclusively on humanitarian response, with many development-oriented activities being delayed or not taking place. The interventions of UNFPA were no exception to this overall trend.

[56] UN Iraq (2015): UNDAF, Iraq 2015-2019.

The evaluation finds that the CP was in line with the mandate and priorities of UNFPA expressed in its Strategic Plans for 2014-2017 and 2018-2021.[57] However, within the four outcome areas in the Strategic Plans, the CP focused primarily on Outcome 1 on enhanced access and use of integrated SRH services and Outcome 3 on advancing gender equality and women's empowerment. As part of these outcomes, the UNFPA Iraq CO placed emphasis on direct provision of RH services and response services for GBV survivors respectively. Outcome 2 on the empowerment of adolescents and youth and Outcome 4 on strengthening the generation, use and analysis of population data for the formulation of development policies received much less attention and resources.

The UNFPA CPD was also aligned to the Iraq Development Plan 2018-2022 and its predecessor, which identify issues of population, youth and reduction of maternal and child mortality among its main priorities and proposes a series of strategies and actions to achieve improvements in the quality of life of people which correlate with the interventions recommended in the UNFPA mandate. However, as explained above, the implementation of the UNFPA CP focussed on humanitarian service provision. Consequently, a number of development-oriented interventions planned in the CPD were not carried out.

In terms of global commitments, the UNFPA CPD and CPAPs reflect the ICPD Plan of Action and the Sustainable Development Goals (SDGs), by emphasising the importance of strengthening the supply of and demand for SRHR and FP services and providing GBV prevention and response. Through the Rapid Response Mechanism (RRM), UNFPA with UNICEF and WFP adopted a flexible approach to providing services and lifesaving packages of assistance along the routes of displacement, including UNFPA's deployment of mobile health teams along the Mosul corridor, a crucial path for people fleeing the violence. As a leading partner for RRM during the Mosul operation and its aftermath, UNFPA provided critical supplies and services to the victims of the Iraqi crisis. When women of reproductive age were unable to access lifesaving SRH and GBV services and protection, UNFPA was able to provide critical humanitarian assistance through mobile and static clinics to populations on the move, in camps and in host communities.[58]

4.3 Coverage

EQ 5) To what extent did UNFPA interventions reach the population groups with the greatest need for RH and GBV services, in particular, the most vulnerable as defined by the HCT?

FINDINGS SUMMARY

The UNFPA humanitarian response under the CP (2016-2019) primarily targeted women and adolescents and youth of IDP and refugee communities living in formal camp settings. The response also targeted Iraqi returnees as the country slowly transitioned from an acute emergency to a post-conflict context, beginning in 2018. As IDPs and refugees in camps were consistently identified as the most vulnerable by the HCT, UNFPA humanitarian assistance paid limited attention to the needs of host communities and IDPs and refugees outside of camps. While programming focused on some marginalized groups, in particular former wives/widows and children of ISIL fighters in IDP and refugee camps, focus on marginalized groups was generally limited, including on people with disabilities and female-headed households.

UNFPA directed most of its humanitarian support to the three governorates in the Kurdistan Region (Erbil, Dohuk and Sulaymaniyah) which had the highest concentration of IDPs and refugees, as well as other governorates in the north and central-south with highest severity of needs, in particular Ninewa (in the aftermath of the liberation of Mosul from ISIL) and Anbar. UNFPA has been able to steadily expand its geographic coverage over the course of the CP due to the presence of field offices in proximity to hotspots and the Government's increasing control over territory. Geographic coverage has also varied according to thematic area of programming, with awareness-raising activities for adolescents and youth having been undertaken in all governorates and RH services having been mostly limited to northern and central Iraq.

[57] UNFPA (2014): UNFPA Strategic Plan, 2014-2017.
UNFPA (2018): UNFPA Strategic Plan 2018-2021.

[58] UNFPA (2018): Individual Self Reflection 2020 on World Humanitarian Summit Commitments and Initiatives - United Nations Population Fund (UNFPA).

During the period of the 2nd UNFPA CP in Iraq (2016-2019), the HCT defined IDPs, refugees and, following the end of military operations against ISIL, returnees as the most vulnerable populations. These were the major target populations of UNFPA interventions during the first three years of the CP (2016-2018), with particular focus on women and girls of reproductive age (15-49), GBV survivors and adolescents and youth (10-24) living in refugee and IDP camps. The camps served by UNFPA included particularly marginalised populations, such as former wives/widows and children of ISIL fighters.

In the period 2016-2018, UNFPA-supported interventions reached a total of six million persons in 83 IDP and refugee camps and host communities.[59] Whereas UNFPA-supported interventions targeted mostly host communities and some camps in the previous CP cycle, during the current CP period the increasing pace and scale of displacement prompted the UNFPA Iraq CO to target its efforts and resources to IDPs and refugees in camp settings, with less focus on host communities. The UN humanitarian response plan was also focusing on the vulnerable population residing in the camps hosting IDPs and refugees. Therefore the primary focus of UNFPA humanitarian response was to follow HRP priority target groups designated each year's plan. Also, the rationale for the primary focus on IDP and refugee camps was that the most vulnerable individuals and families with the least resources sought entry into camps.[60] In addition, the UNFPA Iraq CO also sought to extend coverage of RH and GBV services to refugees within host communities through support to primary health centres in non-camp settings with a high presence of refugees.[61] 80% of women centres and RH centres were located in camps and 20% were located in host communities. UNFPA furthermore worked with IPs to reach vulnerable populations that did not reside in the camps by dispatching mobile teams to more remote host community areas.

By 2019, UNFPA was actively supporting the functioning of RH 86 centres, including 66 RH clinics, 13 basic emergency obstetric and neonatal (BEmONC) facilities providing normal deliveries, 2 comprehensive emergency obstetric and neonatal (CEmONC) facilities, and 5 mobile clinics. UNFPA under its RH programme was active in 10 governorates (Anbar, Babilon, Dahok, Diyala, Erbil, Kirkuk, Ninewa, Qadissiya, Salahaldin and Sulimaniyah). The majority of the RH centres (61) wer located in the South Central region (Ninawa, Anbar, Salahaddin and Kirkuk), whereas the remaining 25 centres in KRI wer located in Dohuk, Erbil and Suleymaniya governorates. It worth mentioning that 71 RH centres were targeting IDPs and returnees, 10 were targeting returnees and 4 RH centres were targeting host communities. 35 RH centres were located in the camp and 51 in host communities.[62]

At the same time, UNFPA supported 4 youth centres located in KRI: two in Erbil, one in Dohuk, and one in Anbar. Of these, three centres were targeting refugee beneficiaries in Domiz, Darashakran and Kawergosk camps, whereas the Anbar centre targeted both host community and the IDPs in the camp.

UNFPA also supported 119 women and girls support centres, 89 in the South-central region and 30 in KRI. The regional distribution of these centres was as follows Anbar 10, Babylon 3, Baghdad 9, Diyala 5, Erbil 10, Kerbala 4, Kirkuk 4, Najaf 2, Ninewa 43, Sulaymaniyah 5, Dohuk 15, and Salahadin. The governorates with most women and girls support centres were Ninewa, Dohuk, Erbil and Anbar. More than half of the centres (52%) were in non-camp settings and 48% were located inside the camps. 45 centers or 37% were targeting IDPs, returnees, 8.4% were targeting refugees and more than half or 56% were targeting mixed population groups host community, IDPs and returnees.

Government officials interviewed stated they were grateful for UNFPA support to IDPs, refugees and returnees. However, some officials noted that they would have preferred a greater emphasis on assisting host communities and other vulnerable populations across the country. Such as poor rural communities living in remote, hard-to-reach areas far away from the urban areas. Donor representatives expressed views that UNFPA can and should do more to work on all aspects of its mandate, including sexual and reproductive rights by, for example, promoting access to SRH knowledge and services for non-married young people, especially adolescents girls and young women, and for vulnerable groups, such as sexual minorities.[63]

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59 UNFPA Iraq data.

60 UNFPA (2018): Evaluation of the UNFPA response to the Syria crisis (2011-2018). UNFPA Evaluation Office, p. 33.

61 Ibid.

62 Data provided by the UNFPA Iraq CO.

63 Sexual minorities include Lesbians, Gays, Bisexuals and Transgender persons (LGBT).

UNFPA delivered its CP through four offices in Iraq, including the main office in Baghdad, its sub-office in Erbil and field offices in Dohuk and Sulaymaniyah, which enabled it to cover the Kurdistan Region and large parts of the South-Central Region in Iraq. The bulk of the humanitarian support of UNFPA was provided in the three governorates of Dohuk, Erbil and Sulaymaniyah through the UNFPA sub- and field offices), where the highest concentration of Iraqi IDPs and Syrian refugees were located. The offices in these governorates also served as bases from which humanitarian support was provided to vulnerable populations in the neighbouring governorates of Ninewa (following the liberation of Mosul and surrounding areas), Diyala and Kirkuk. UNFPA also undertook humanitarian action in the Baghdad governorate, and used the main office in this governorate to deliver humanitarian assistance to target populations in the governorate of Anbar. The sub-office in Erbil allowed for greater mobility of UNFPA staff, greater proximity to the humanitarian crisis in the Kurdistan Region, as well as better interaction with the Kurdistan Region Government. Similarly, the field offices in Dohuk and Sulaymaniyah were useful in facilitating access to affected populations within these two governorates and neighbouring governorates that experienced higher levels of insecurity, as well as to improve liaison with local authorities and IPs.

The IDP and refugee camps supported by UNFPA were located both in urban areas and in rural areas, including some in quite remote areas. The CP supported centres in the following governorates: Ninewa 24, Dohuk 25, Erbil 19, Sulaymaniyah 8, Anbar 8, Baghdad 3, Diyala 3, Salahadin 3, Kirkuk 2, Kerbala 1. The camp sites that UNFPA support covered were identified by the UNFPA Iraq CO in consultation with the HCT, IPs and local authorities, taking into account perceived needs, geographic access, security risks and available resources. The RH services and activities in women centres and youth centres were available to all the people in the camps. The CP did not make any specific efforts to reach people with disabilities and ensure they had access to RH services, youth and GBV services for people with disabilities. The HRPs of 2016, 2017 and 2018 estimated that humanitarian needs were largest and most acute in the governorates of Ninewa, Kirkuk and Anbar. However, for security reasons, access to those governorates was severely limited. UNFPA sought to overcome this barrier by collaborating with local and international NGOs that could secure access and provide RH and GBV services in highly insecure and hard-to-reach areas where United Nations agencies could not be present. As a consequence, support to people in need was mostly uninterrupted, in spite of security issues and instability.

Demographic coverage

The scope and target groups of the humanitarian interventions supported by the CP were generally determined based on the HRP produced every year for people in need of RH and GBV services and for the youth (age 15-29) cohort across the health and protection clusters. The actual targeting varied between years and was determined in SIS each year based on available funding. The total population targeted for the 2016-2019 period was 6 million persons. The target groups as mentioned above were determined in HNO/HRP and included women and girls of reproductive age (15-49 year old) for RH services, women and men of over 15 year for GBV services, youth 15-29 year old, disability status, IDPs in camps, refugees in camps, IDPs outside of camps, refugees outside of camps, host community members especially those in post-conflict areas, returnees, host communities and IDPs in cross-border areas, marginalised groups such as the Yezidi minority, etc.

Geographic coverage

SRH: Overall, more than 70 reproductive health service points were established and running during the Mosul crisis, including nine mobile delivery units and six mobile reproductive health clinics, with more than 25 service-delivery points inside Mosul city. UNFPA provided 13 ambulances to ensure the effectiveness of the referral pathways, most of which served in west Mosul. RH services were also rapidly deployed and provided across the referral pathways established in Hawija (Kirkuk), Telafar (Ninewa) and west Anbar. Services continued to be provided to the IDP camps and the most vulnerable populations in urban areas. UNFPA worked to ensure that referral pathways existed between the RH clinics and both the BEmONC facilities providing normal deliveries and the CEmONC facilities providing caesarean sections. Following the end of combat, the entire United Nations system, including UNFPA, started to increase its presence and program work in the south-central part of Iraq in the areas that were not accessible before due to security restrictions such as Mosul and adjacent areas, some areas of Anbar, Falluja, and Kirkuk etc. The Mosul operations was the turning point for the UN as a whole to gain access

to and guarantee programme implementation in areas that were previously inaccessible due to active terrorist groups and cells.

Outreach to the Kirkuk and Diyala governorates by the CP was undertaken by local NGOs whose outreach workers visited IDP camps to provide awareness to girls and women in reproductive age.

Between early 2016 and late 2018, the CP reached 846,239 women with antenatal/postnatal care and family planning services and 336,283 women with SRH awareness-raising activities, and supported 217,438 normal deliveries and 95,636 caesarean sections. These included: 71% IDPs and returnees, 17% members of host community and 10% refugees. The host community were reached in Anbar, Ninewa, Kikruk and Salahaldin governorates. Due to the intense need for response delivery to most people in need IDPs and refugees, the implementing partners reported to have reached 120 persons with disability. In 2019 UNFPA decided to increase its focus on beneficiaries with disability and requested implementing partners to facilitate the access by persons with disability to RH services. UNFPA furthermore committed to including this aspect in its future programme in the new CPD.

Adolescents and Youth: UNFPA was able to support youth activities through the establishment of four youth centres incluidng Domiz Camp in Dohuk and Darashakran and Kawergosk camps in Erbil which targeted Syrian refugees and one centre in Anbar targeting IDPs and the host community. With UNFPA support, the youths centres provided recreational activities, life skills education, peace building and social cohesion, peer education sessions. In addition, Y-PEER volunteers were able to conduct some awareness-raising on SRH, GBV and empowerment in all governorates of the country. Between early 2016 and 2019, the CP reached 421,404 young people, including 250,000 adolescents and youth with awareness-raising activities. The youth programme covered 16 of the 18 governorates in Iraq with youth interventions. This included: 60,856 host community youth, 89,763 IDP youth, 210,557 refugee youth. The majority of youth reached were in Dohuk (40%), Suleymania (10%), Ninewa (7.5%), Salahadin (7.3%) and Erbil governorates (5%). There is no data on any disabled youth being reached during the CP period.

Gender Equality and Women's Empowerment: Under the CP (2016-2019), UNFPA supported women centres in IDP and refugee camps and some host communities in the three governorates in the Kurdistan region, in the Ninewa and Kirkuk governorates in the north of the country, the Baghdad, Anbar, Diyala and Salahadin governorates in the centre, and in the Najaf and Kerbala governorates in the south. Some governorates were reached through local NGOs due to high security risks. Between early 2016 and late 2018, the CP reached around 1.5 million women, girls and community members with awareness-raising on SRH, GBV and other harmful practices, reached 223,414 vulnerable women and girls with dignity kits, and provided basic GBV management services to 140,293 women and girls survivors. The CP reached beneficiaries population groups IDPs 65%, host community 22.4% refugee 12%. The GBV covered 12 Governorates in Iraq: Anbar, Babylon, Baghdad, Dohuk, Diyala, Erbil, Kerbala, Kirkuk, Najaf, Ninewa, Salah-al Din, Sulaymaniyah and two governorates in Syria: Al-Hasakeh, Ar-Raqqa. The governorate where the most IDPs reached were in Ninawa 35%, Salahaldin 13%, Dohuk 11%, Erbil 11% and Anbar 10%. All IDPs were reached via women centres located inside the camps. Host community in Iraq were reached in Ninawa 60% and Kikrkuk 22%, Anbar 8% and Salahaldin 7%. In addition, UNFPA supported host community in Syria governorates Al-Hasakeh 99% and Ar-Raqqa 1%. The host communities were reached via centres in located out of camps and mobile teams, those areas that prone to instable security such as in Syria. Refugees were entirely reached in Dohuk 58%, Ninewa 34% and Erbil 7%. The refugees were reached entirely via centres located inside the refugee camps in these governorates. The activities that included were provision of essential GBV services GBV awareness session, psychosocial session, recreational activities, registering GBV incidents and case management, referrals and provision consultations to vulnerable women and girls of IDPs and returnees, refugees inside the camp and out of camps especially female headed households in host communities. The GBV programme included a targeted response to reach adolescent girls through coordination with UNICEF and the implementation of the Adolescent Girls Toolkit.
Through the GBV sub-cluster UNFPA strengthened coordination of the GBV response via 55 member partners which were active throughout Iraq. The results of interventions were provided by partners with web-based platform ActvtityInfo which was adopted platform for clusters active in Iraq. In addition, GBV cluster discussed actual issues in the monthly meetings where GBV working groups raised GBV issues in the camps and communities, movement of displaced people, emerging security and natural disaster issues, update referral pathways, service mapping etc. As a result of the agreements in the meetings GBV cluster partners coordinated the response and solutions that helped to tackle the raised issues.

In addition, GBV Sub-cluster also coordinated the work of GBV IMS, a reporting platform for GBV incidents where 15 data gathering organizations were supported to generate routine data, monthly GBVIMS reports and infographs were compiled to inform programming and advocacy.
The SOP guide published by UNFPA contains a special section on case management for people with disability, and staff from UNFPA partners were trained on the SOP in 2019. However, the data from GBV services reported by partners do not include any specific data on numbers of people with disability reached. It is expected that results of the capacity development and adoption and roll-out of SOP by partner organization will take effect in the next year in 2020.

Population Dynamics: the population dynamics component of the CP did not receive much focus due to the humanitarian emergency (see section 4.4). Where PD activities were supported, they focussed mainly on some strengthening of Government PD institutions in Baghdad and Erbil. it seems that population dynamics support has mostly focused on the Kurdistan Region and none of the governorates in the south-central region.

4.4 Effectiveness

EQ 6) To what extent did the UNFPA Iraq CP (2016-2019) contribute to an increased access to and utilisation of quality RH services, including maternal health services, for the target population, and contribute to the prevention of and response to GBV among the affected populations?

Sexual and Reproductive Health and Rights

FINDINGS SUMMARY
During 2016-2018 the emphasis of the UNFPA CP was on providing basic reproductive health (RH) and GBV response services to populations affected by humanitarian crises, with focus on IDPs, refugees and returnees living in camps and in areas liberated from ISIL. The evaluation team was not able to identify the **contribution by UNFPA and its partners to the CP outcome and output objectives since the CP did not document these.**
The CP RH programme was effective in providing **quality RH services** to women and girls of reproductive age living in IDP and refugee camps by establishing and supporting up to 74 RH services in camps, supporting referrals to nearby maternity hospitals, and strengthening the capacity of government maternity hospitals in nearby host communities catering for women from IDP and refugee camps. The rapid RH and GBV response by UNFPA to the Mosul crisis in late 2016 is seen as a best practice example for which UNFPA was commended nationally and internationally. Close cooperation with WHO and other UN agencies led to many achievements in joint planning and rapid responses.
Because of the humanitarian situation, the CP was not able to focus much on capacity building of MoH and civil society, except for some training of government and civil society health staff in how to provide emergency RH services in humanitarian settings. Male engagement in the awareness-raising on FP and RH information was not strong. The management of the high-value RH kits by the CP was not efficient. In 2018 the CP started its handing over and/or closing RH services to government or other partners, as per government policy. The CPE team could not find evidence of technical handover guidance provided to governorate DoHs and partners.
The evaluators noticed shortages of the most needed RH medications and of IUDs in most facilities. The management by the CP of the high value RH kits by the UNFPA Iraq CO was inefficient. In addition, limited CP resources meant that the UNFPA Iraq CP could not focus much on community outreach and strengthening male engagement in the field of RH. This is a missed opportunity since interviews with IPs suggest that the male populations in Iraq is not receptive to family planning.

Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.

Table 7: Achievements for Outcome 1 against outcome and output indicators

CP outcome Indicators	CP targets	Level of achievement	Comments
R.1.1Modern contraceptive prevalence rate	Baseline: 33.6%. Cumulative CP target: 36.0%. (source: UNFPA annual and monitoring reports)	36.1% by Dec. 2018 (source MICS 2018) - **Total cumulative CP target achieved**	As the main procurer of contraceptives to camps and host communities in Iraq, UNFPA contributed considerably to the national target.
R.1.2 Proportion of deliveries attended by skilled health workers	Baseline: 90.6%. Cumulative CP target: 95.0%. (Source: MICS 2011)	96.0% by Dec. 2018 (source MICS 2018) – **Total cumulative CP target achieved**	UNFPA is contributing considerably to the national target.

CP output 1	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.

CP output indicators	CP targets	Level of achievement	Comments
O.1.1 Proportion of primary health care units in the target areas providing family planning services	Baseline: 15%. Cumulative CP target: 50%. (Source: UNFPA annual CP reports)	30% by Dec. 2018 - **100% of 2018 target of 30% achieved; 60% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	Number of primary health care units providing family planning services was 15 by Dec. 2018.
O.1.2 Percentage of health care providers with capacity to deliver family planning method mix in the target areas	Baseline: 40%. Cumulative CP target: 50%. (Source: UNFPA annual CP reports)	45% by Dec. 2018 **- 100% of 2018 target of 45% achieved; 90% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	Number of health care providers trained in providing family planning was 977 by Dec. 2018.
O.1.3 Number of primary health care centres that have integrated youth-friendly services into the basic package of health services	Baseline: 17. Cumulative CP target: 40. (Source: UNFPA annual CP reports)	25 by Dec. 2018 - **2018 target of 30 achieved by 83.3%; 62.5% of total CP target achieved.** (Source: UNFPA annual CP reports)	
O.1.4 Number of health centres with delivery rooms complying with EmONC	Baseline: 26. Cumulative CP target: 52. (Source: UNFPA annual CP reports)	37 by Dec. 2018 - **2018 target of 42 achieved by 88%; 71% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	By Dec. 2018 37 health facilities were supported by the CP. However, this number was higher during the preceding years when the emergency situation was more acute: e.g. 74 facilities were supported in 2016 and 50 facilities in 2017 (source Annual SIS UNFPA annual CP reports). The number of health facilities supported by UNFPA has decreased since 2016 as UNFPA has started closing or handing over facilities back to the MoH. Indicator not formulated correctly: should mention "health centres *supported by UNFPA* with delivery ..."
O.1.5 Number of UNFPA-funded women centres	Baseline: 0. Cumulative CP target: 80.	30 by Dec. 2018 - **2018 target of 30 achieved by 100%;**	The number of women's centres supported by UNFPA has decreased since 2017-2018 as UNFPA has started

CP output indicators	CP targets	Level of achievement	Comments
implementing the SRH awareness programme	(Source: UNFPA annual CP reports)	**37,5% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	closing or handing over women's centres to other partners.

The analysis of the level of achievement of the output indicators according to the UNFPA CPAP Planning and Tracking Tools for 2016-2017 and 2018-2019 shows that by December 2018 three out of five indicators had achieved their targets for 2018.[64] In addition, three out of five output indicators were well on track to attain their overall targets for the period of the CP by the end of 2019.

For the purpose of Output 1 on SRH, the UNFPA Iraq CO partnered with the federal MoH in Baghdad, as well as the regional Kurdistan Ministry of Health in Erbil, and the Departments of Health in the governorates where UNFPA operated. The UNFPA Iraq CO supported the development of Government capacity to provide life-saving RH services in humanitarian emergency situations, with a focus on capacity development of Government health providers working in RH clinics in IDP and refugee camps. In addition, UNFPA strengthened the capacity of Government-run maternity hospitals within host communities in areas with a large influx of IDPs and refugees through the provision of maternity equipment, medicines and RH commodities, as well as furniture and non-health supplies. This also included the creation of incentives for staff to work in the maternity hospitals in these crisis-affected areas. The maternity hospitals in host communities served as referral hospitals for deliveries for pregnant women and girls in IDP and refugee camps.

At the same time, the UNFPA Iraq CO developed the capacity of civil society partners that manage RH clinics in camps and delivered the majority of RH services to IDPs and refugees under the CP (2016-2019). This included international NGOs, such as Islamic Relief, Women Health Alliance, and International Medical Corps, and national NGOs, such as Zhian Health Organization, Dary Human Organization, Iraq Health Access Organization, the United Iraqi Medical Society, the Civil Development Organization and Harikar.

In the framework of the CP (2016-2019), UNFPA specifically aimed to strengthen the capacity of Government and civil society organisations to provide ante-natal care (ANC) and family planning (FP) services to women and girls of reproductive age at health facilities in areas affected most by the humanitarian crisis. The majority of the RH services that UNFPA supported were provided within primary health care clinics in camps that were established and managed by other development agencies to meet the SRH needs of refugee and IDP populations. In an effort to increase access to RH services for women whose movement is restricted, as well as women in areas where it was not possible to establish static services, the UNFPA Iraq CO and its IPs deployed mobile RH teams, mobile gynaecological units and mobile delivery units.

Between 2016-2018, UNFPA trained 2,497 service providers on Emergency Obstetric and Neonatal Care, ANC, postnatal care, and FP.[65] The capacity building activities for health workers providing RH and FP services were not limited to gynaecologists who are responsible for providing RH and FP services in the Iraqi health system, but extended to general medical doctors and midwives/nurses, so that they could provide the services when gynaecologists are absent. The evaluation team could not find any data to determine whether the capacity of trained health providers was increased, as the CP did not monitor or assess changes in technical knowledge, skills and competencies of individual health providers, nor changes in structures and capacities within organisations which benefited from capacity development support. The evaluation found evidence that not all service providers underwent training. Some health providers in UNFPA-supported RH clinics in camps visited by the evaluators stated that they depended mainly on their previous field experience and had not been provided with updated information and trained in the use of new techniques, protocols or guidelines by UNFPA and its IPs.

[64] UNFPA (2017): CPAP Planning and Tracking Tools for 2016-2017. Updated to December 2017.
UNFPA (2019): CPAP Planning and Tracking Tools for 2018-2017. Updated to June 2019.

[65] UNFPA Annual Reports over 2016, 2017 and 2018.

To strengthen the capacity of Government and civil society to deliver RH services to vulnerable populations in humanitarian settings, UNFPA also contributed to the development of national guidelines, protocols and policy documents on SRH, including the protocol and guideline on Clinical Management of Sexual Assault Survivors, which were endorsed by the federal MoH at national level in 2016.[66] IPs have since rolled out the guidelines to health facilities that they manage in camp settings, whereas the federal MoH started rolling out the guidelines to health facilities and hospitals in host communities. Beyond guidance on clinical management of rape, the UNFPA Iraq CO contributed to updating the national Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) Strategy for 2018-2020, which was approved in 2017, but to date has not been rolled out yet.[67] In 2019, UNFPA started supporting the federal MoH in the development of the new national "Family Planning Strategy" for 2019-2022.

The UNFPA Iraq CO was effective in providing RH services to populations, mainly IDPs, refugees, and, at a later stage of the humanitarian crisis, returnees in northern and central Iraq. Under the CP, the CO supported the establishment and operations of RH services and structures in the camps (see coverage section above for numbers of beneficiaries reached).

The evaluation was not able to assess the CP contribution to changes in the proportion of deliveries assisted by skilled health workers related to pregnant women based in camps, or to the contraceptive prevalence rate amongst camp populations, because the CP does not collect such outcome data.

The rapid response of UNFPA to the Mosul liberation between October 2016 and mid-2017 emerged from stakeholder interviews and documentation reviewed as the main RH achievement of the UNFPA Iraq CO during the CP period under review. In the Mosul crisis, UNFPA managed to establish life-saving emergency obstetric care (safe delivery services) and GBV response services within 48 hours of arriving on-site, in close cooperation with WHO. This included the establishment of emergency obstetric wards adjacent to emergency hospitals established by WHO. The obstetric operating theatre in the Mosul general hospital was reportedly the first operating theatre functional in the city following its liberation.

The rapid response of UNFPA following the Mosul liberation was internationally recognised and the UNFPA Iraq CO commended by the United Nations Country Team in Iraq and the UNFPA Regional Office for Arab States in Cairo. The fact that European Union emergency funding from ECHO defined the involvement of UNFPA in the provision of health services as a condition for WHO to receive funding successfully promoted the model of inter-agency cooperation described above. The evaluation found that responding to the massive displacement was an immense challenge. Previously UNFPA had relied on a camp-centric aid approach and mobilised all its available resources to front-line areas, providing basic services to civilians located within newly or nearly liberated neighbourhoods of Mosul.[68] By May 2017, the UNFPA Iraq CO had managed to increase its capacity to provide emergency RH services at the front-lines and strengthened referral pathways through five maternity hospitals, 14 mobile and static delivery rooms and 35 mobile and static RH clinics in IDP camps as well as host communities in East and West Mosul.[69] The RH facilities were supported with personnel, equipment and supplies.

An assessment on the emergency response during the Mosul liberation that Médécins Sans Frontières (MSF) conducted in 2017 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*."[70] A study by John

[66] Iraq Ministry of Health (2016): Protocol / Guideline for Clinical Management Of Sexual Assault Survivors.

[67] Republic of Iraq/ Ministry of Health (2016): National Reproductive, Maternal, Neonatal, Child and Adolescent Health Strategy (2016-2020).

[68] UNFPA video https://iraq.unfpa.org/en/video/responding-humanitarian-crisis-mosul-oct-2016-dec-2017

[69] Interview with UNFPA Representative to Iraq in May 2017. http://www.uniraq.org/index.php?option=com_k2&view=item&id=7410:who-and-unfpa-scale-up-trauma-and-emergency-obstetric-response-capacity-to-safe-guard-lives-of-newly-displaced-families-from-west-mosul&Itemid=605&lang=en

[70] Fox, Hosanna at all (2018): Emergency Trauma Response to the Mosul Offensive, 2016-2017: A Review of Issues and Challenges. A Humanitarian Outcomes study commissioned by Médécins Sans Frontières.

Hopkins University came to similar conclusions.[71] According to the UNFPA Iraq CO RH, their emergency preparedness work, including the prepositioning of RH and GBV commodities in the weeks leading up to the liberation of Mosul, contributed to the ability of UNFPA to rapidly respond, despite the challenge of UNFPA not allowing pre-positioning of RH commodities in the region.

During and following the Mosul liberation, UNFPA carried out urgent renovation and revitalisation of key existing Government health infrastructure destroyed during the crisis, in order to speed up availability of facilities and service provision. Although renovation and revitalisation of destroyed infrastructure is not part of the normal intervention practice of UNFPA, the revitalisation of infrastructure during the Mosul crisis was key as it resulted in reopening essential facilities to support life-saving service provision. In addition, it contributed to the sustainability of Government structures.

During the site visits to RH clinics in camps and to maternity hospital in urban areas, the evaluation team observed that the physical condition and structures of the RH sections or buildings were good, although some of the spaces were rather small. The team noticed the availability of adequate supplies and tools for the provision of basic RH services, and that privacy was ensured. In a number of locations visited, the client follow-up was found to be correct with clients being provided with the Women Health Booklet and follow up cards. The team also noticed that UNFPA and donors were made visible in the RH spaces, mainly through stickers and posters.

Between 2016 and 2018, the UNFPA procured and distributed 1,980 RH kits to health facilities of different levels in the health system.[72] During the field visits, the evaluators noticed shortages of the most needed RH medications and of IUDs in most facilities.[73] The evaluation team noticed that some equipment donated to maternity hospitals did not display stickers, indicating the equipment had been provided by UNFPA or the donor. The evaluation 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 of the high value RH kits by the UNFPA Iraq CO was inefficient. After the acute emergency situation had been overcome, UNFPA continued to provide various RH kits with medicines and supplies to health facilities (most often via the governorate DoH). Much of the kits' content is not considered adapted to the country context by interviewed health facility managers. As a consequence, many kit items were not used and were either returned to DoH medical stores or expired within the facilities. 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 wastage of unused items. UNFPA Iraq CO staff responded that the CO only provides generic medicines, whereas many health care providers in the supported facilities in Iraq requested brand medicines. 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 provided items.

In addition to the distribution of emergency distribution by UNFPA of RH kits to health facilities, the UNFPA Iraq CO, along with agency partners UNICEF and WFP, co-led the Rapid Response Mechanism (RRM) consortium. This consortium ensures that a unified kit of aid items is distributed to IDP families and other vulnerable families during the first 72 hours after the outbreak of a crisis. These RRM kits contain a week-long supply of water, food, hygiene and dignity items that are essential for a family to sustain themselves until either the at-risk individuals can reach more consistent aid, or further aid can reach them in place.

Apart from supporting service delivery and distributing RH kits, the CP also supported SRH awareness-raising sessions among targeted populations. In 2017-2018, 336,283 women were reached with

[71] John Hopkins Centre for Humanitarian Health (2018): the Mosul trauma response; a case study.

[72] UNFPA Annual Reports over 2016, 2017 and 2018.

[73] The Impact Assessment Report conducted in 2018 for Global Action Canada, the same point was highlighted where 52 percent of respondents were concerned about the lack of medicine. However, we do not know the proportion of respondents who were interviewed in Iraq.
UNFPA (2018): Impact Assessment Report; Global Action Canada; UNFPA Multi-Country Response to the Syria Crisis: Syria, Turkey cross-border operations into Syria, Lebanon, Iraq and Jordan. May 2018.

awareness-raising sessions.[74] Awareness raising was undertaken primarily by medical doctors and to some degree through women centres and community mobilisers.

The few beneficiaries of RH services that the evaluation team interviewed expressed their appreciation of the maternal health services they received. This feedback is in line with two impact assessments in which beneficiaries were asked their view of the services they received and their accessibility. More than90 percent of beneficiaries responded that they were highly satisfied or satisfied.[75] However, RH service beneficiaries interviewed by the evaluation team did not seem to get little orientation on family planning from the RH service providers. This is owed to the fact that the CP implementation focused on providing ante-natal and delivery services to IDP and refugee populations, while fewer efforts were made to strengthen FP services and the delivery of adolescent-friendly services. However, all these areas were included amongst the CPD focus areas. In addition, limited CP resources meant that the UNFPA Iraq CO could not focus much on community outreach and improving male engagement in the field of RH. This is a missed opportunity since interviews with IPs suggest that the male population in Iraq is not receptive to family planning.

Another missed opportunity is the low integration of RH programming with other CP components, such as gender equality, GBV prevention and response and youth programming. An example of this is the development and roll-out of the protocol for clinical management of rape (CMR), which should have been led by the UNFPA RH programme, but which - due to RH programme funding constraints – was funded by and led by the UNFPA gender programme. As the gender programme does not have a strong relationship with the MoH, this resulted in UNFPA supporting the development and implementation of the CMR protocol without strong ownership of the MoH. Another challenge to the success of the CMR protocol is the fact that, although it was approved by the Ministry of Interior, the protocol, that was developed with the support of UNFPA, does not take into consideration the current legal context in Iraq (see below on Output 3).

In 2018, the RH programme started its transition to a more resilience- and development-oriented focus, moving away from supporting frontline service provision and increasing emphasis on strengthening national health systems. This included the gradual handover and/or closing of RH services to Government or other partners, as per Government policy. By the end of 2018, UNFPA and IPs had handed 40 out of the 112 supported RH facilities over to the Government. According to the UNFPA Iraq 2018 Annual Report, the Government assumed responsibility for full support of those health facilities.[76] The CPE team found that all RH facilities that were handed over to the Government in KRI were closed, as per Government policy to not maintain any health facilities in camps. Health authorities in one governorate interviewed by the evaluation team observed that access to and uptake of FP services by the camp populations decreased where RH facilities had been closed. As a reason for this they indicated that camp populations had to attend nearby Government clinics where staff do not receive incentives to provide FP. The criteria that the UNFPA Iraq CO used to decide which RH facilities should be closed first were not clear to the evaluation team. The evaluators observed that some RH facilities located close to local towns or cities are still being supported, whereas other RH facilities serving small populations of highly vulnerable or isolated groups have been closed. For some RH structures supported during the current CP, particularly in the central/southern area of the country, UNFPA succeeded to promote ownership of local authorities, which contributed to Government commitment to take over the structures.

As part of the transition towards a greater development focus, the UNFPA Iraq CO conducted advocacy with the Government and partners in the second half of 2018 on the need to increase FP coverage in Iraq. This resulted in the establishment of a working group for the development of a national Family Planning Strategy by the MoH. An enabling factor was that the Minister of Health who was appointed in 2019 has a background in international development and used to work for the United Nations. His commitment to advancing issues around population dynamics is illustrated by the Minister's leadership of the working group for the FP Strategy and his support to preparations for the population census planned for 2020.

[74] UNFPA Annual Reports over 2017 and 2018.

[75] UNFPA (2018): Impact Assessment Report; Global Action Canada; UNFPA Multi-Country Response to the Syria Crisis: Syria, Turkey cross-border operations into Syria, Lebanon, Iraq and Jordan. May 2018. UNFPA (2018): Impact Assessment Report; Sida; UNFPA Multi-Country Response to the Syria Crisis: Syria, Turkey cross-border operations into Syria, Lebanon, Iraq and Jordan. May 2018.

[76] UNFPA Iraq (2018): 2018 Annual Report – Iraq. Report generated by UNFPA SIS system.

The CP suffered from considerable external challenges. The security situation in Iraq, in combination with political/sectarian conflicts and a high level of corruption, constituted major challenges for UNFPA in its system strengthening efforts. Furthermore, the curative focus of the Iraqi health system results in the Government taking less ownership of the preventive aspect of SRH programmes. There is scarcity of qualified human resources in the public sector in terms of quantity and quality. This is exacerbated by high turnover of Government officials and civil society staff without adequate systems for handover to successors, and by the recruitment freeze applied by the Iraqi Federal Government and the Kurdistan Regional Government, affecting the ability of Government structures and facilities to hire new staff when existing staff retires or is transferred. Partner NGOs also reported the difficulty of recruiting and retaining qualified personnel due to the incentives that Government benefits and salaries packages offer. Consequently, the CP was affected by the continued loss of human resources whose capacity had been built by the programme. The push of traditionalism and conservatism in the country also had a negative impact on the willingness of authorities and communities to act on all issues of the UNFPA mandate, such as the right of unmarried adolescents and young people to access information on SRH, as well as on the ease and motivation of the UNFPA Iraq CO to openly advocate on these issues.

Lessons learned and best practices

- During the Mosul operation, the strong coordination between UNFPA and WHO - facilitated by joint / linked donor funding - led to many achievements in joint planning and rapid responses.
- Pre-positioning of emergency supplies and materials by the UNFPA Iraq CO helped ensure a timely humanitarian response.
- Training and utilisation of other cadres including general medical doctors and midwives/nurses to provide RH services boosted the coverage in the absence of gynaecologists.
- If RH kits are used after an acute crisis has ended, their contents need to be adapted to the country context.

Adolescents and Youth

FINDINGS SUMMARY

Within the **youth programme**, the CP prioritised direct service provision to and SRH and GBV awareness-raising of adolescents and youth in humanitarian settings, mainly through the establishment and management of 19 youth centres and outreach activities. Im Y-PEER youth volunteers were supported to provide awareness-raising on health and SRH, GBV prevention, life skills, participation in social changes and civic engagement to youth in 18 governorates. In close collaboration with UNICEF, UNFPA developed and rolled-out of the Adolescent Girls toolkit, one of the main tools used for the awareness-raising on SRH amongst adolescents. Adolescents and youth interviewed by the CPE team reported that the youth centres had made a difference in their lives by increasing their understanding of the importance of attending and finishing education, of their right not to be maltreated by their family members and had convinced several adolescent girls and their families not to marry young. The CP capacity building efforts targeted to government staff on youth issues were limited, whereas capacity building efforts of civil society organisations focussed on CP IPs. No significant efforts took place to address the legal context of youth interventions.

From mid-2018 the UNFPA youth team shifted its focus to developing a coherent youth programme, with increased emphasis on strengthening cooperation and advocacy on youth issues with central and regional authorities and to develop a national youth agenda. Preparations for the National Youth Survey was an example of this new orientation.

Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services.

Table 8: Achievements for Outcome 2 against outcome and output indicators

CP outcome Indicators	CP targets	Level of achievement	Comments
R.2.1 Country has laws and policies that allow adolescents (regardless of marital status) access to sexual and reproductive health services.	Baseline: No. Cumulative CP target: Yes. (Source: UNFPA annual CP reports)	No by Dec. 2018 (source UNFPA annual CP reports) – **2018 target not achieved.**	No laws in place (yet) in Iraq allowing adolescents to access SRH services. During 2016-2018 the CP focussed on humanitarian service provision. However, the National Health Strategy has outputs to promote adolescent health through health care providers and school health programmes.

CP output 2	Enhanced capacity of the 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.

CP output indicators	Targets	Level of achievement	Comments
O.2.1 Number of centres that train vulnerable adolescents and youth in life skills.	Baseline: 0. Cumulative CP target: 30. (Source: UNFPA annual CP reports)	4 by Dec. 2018 – **26.7% of 2018 target of 15 achieved; 13.3% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	
O.2.2 Number of governorates covered under Y-PEER capacity-building interventions.	Baseline: 5. Cumulative CP target: 8. (Source: UNFPA annual CP reports)	18 by Dec. 2018 – **225% of 2018 target of 8 achieved; 225% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	By the end of 2018, Y-PEER capacity building was undertaken in 18 governorates, which means in all governorates of the country.
O.2.3 Revised National Youth Strategy.	Baseline: 0. Cumulative CP target: 1. (Source: UNFPA annual CP reports)	1 by Dec. 2018 – **100% of 2018 and of cumulative CP targets.** (Source: UNFPA annual CP reports)	The baseline and target should have been formulated differently: Baseline should have been defined as: "national youth strategy in draft form available", with the target defined as: "strategy developed, approved and in implementation."

The analysis of the level of achievement of the output indicators according to the UNFPA CPAP Planning and Tracking Tools for 2016-2017 and 2018-2019 shows that by December 2018, two out of the total of three output indicators had been achieved.[77]

The strategic partner of the UNFPA Iraq CO in this programme area is the central Ministry of Labour and Social Affairs (MoLSA) in Baghdad, the regional Kurdistan MOLSA in Erbil and the Departments for Labour and Social Affairs (DOLSA) in the governorates, and the central Ministries of Youth and Culture (MoY) and Education (MoE). Civil society partners included Al-Mesalla in Erbil, Harikar and IMC in Dohuk, CDO in Sulaymaniyah, Al-Tajdid in Baghdad, and Qandil and Y-PEER in all governorates.

CP achievements on youth are partially in line with the CP output on "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." Due to the humanitarian crises, during 2016-2018, the UNFPA Iraq CO assigned priority to emergency responses in the programme areas of RH and GBV. Within the youth programme the CP focussed on facilitating leisure and learning activities and SRH and GBV awareness-raising among adolescents and youth in humanitarian settings, mainly through the establishment and management of youth centres and outreach activities. Capacity building of the

[77] UNFPA (2017): CPAP Planning and Tracking Tools for 2016-2017. Updated to December 2017.
UNFPA (2019): CPAP Planning and Tracking Tools for 2018-2017. Updated to June 2019.

Government for youth programming was therefore extremely limited under the current CP. The limited capacity building efforts that took place focussed on strengthening the capacity of civil society organisations that were CP IPs. No significant efforts took place to address the legal context of youth interventions.

Thus, the youth programme focused mostly on two of the five key actions of the Compact for Young People in Humanitarian Action[78] to which UNFPA is a signatory: 1) it promoted and increased age- and gender-responsive and inclusive programmes that contributed to the protection, health and development of young women, young men, girls and boys within humanitarian settings (action 1); 2) it strengthened the capacity of adolescents and youth. To a lesser degree, the CP empowered and strengthened the capacity of youth-led organisations such as Y-PEER (action 3); and it mobilised and allocated resources to address the needs of adolescents and youth affected by conflict and displacement (action 4). In the second half of 2018 the UNFPA Iraq CO started efforts towards achieving progress on youth participation through its support to the establishment of youth boards (action 2); and on the generation of data on young people through the Adolescent Survey (action 5).

The UNFPA Iraq CO supported the development of national policy documents by the Government and partners, including the revision and launch of the National Youth Strategy 2016-2026, with its associated five-year action plan for youth and sports 2018-2022,[79] and the development of the national youth volunteer strategy (still in drafting stage).[80] UNFPA also supported the design of and preparations for the National Adolescent and Youth Survey, which was to be s conducted in 2019 by the Central Statistics Office under the Ministry of Planning and the Kurdistan Region Statistics Office, in consultation with the Ministry of Culture and Youth. The survey is expected to cover 11,850 households and 54,000 male and female adolescents and youth aged 10-30 years. It is expected to provide important data for evidence-based programming for adolescents and youth in the country and is also used as a tool for UNFPA and partners to advocate with the Government on the importance of taking into consideration the needs of adolescents and youth in the development of the country. The CP furthermore supported the development and roll-out of the Adolescent Girls Toolkit, in close collaboration with UNICEF.[81]

During 2016-2017, the main focus of the youth programme was on supporting life skills training and awareness-raising on SRH, GBV and other harmful practices, such as child marriage and forced marriage, among adolescents and youth. For this purpose, the UNFPA Iraq CO supported the establishment of 19 youth centres that were managed by civil society IPs in refugee and IDP camps in Kurdistan. It also supported youth centres in host populations in the northern and south-central parts of the country. In order to increase access to youth centres and spaces managed by MoLSA for young people, UNFPA supported the rehabilitation of some government buildings in south-central Iraq, and supported the Government in conducting youth awareness sessions in the north. During 2016-2018, the UNFPA Iraq CO raised awareness on child and forced marriage, youth communication, STDs, SRH, peace building and other youth-related topics of a total of 278,858 adolescent boys and girls from IDP and refugee populations through indoor awareness-raising activities and of a total of 123,969 young people through outreach activities. The UNFPA Iraq CO furthermore supported capacity building of 12,763 youth to develop their vocational skills.[82]

The evaluation team was impressed with the youth centres visited in IDP and refugee camps, and observed that they are a useful way to work with adolescents and youth living in camps and that they make a real difference in their lives. Interestingly, the UNFPA Iraq CO also used women's centres for implementing adolescent girls' activities. This increased access to awareness-raising on SRH and GBV, and to GBV response services for adolescent girls . Stakeholders interviewed questioned the capacity of the civil society IPs used for youth programming, particularly to work with adolescents and youth in challenging settings (e.g. ultra-conservative communities) and suggested that UNFPA should pay more attention to this.

[78] UNFPA (2018): Igniting hope; Compact for Young People in Humanitarian Action.

[79] Iraq Ministry of Youth and Sport (2016). National Youth Strategy 2016-2026.
Iraq Ministry of Youth and Sport (2018): 5-Year Action Plan for Youth and Sports 2018-2022.

[80] Ministry of Youth and Sports (2019): National Youth Volunteerism Strategy. Not yet published.

[81] UNFPA and UNICEF Iraq (2016): Adolescent Girls Toolkit.

[82] UNFPA Annual Reports over 2016. 2017 and 2018.

The evaluation team was not able to obtain any data on progress towards the achievement of the outcome indicator of ensuring that Iraq has laws and policies in place that allow adolescents (regardless of marital status) to access SRH services.

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

Another channel for conducting awareness-raising of adolescents and youth was the Y-PEER network, established by the UNFPA Iraq CO in 2009. While in 2016, UNFPA supported Y-PEER activities in six governorates only, this was expanded to all 18 governorates in 2018. In 2018, Y-PEER youth volunteers reached 9,544 young people with awareness-raising on 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, sport events, meetings and public events. Y-PEER volunteers are male and female, and targeted both female and male adolescents and youth, thus strengthening male engagement. Y-PEER also conducted advocacy with decision-makers. Some IPs supported the establishment of local Y-Peer networks, such as in Dohuk through Harikar. While the CP did not allocate much funding for supporting Y-PEER activities, UNFPA staff in south-central Iraq encouraged Y-PEERs to mobilise resources from other United Nations agencies, INGOs, and the private sector.

The evaluation team observed that the UNFPA youth programme was mainly implemented through a number of international NGOs and MoLSA, whereas the numbers of young people reached through Y-PEER networks was more limited. 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 the sense that working through Y-PEER is a cost-effective and sustainable way for peer education and community awareness-raising campaigns, compared to working through a national or international NGO. As a consequence of the limited funding disbursed to Y-PEER for supporting its activities in Iraq, the network has had to make an even greater appeal on the voluntarism of its members. This meant that since 2018 members have been asked to offer their time to conduct activities not only without salary or monetary compensation, but they also have been paying for transport, food and drinks for both themselves and visitors out of their own pockets. This resulted in the Y-PEER network reducing its geographic reach. It was also suggested to the evaluation team that not all UNFPA programme staff were equally supportive in facilitating Y-PEER application to other partners for funding opportunities.

The CP supported the implementation of the Youth, Peace and Security Agenda. This included training of 4.000 youth in South-central Iraq on reconciliation and negotiation skills, with financial support from the German Government. Youth leaders were trained 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 efforts. This programme was expanded to Kurdistan in the second half of 2019. In 2018, the UNFPA Iraq CO supported capacity building of government staff, including 110 instructors of government youth centres, on peace and security and delivered refresher training on the Life Skills and Civic Engagement Kit to 22 participants from the MoLSA in KRI. The UNFPA Iraq CO did not monitor or assess the increase of knowledge and capacity of youth and government staff and its impact on service provision.

Adolescents and youth 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 that they received and their participation in the activities, and that this had a positive impact on their status in their homes and communities. For example, they gained an understanding that they have a right to go to school and not to marry young; that they should not accept sexual harassment and should report SGBV issues; and that they have the power to participate in their communities, to express their opinion, etc. They developed the ability to express themselves and discuss their issues related to home and school; some of them developed skills in areas

such as music, painting and handicraft and others benefited from vocational training. Young adolescent girls also reported that whereas previously they thought it was preferable to marry at a young age, they changed their minds and decided to focus on finishing school. Some girls also reported that since they have attended activities in the youth centres, they can move around in the camp without being harassed by men and boys, and that their families and the camp communities have become more accepting of them moving around in the camp without being accompanied by adults.

A key achievement of the CP – mentioned by the majority of youth stakeholders interviewed - was the development and roll-out of the Adolescent Girls Toolkit; one of the main tools used for awareness-raising on SRH amongst adolescents. This toolkit was developed in partnership with UNICEF in 2016 and made available in Arabic, Kurdish language, with funding from Norway. The toolkit provides tools for teaching SHR and life skills to adolescent girls, as well as tools for teachers. It contributed to unifying approaches between UNICEF, UNFPA and other partners and helped to standardise tools used by the Government and its partners in Iraq when working with adolescent girls. The UNFPA Iraq CO supported the roll-out of the Adolescent Girls Toolkit by strengthening the capacity of service providers working with young people, such as youth workers, NGOs, and government entities to use the toolkit. The toolkit includes tools for special sessions with parents (mothers), which contributed to closing the gap between young girls and mothers, and helped them to build better relations. This also contributed to changing mothers' views on child marriage and girls' empowerment, and on the importance of communication with young girls. There is international interest in the toolkit, with partners in other countries reportedly interested in using the toolkit in their countries.

UNFPA staff reported the difficulty of mobilising funding for youth programmes in a humanitarian context, with the humanitarian agenda and donors predominantly focusing on SRH and GBV interventions. An achievement was that UNFPA linked GBV interventions with youth interventions in GBV programme proposals submitted to donors. This ensured some funding to support services and resilience interventions that reached adolescents and youth affected by the crisis, particularly adolescent girls.

External challenges affecting the implementation of the young programme included the fact that the Iraqi Government does not allocate adequate budgets for adolescent and youth programming and has not started to implement the National Youth Strategy yet. Another challenge is the considerable variation in government support to youth centres across governorates in the country.

The lack of UNFPA youth programme staff, programmatic leadership and adequate funding affected the quality and quantity of youth programming during the first years of the CP, when the youth programme was mainly implemented through small project activities focusing on direct service provision without a coherent vision programme. During this time, UNFPA engagement with the Government on youth issues was limited, and consequently the UNFPA Iraq CO 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 Ministry of Culture and Youth in KRI before 2018 was minimal, which is surprising in view of the fact that the CP Action Plans state that the Ministry of Youth "will coordinate adolescent and youth programmes". The reason given by CO staff for this lesser engagement with the Ministry of Culture and Youth was that this Ministry was not an IP of the CP.

Since the arrival of the international Youth Specialist in mid-2018, the UNFPA youth team has focused on developing a coherent youth programme, with special emphasis on supporting life skills training, youth participation and knowledge generation, while strengthening cooperation and advocacy on youth issues with central and regional authorities, including to develop a national youth agenda. UNFPA supported the secondment of youth advisors to three governorates. The UNFPA support to the establishment of Youth Advisory Boards in two governorates in South-central Iraq (Najaf and Diyala), in collaboration with the MoYS, is also an effort to promote youth participation and empowerment. The board members consist of young persons who advise the Government on needs and priorities for youth programming, policy development and needs for resource allocations in government annual plans.

The UNFPA Iraq CO has also been working with the central MoYS on the systematic introduction of sustainable Civic Values and Life Skills (CVLS) Education within the education system, to provide the

foundation for a better future of young people.[83] The CP focused on strengthening institutional and staff capacities of the Ministries of Education (MoE), MoLSA and MoYS to deliver quality formal and non-formal education through the promotion of CVLS and the capacity to integrate CVLS education in the Vocational Training Centres (VTC) operating under the MoLSA and the Vocational Education Schools (VES) of the MoE.

Since mid-2018, the UNFPA Iraq CO 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 in camps in more remote locations were closed.

Lessons learned and best practices

- Linking GBV programs with youth interventions in all GBV proposals to donors ensured that some services and resilience interventions reached a large section of youth affected by the crisis, particularly adolescent girls.
- Using women's centres for implementation of adolescent girls' activities allowed for greater access to young girls for SRH/GBV awareness-raising and GBV response programming.
- Advocacy efforts are required with the new government on the youth agenda in south-central Iraq.
- Planning of UNFPA youth programmes requires equal attention in Iraq and Kurdistan Region to bring a balance of UNFPA support to government. During the first three CP years, more policy advocacy work was carried out in south-central Iraq whereas more humanitarian focused interventions were supported in KRI.

Gender Equality and Women's Empowerment

FINDINGS SUMMARY

The CP GBV programme effectively provided **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 the end of 2018, the CP had established 108 women centres, with focus on IDPs / refugee settings and host communities. The CP furthermore supported awareness-raising of camp communities on GBV and early and child marriage. The CP also supported some capacity building of government and civil society health service managers and providers, legal institutions and police staff on GBV prevention and response, and supported general capacity building of government women's authorities at central level. Moreover, the CP supported the development and the roll-out of the protocol and guideline for clinical management of rape (CMR) and Standard Operating Procedures (SOP) for South-Central Iraq and for Kurdistan on GBV prevention and response. Users of women's centres interviewed by the CPE team expressed their appreciation for the services provided and their impact on their lives in terms of having a place to share experience, their increased empowerment, increased acceptability in the community of women and girls attending the women's centres and acceptability of speaking out about violence against women. The CP and GBV sub-cluster supported GBV service mapping and documentation of referral pathways and the vulnerability of GBV survivors. They also the supported the establishment of the GBV Information Management System (GBV-IMS). Efforts by UNFPA to ensure consistency and minimum quality standards in the development and use of BCC materials by IPs were limited. The CP has started to handover women's centres to government.

The legal environment in Iraq still represents an important external challenge for the promotion of gender equality. The Iraqi constitution and laws still allow and condone practices such as marital rape, child marriage, polygamy, etc. Furthermore, 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, marital rape, child marriage, etc.

[83] The CVLS encompasses concepts of Civil Values: human rights, citizenship, national identity, tolerance and gender equality; and Life Skills: interpersonal communication skills, negotiation skills, teamwork, advocacy skills, decision-making and problem-solving skills, critical thinking skills, skills for managing feelings as well as stress management skills.

Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.

Table 9: Achievements for Outcome 3 against outcome and output indicators

CP outcome Indicators	Targets	Level of achievement	Comments
R.3.1 Percentage of women aged 15-49 years who think that a husband/partner is justified in hitting or beating his wife/partner under certain circumstances.	Baseline: 64.0%. Cumulative CP target: 30.0% (source: MICS 2011).	36.5% by Dec. 2018. **104.5% of 2018 target achieved; 93.5% of cumulative CP target achieved.** (Source: MICS 2018)	
R.3.2 Number of women and girls accessing GBV services in UNFPA supported facilities.	Baseline: 420,000. (source: UNFPA annual CP reports) Cumulative CP target: 2019: 1,000,000 (source UNFPA annual CP reports).	290,314 by Dec. 2018 – **101.4% of 2018 target of 700,000 achieved; 29.7% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	
R.3.3 Number of women accessing sexual violence clinical services.	Baseline: 650. Cumulative CP target: 2019: 5,000 (source: UNFPA annual CP reports).	294 by Dec. 2018 – **31.4% of 2018 target of 3.000 achieved; 18.8% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	

CP output 3	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.

CP output indicators	Targets	Level of achievement	Comments
O.3.1.A Number of health service providers, social workers and law enforcement personnel trained to respond to gender-based violence in the five most affected governorates - Medical Personnel	Baseline: 51. Cumulative CP target: 100 (source UNFPA annual CP reports).	103 health providers trained by Dec. 2018 - **147% of 2018 target of 70 trained achieved; 103% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	2018 and cumulative CP targets for health service providers trained have been achieved. Indicator formulation does not seem correct – last 2 words should read "health service providers" instead of "medical personnel".
O.3.1.B Number of health service providers, social workers and law enforcement personnel trained to respond to gender-based violence in the five most affected governorates - Social Workers	Baseline: 163. Cumulative CP target: 200 (source UNFPA annual CP reports).	959 social workers trained by Dec. 2018 – **533% of 2018 target of 180 achieved; 480% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	2018 and cumulative CP targets of social workers trained were surpassed considerably.
O.3.1.C Number of health service providers, social workers and law enforcement personnel trained to respond to gender-based violence in the five most affected governorates - Uniformed Personnel	Baseline: 224. Cumulative CP target: 400 (source UNFPA annual CP reports).	594 uniformed personnel trained by Dec. 2018 – **187% of 2018 target of 320 achieved; 149% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	2018 and cumulative CP targets of uniformed personnel trained were surpassed considerably.

CP output indicators	Targets	Level of achievement	Comments
O.3.2 Number of women centres supported by UNFPA to provide gender-based violence services in humanitarian settings	Baseline: 54. Cumulative CP target: 80 (source UNFPA annual CP reports).	108 centres by Dec. 2018 – **153% of 2018 target of 70 centres achieved; 135% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	2018 and cumulative CP targets of the number of centres providing GBV services were surpassed considerably.
O.3.3 Number of UNFPA-supported advocacy campaigns at the governorate level against female genital mutilation.	Baseline: 0. Cumulative CP target: 40 (source UNFPA annual CP reports).	50 campaigns by Dec. 2018 – **250% of 2018 target of 20 campaigns achieved; 125% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	2018 and cumulative CP targets of the number of centres providing advocacy campaigns supported were surpassed considerably.
O.3.4 Sexual and gender-based violence minimum standards adopted at sub cluster level	Baseline: No. Cumulative CP target: Yes (source UNFPA annual CP reports).	Yes, standards adopted since 2016. **100% of 2018 target of yes; 100% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	It would have been useful to change this indicator from "adopted at sub-cluster level" to "adopted by national and regional authorities and implemented".
O.3.5 Number of women centres offering gender-based violence prevention services that are adhering to standard operating procedures (staff trained, monitoring system in place)	Baseline: 0. Cumulative CP target: 2019: 70 (source UNFPA annual CP reports).	**66% of 2018 target of 30 centres achieved; 28.5% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	20 centres were offering GBV services adhering to standard operating procedures by December 2018
O.3.6 Proportion of woman centres handed over to Government	Baseline: 0. Cumulative CP target: 2019: 100% (source UNFPA annual CP reports).	30 women's centres by Dec. 2018 – **54% of 2018 target of 55 centres achieved; 36.1% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	This is a new indicator that was not originally included in the CPD and introduced by the CO in 2018.

The analysis of the level of achievement of the output indicators according to the CPAP Planning and Tracking Tools of 2016-2017 and 2018-2019 shows that by December 2018, six out of eight output indicators had been achieved.[84]

For the purpose of output 3 on GBV and harmful practices, the UNFPA Iraq CO partnered with the Federal Ministry of Labour and Social Affairs (MoLSA), the regional Kurdistan MoLSA and the Departments for Labour and Social Affairs (DOLSA) in the governorates, the Ministry of Interior (MOI), the Directorate of Combating Violence Against Women (DCVAW), and the Kurdistan High Council of Women Affairs (KHCWA). Civil society partners included Al-Mesalla in Erbil, Harikar in Dohuk, CDO in Sulaymaniyah, Al-Tajdid in Baghdad, and Qandil for monitoring and evaluation across the country.

The CP achievements are mostly in line with the output on "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." However, due to the increase in acuteness of the humanitarian situation during 2016-2017, the main CP focus was on direct service provision, and less on capacity strengthening. The UNFPA Iraq CO undertook some capacity building of the Government, although most of the capacity building efforts under the current CP focused on civil society. Among these organisations were mainly the civil society IPs of UNFPA-supported interventions to prevent and respond to GBV and harmful practices. Furthermore, the CP focused mainly on the response to GBV, and to a lesser extent on GBV prevention within communities, while some attention was paid to other

[84] UNFPA (2017): CPAP Planning and Tracking Tools for 2016-2017. Updated to December 2017. UNFPA (2019): CPAP Planning and Tracking Tools for 2018-2017. Updated to June 2019.

harmful practices, particularly early and child marriage. The main target group of this programme area were vulnerable women and girls in IDP and refugee camps.

The CP supported the Government in the development of national laws and policy documents, such as the amendment of the law for combating violence against women[85], the National Strategy to Combat Violence against Women 2018-2030 in Iraq[86], the National Strategy combating violence against women in Kurdistan Region (2017-2027)[87], the Kurdistan National Strategy for the Development of Women 2016-2026, the Communication for Behavioural Impact (COMBI) plan on prevention of child marriage in Kurdistan[88], the protocol and guideline for clinical management of rape (CMR)[89], the standard operating procedures (SOP) on GBV prevention and response for South-Central Iraq and for Kurdistan[90], draft bylaws for women's shelters, and the draft National strategy on Female Genital Mutilation (FGM) (to be finalised in 2019). The UNFPA Iraq CO also supported preparations for the next Iraq Women Integrated Social and Health survey I-WISH, planned to be conducted in 2020.[91]

The UNFPA Iraq CO effectively provided GBV response services to survivors in humanitarian crises and in hard-to-reach areas, in many of which no GBV response capacity existed previously. This included continuing to support the women's centres / safe spaces established in refugee and IDP camps during the previous CP cycle, as well as the establishment of additional women's centres and GBV response outreach services during the increased humanitarian crisis in 2016-2017. An achievement was the timely provision of emergency GBV response services to populations in newly liberated areas, such as in/around Mosul crisis. The UNFPA Iraq CO ensured that GBV teams were adequately trained and located close to crisis locations. By December 2018, UNFPA had established 108 women safe spaces, with a focus on IDP and/ refugee camps and host communities where all initial services of case management (psycho-social support (PSS), case management, and referral) were provided to GBV survivors.[92] In 2018, the UNFPA Iraq CO supported GBV case management services for 140,293 women and girls in humanitarian settings.[93] Between 2016 and 2018, 223,414 vulnerable women and girls received a dignity kit.

During 2016-2018, the UNFPA Iraq CO supported the capacity development of 12,799 services providers and GBV actors on GBV case management, the implementation of CMR, referral pathways, the GBV core concept, and child case management. In addition, IP staff was trained on Protection from Sexual Exploitation and Abuse (PSEA).[94] The UNFPA Iraq CO furthermore strengthened the GBV response capacity of police and legal institutions through capacity building on case management and the GBV core concept of 250 security force members and 39 judges t.

As part of the integration of GBV and RH programming, a number of United Nations agencies, including UNFPA, together with partners developed the CMR protocol that was endorsed by the Government. However, there were challenges in the implementation of the protocol, as some protocol elements are not in line with current laws in Iraq, such as provisions on mandatory reporting of incidents of rape.

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[85] Republic of Iraq: Article No 8, 2011, The Act of Combating Domestic Violence in Kurdistan Region.

[86] Iraq Women Empowerment Department (2018): National Strategy to Combat Violence against Women 2018-2030.

[87] Kurdistan Regional Government High Council of Women Affairs (2017): National Strategy combating violence against women in Kurdistan Region for ten years 2017-2027.

[88] Kurdistan Regional Government and UNFPA (2017): Behavioral Change Campaign for Reducing Child Marriage in Kurdistan Region, Iraq; "Securing My Future", July 2016 – October 2017. Communication for Behavioral Impact COMBI plan.

[89] Iraq Ministry of Health (2016): Protocol / Guideline for Clinical Management Of Sexual Assault Survivors.

[90] UNFPA Iraq (2017): Standard Operating Procedures for Prevention of and Response to Gender-Based Violence in Kurdistan Region of Iraq.
UNFPA Iraq (2018): Standard Operating Procedures for Prevention of and Response to Gender-Based Violence in south-central Iraq.

[91] Iraq Ministry of Planning, Central Statistical Organization-CSO (2012): Iraq Woman Integrated Social and Health Survey (I-WISH); Summary Report. March 2012.

[92] UNFPA Iraq (2018): 2018 Annual Report – Iraq. Report generated by UNFPA SIS system.

[93] Ibid.

[94] Iraq Gender-Based Violence Sub-Cluster (2018): GBV sub-cluster Iraq, February 2018.

The GBV survivor centre that was established in Dohuk with the support of UNFPA, 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 the Anbar governorate. The UNFPA Iraq CO furthermore supports six shelters in the country. Whereas women's centres and survivor spaces provide out-patient services related to GBV prevention and response to survivors and surrounding communities, shelters are locations where GBV survivors and their children can stay overnight, if they need to leave their homes to protect themselves. The UNFPA Iraq CO built the capacity of women's shelter staff in managing the facility (including orientations on the international legal framework on women's rights and gender equality, the shelter objective, shelter, and guiding principles and standard operating procedures) and facilitated exchange of experiences and good practices between the supported shelters in Iraq. Furthermore, as co-lead of the shelter working group, UNFPA assisted in coordinating the drafting of the shelter by-laws.

As planned in the CPAP, the UNFPA Iraq CO supported efforts to prevent GBV and other harmful practices such as child and early marriage by implementing activities to increase public awareness on the detrimental effects of these practices on families and communities. The UNFPA Iraq CO supported the conduct of multiple awareness-raising campaigns by IPs and staff of youth centres, women's centres and by Y-PEER volunteers. UNFPA Annual Reports state that the CP reached 1.5 million women, girls and community members with awareness-raising on SRH and the negative impact of GBV and child marriage (2016-2018), as well as female genital mutilation(FGM) (2018). 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 training of health service providers, social workers and law enforcement personnel. Staff of 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 increasing awareness on GBV and RH. In one IDP camp (Mamarashan) in the Dohuk governorate, UNFPA strengthened community communication by supporting the establishment of a radio station. Camp management and organisations active in the camp highly appreciated the radio station and regretted that it was closed in 2018 due to lack of funding. However, overall awareness-raising and behaviour change communication targeted specifically at men and boys and the wider community, such as community leaders, religious leaders, youth clubs and sports clubs, was limited. A number of interviewed stakeholders questioned the impact of the UNFPA-supported awareness-raising activities on behaviour change. Awareness-raising on other harmful practices occurring in Iraq, such as honour killings and FGM was also limited. The CP did not document the effect of the awareness-raising activities on attitudes and behaviours in target groups and communities.

The CPE team observed a lack of unified IEC / BCC materials used by IPs. Efforts by UNFPA to ensure consistency and minimum quality standards in the development and use of BCC materials by UNFPA's IPs were limited. Each IP developed their own BBC materials, which resulted in different partners using different materials with different BCC messages on the same subject. Moreover, once BCC materials were produced by an IP, there was limited follow up by the UNFPA team to ensure that the materials were sufficiently disseminated and used by partners. Recently, the UNFPA-led GBV Sub-Cluster initiated advocacy at national and governorate levels to encourage GBV actors to standardise BCC materials.

During interviews with GBV survivors and IPs, these indirect and direct beneficiaries expressed a high level of satisfaction with the services provided inside the women's centres. IPs interviewed reported that the numbers of women and girls attending the women's centres greatly increased over the period of the CP, which indicates that the acceptability of attending increased in the communities. The manager of a women's centre reported: "*The first month only women came to the centre, the next month the same women returned with their daughters and neighbours, and later there were fathers who drove their wives and daughters to the centre*". A social worker of an NGO providing GBV response services reported that after attending awareness-raising sessions, some women changed their mind and no longer allowed their young daughters to marry and lobbied with their husbands to prevent their daughters from getting married under age. Awareness-raising activities also resulted in some men accepting to attend awareness-raising sessions on various topics. Some men in Kurdistan and Anbar reportedly requested psycho-social support for themselves. Stakeholders interviewed reported that another indicator of the positive impact of the work of UNFPA on the lives of beneficiaries is that speaking out about gender equality and GBV is now more accepted in the country. The CPE did not document the change in knowledge, awareness and acceptance of GBV and violence against women amongst the targeted populations.

Interviewees reported that the women's centres and the social workers helped to build the capacity of the beneficiaries and contributed to strengthening their self-esteem and to developing skills and competencies which will serve them even after returning to their places of origin. The vocational training provided in the women's centres has been much appreciated by beneficiaries and helped some of them to find a job. The girls and women who participated in these activities requested further assistance from UNFPA to set up their own businesses. Women's centres' staff interviewed reported that it was a challenge that the centres do not have resources to organise or facilitate livelihood support or follow-up on livelihood capacity building provided to women and girls visiting the centres.

Under UNFPA leadership, 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.[95] The GBV sub-cluster also coordinated the development of GBV response SOPs and their roll-out to GBV actors (see section 4.7 on coordination).[96] Furthermore, in late 2018 the UNFPA Iraq CO supported the DCVAW of the Kurdistan Regional Ministry of Interior to launch the 119 telephone hotline, which is a 24-hour call centre to provide confidential support and guidance to survivors of GBV. It is expected to reach 3,600 survivors per year.[97] UNFPA trained DCVAW social workers and telephone operators on the hotline procedures and guidelines and supported awareness-raising to the public on this new initiative. At time of writing this report, the DCVAW and UNFPA have not published any data on the use of the hotline or its impact on reporting by GBV survivors yet.

In addition to training service providers on methods and procedures of GBV response, the UNFPA Iraq CO 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. UNFPA supported the capacity building of women's institutions at central level (e.g. the newly established central Women Empowerment Department, and the Kurdistan HCWA and DCVAW) in the field of management, such as project management and reporting, financial management and human resource management. The UNFPA Iraq CO also supported the institutions in the development of programmatic documents, such as the internal bylaws. The DCVAW was further supported through the establishment of a database on GBV survivor data, and in the drafting of reports, handling of complaints, and case management. Iraqi academic institutions focusing on gender and women's studies lack capacity and require support from UNFPA and other partners, particularly in the area of incorporating gender subjects into study curricula and/or in the organisation of additional gender-specific courses for university students.

The UNFPA Iraq CO conducted and supported advocacy with central and regional government on GBV, including through the commemoration of national days, for which UNFPA 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.[98] The decision taken by the Iraqi Prime Minister in 2017 to hold security actors accountable for acts of violence against women and girls in IDP and refugee camps was the result of advocacy conducted by the GBV sub-cluster under the leadership of UNFPA.[99]

Several IPs and GBV sub-cluster members interviewed mentioned the lack of clear procedures between UNFPA GBV programming, the GBV sub-cluster and the Child Protection sub-cluster regarding GBV case management for minors. In particular, there is a lack of clarity on which type of organisation – GBV organisations or child protection organisations - is responsible for the provision of care to GBV survivors who are minors. A number of times, UNFPA IPs referred cases of minors to GBV actors after which the

[95] United Nations Protection Cluster (2018): Periodic Monitoring Report; January to May 2018.

[96] No author (2018): Summary Report for the South-Central Iraq GBV SOPs rollout workshops on 3-5 September 2018.

[97] https://iraq.unfpa.org/en/news/119-free-helpline-gbv-survivors-and-message-hope-kurdistan

[98] Such as the Annual International Day for the Elimination of Sexual Violence in Conflict in June 2019, the the International Day of Zero Tolerance for Female Genital Mutilation and the 16 days of activism for the Elimination of Violence against Women.
https://iraq.unfpa.org/en/news/un-emphasizes-importance-survivor-centred-approach-towards-victims-isil-abuses. https://iraq.unfpa.org/en/news/protecting-girls-iraq-female-genital-mutilation
https://iraq.unfpa.org/en/news/call-put-end-violence-against-women-and-girls-iraq
https://iraq.unfpa.org/en/news/unfpa-advocates-women's-rights-iraqi-parliament

[99] Communication by UNFPA staff.

GBV actors returned the cases to the UNFPA IPs because of the GBV survivors being minors. In 2019, the GBV sub-cluster and the Child Protection sub-cluster started piloting approaches to address the needs for care of child and adolescent survivors of GBV. The CPE is not monitoring the degree of implementation of the GBV SOPs by service providers.

As part of the CP's transition to a greater focus on resilience and development, the UNFPA Iraq CO initiated a dialogue with the Government on handing over women's centres to local government authorities. In 2018, 20 centres were handed over to the Government. Partners interviewed by the evaluation team reported that during the various cluster coordination meetings, UNFPA generally shared information on their intention to close or handover women's centres or other GBV-related services, such as the radio station in the Baharka camp in Dohuk Governorate, only after UNFPA had taken the decision; and usually on very short notice before the closure or handover (e.g. one week in advance). This lack of timely consultation with partners is a missed opportunity as other partners may have resources available or may be able to help in preventing the closure of women's centres. The final decisions or specific dates for closure were also not communicated in a timely manner to the relevant IPs, which caused considerable uncertainty for IPs and their employees. Ownership of women's centres by DoLSA was also reported as a challenge. Staff of some women's centres visited by the evaluation team observed that they had not received any monitoring visits from DoLSA in over a year. This may be due to UNFPA's gradual suspension of financial support to DoLSA to conduct monitoring visits. Staff of a survivor centre in central Iraq reported that the reduction of financial support to the centre resulted in the reduction of social worker staff from two to one, with the only social worker remaining being a woman, which hampers the centre's capacity to adequately manage male survivors.

According to the CPAP 2016-2017 and the CPAP 2018-2019[100], the UNFPA Iraq CO planned to support the integration of RH/GBV and mental health services at health facilities, to include mental health support in the management of SGBV cases (staff training and development of protocols and educational materials). However, during the field visits of the evaluation team, this integration seemed poor. Many IPs, stakeholders, and indirect beneficiaries interviewed identified the lack of mental health services as an important gap.

The UNFPA Iraq CO also provided emergency assistance to women and girls in host communities that were affected by natural disasters. In 2017, UNFPA supported areas affected by an earthquake, which damaged maternity wards, by deploying a gynaecology mobile clinic, providing medicines and reproductive health kits to health facilities, and distributing dignity kits to over 500 women and girls.[101] In 2019, the CP distributed 568 dignity kits in flood-affected areas in the Diyala and Salahadin governorates.[102]

In terms of knowledge generation, the UNFPA Iraq CO established the Gender Based Violence Information Management System (GBV-IMS), which was one of the targets of the CPAP for 2016-2017. This system for safe and ethical GBV incident data management is managed by UNFPA and records data from 15 United Nations agencies and civil society organisations on all GBV cases reported in the country. The GBV-IMS system documents about 8,000 cases per year, which according to UNFPA staff points at a relatively high reporting rate of cases compared to other countries in the region. However, the majority of the GBV cases in the country go unreported. The GBV-IMS is currently managed by UNFPA without clear links with or inclusion of the Government. Moreover, not all partners of UNFPA or partners active in the area of GBV are members of the system. This means that cases reported to or addressed by government actors are not captured in the GBV-IMS. According to UNFPA staff, in humanitarian settings where government capacity is weak, it is standard procedure not to include the Government in the GBV-IMS system. In Iraq, the decision not to include the Government was reportedly taken at the request of representatives of GBV-IMS civil society member organisations because they feared prosecution of survivors by the Government, as some of the GBV perpetrators are security officials or other government staff. However, trust in the Government will need to be strengthened rapidly because UNFPA is working towards handing over all women's centres to the Government. At the same time, the UNFPA Iraq CO supports the Government in the development of a separate database which is not part

[100] UNFPA Iraq (2016): Country Programme Action Plan (CPAP) for 2016-2017.
UNFPA Iraq (2018): Country Programme Action Plan (CPAP) for 2018-2019.
[101] https://iraq.unfpa.org/en/news/unfpa-scales-response-after-earthquake-hit-iraq
[102] https://iraq.unfpa.org/en/news/unfpa-reaches-more-500-women-affected-floods-dignity-kits

of the GBV-IMS. To date, the GBV-IMS has been used primarily as a data collection mechanism and hardly for data analysis. Even when analyses were produced, the results were not regularly shared with partners. The evaluation team found that some GBV-IMS members were reporting to the database without having a clear understanding of its purpose and the final destination of data shared. A challenge is that the same cases can currently be recorded both in the GBV-IMS and in the Government database. There is no evidence that the Government uses the data from the GBV-IMS..

Under the leadership of UNFPA, the GBV sub-cluster commissioned GBV Survivors Assessments for 2016 and 2018.[103] [104] Results from interviews with 1,000 GBV survivors in 11 governorates during the 2018 assessment indicated that the level of survivors' access to GBV prevention and response services was the lowest amongst returnees (24%), followed by members of host communities (65%), IDPs (70%), and refugees (88%). The level of satisfaction with health, psychosocial support, safety, legal and referral pathway services among GBV survivors was as follows: 35% among returnees, 54% among refugees, 59% amongst host communities, and 60% amongst IDPs. Psychosocial support services were rated the most satisfactory, while case management services received the lowest rating.

The legal environment in Iraq still represents an important external challenge for the promotion of gender equality. The Iraqi constitution and laws still allow and condone practices such as marital rape, child marriage, polygamy, etc. Furthermore, the conservative social and cultural norms in Iraq represent considerable external challenges to working on promoting women's equality and empowerment and to raising awareness about the RH and reproductive rights of adolescent girls and young women, marital rape, child marriage, etc. However, interviews with stakeholders and beneficiaries indicate that engagement of men and boys was not very developed, nor systematic in UNFPA GBV programming. Some beneficiaries interviewed stated that their husbands threatened them that once their family returned to their place of origin, the women would no longer be able to seek help at women's centres. A few camp managers mentioned that men and religious leaders approached them complaining that women's centres undermined the traditional culture.

Lessons learned and best practices

- Women's centres and survivor centres which had sufficient resources to conduct recreation and vocational activities helped survivors in engaging in the community and acquiring livelihood skills (to develop their business or find job opportunities).
- Ensuring that GBV teams were adequately trained and located close to crisis locations enabled UNFPA to respond to the Mosul crisis in a timely manner.
- It is important to ensure that messages and materials for behaviour change communication are standardised across CP implementing partners to achieve consistency in message content.
- Adequate handover of women's centres requires timely coordination with partners and building ownership of government.

Population and Development

FINDINGS SUMMARY

The CO did not consider the **population dynamics programme** as a priority during the humanitarian crisis of the first CP years. Consequently, the CO limited the allocation of financial and human resources to this CP output. Capacity strengthening efforts of government on population issues were limited. In late 2018, the CP started supporting the new government leadership to commence preparations for the National Housing & Population Census planned to take place in 2020.

Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

[103] UNFPA (2016): A report on the GBV Assessment in conflict affected governorates in Iraq.

[104] UNFPA Iraq (2019): The Assessment of the needs of and the services provided to Gender-Based Violence Survivors in Iraq.

Table 10: Achievements for Outcome 1 against outcome and output indicators

CP outcome Indicators	Targets	Level of achievement	Comments
R.4.1 National development plan addresses population dynamics by accounting for population trends and projections in setting development targets	Baseline: 0 Cumulative CP target: 2019: 1 (source UNFPA annual CP reports).	0, which means "no" **CP cumulative target not achieved.** (Source: UNFPA annual CP reports)	It is unlikely that this target will be achieved by the end of 2019.

CP output 4	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

CP output indicators	CP targets	Level of achievement	Comments
O.4.1. Number of staff from relevant government ministries successfully completing workshop on data collection, management, analysis and dissemination.	Baseline: 0. Cumulative CP target by 2019: 80 (source UNFPA annual CP reports).	50 staff trained by Dec. 2018 - **125% of 2018 target of 40 staff trained was achieved;** **93.5% of cumulative CP target achieved** (50 staff were trained in 2017). (Source: UNFPA annual CP reports)	
O.3.2 Number of thematic in-depth analysis reports on key population issues produced	Baseline: 0. Cumulative CP target: 2019: 4 (source UNFPA annual CP reports).	3 reports produced by Dec. 2018 – **100% of 2018 target of 180 achieved;** **75% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	
O.4.3 Number of humanitarian crisis assessments conducted by the Government that reflect sexual and reproductive health, gender-based violence and youth issues	Baseline: 0. Cumulative CP target: 2019: 5 (source UNFPA annual CP reports).	4 assessments by Dec. 2018 – **0% of 2018 target achieved** [105]**;** **80% of cumulative CP target achieved.** (Source: UNFPA annual CP reports)	

The analysis of the level of achievement of the output indicators according to the UNFPA CPAP Planning and Tracking Tools for 2016-2017 and 2018-2019 shows that by December 2018, two out of three output indicators had achieved their targets for 2018.[106] All the three output indicators were well on track to attain their overall targets for the period of the CP by the end of 2019.

The strategic partners of the UNFPA Iraq CO in this programme area were the Central Statistics Organisation of the Federal Ministry of Planning and the Kurdistan Regional Statistics Organisation (KRSO).

The achievements of the CP are somewhat in line with the output on "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." As a result of the deterioration of the humanitarian crisis during 2016-2017, the CO leadership ascribed lower priority to the population dynamics programme and re-allocated staff and funding to the emergency humanitarian response. As a consequence, capacity strengthening efforts supported under the current CP were limited. They included training of a limited number of officials from the Central Statistics Organisation, the KRSO and the Ministry of Planning in the use and analysis of population data, and support to attend courses and seminars abroad, such meetings on the demographic dividend and the tracking of the ICPD-related SDGs.

[105] 4 assessments were conducted in 2016 and 2017. No assessments were conducted in 2018; thus, the annual target for 2018 was not achieved.

[106] UNFPA (2017): CPAP Planning and Tracking Tools for 2016-2017. Updated to December 2017.
UNFPA (2019): CPAP Planning and Tracking Tools for 2018-2017. Updated to June 2019.

UNFPA CO staff made some efforts to integrate population issues into national and regional policies. However, during the first years of the CP period that were characterized by heightened humanitarian crisis, there was little commitment of the Government to address issues of population dynamics or to conduct a population census and other large surveys. The Iraqi NDP 2018-2020 does not address any issues of population dynamics and the demographic dividend, and its objectives do not include the promotion of SRH and family planning.[107] The UNFPA Iraq CO was also not able to provide much support to the national system for monitoring the country's progress on the ICPD agenda and performance, including the ICPD-related SDG indicators.

Using resources from the other CP output areas, the UNFPA Iraq CO supported or led the development of some national studies and surveys, in cooperation with government and partners. This included four humanitarian crisis assessments on SRH, GBV and youth issues undertaken by the Government in 2016, and a survey integrating indicators on youth in conflict, GBV and FGM in Kurdistan in 2016. These studies were used by UNFPA and partners to inform their programme planning. In 2018, the UNFPA Iraq CO supported preparations for the National Adolescent and Youth Survey planned for 2019. The CP furthermore supported KRSO to conduct a demographic survey in Kurdistan in 2017[108], which provided data which was used by UNFPA and partners to inform their programmes. UNFPA is currently supporting preparations for the 2020 National Population and Housing Survey. The CP also supported the UN system to profile IDPS, refugees and host communities in Kurdistan ensuring reflection of GBV and RH issues. In 2016 UNFPA conducted two impact assessments of the Country Programme as a whole, in which beneficiaries were consulted on the accessibility and satisfaction of services received.[109]

In late 2018, under the leadership of the new Prime Minister, the Federal and Regional Governments commenced preparations for the National Housing and Population Census planned to take place in 2020. National commitment to the census is high: the federal government has issued a ministerial decree 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 Iraq CO cooperated with its Arab States Regional Office (ASRO) to attract an international specialist to its CO team, and will support the Central Statistics Organisation in engaging in-house specialists during the upcoming surveys.

The CP cooperated closely with IOM to support KRSO in conducting the Kurdistan Demographic Survey. The survey was useful in providing demographic data on the inhabitants of Kurdistan, and innovative in that it documented the population's disability status. Working relationships between the CSO and KRSO are reportedly excellent, which facilitated the organisation of large data collection initiatives.

The decision by UNFPA senior management to reduced funding to the population dynamics programme area resulted in UNFPA having to cancel supporting a number of south-to-south cooperation initiatives that the government had valued, which caused discontent amongst government partners. Stakeholders interviewed mentioned that the UNFPA CO did not always consult partners before taking decisions on the subject of capacity strengthening efforts. For example, UNFPA decided that capacity building of the Central Statistics Organisation and KRSO staff for the Adolescent Survey would consist of a Training of Trainers course whereas the national partners interviewed observed that they would have preferred for their staff to be trained in data entry and analysis. Government and partner staff interviewed also questioned the timing 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 and Housing Census planned for 2020 have not all been mobilised yet.

[107] Republic of Iraq, Ministry of Planning (2018): Iraq National Development Plan 2018-2022. June 2018.

[108] KRSO, UNFPA, IOM (2018): Demographic Survey, Kurdistan Region of Iraq.

[109] UNFPA (2018): Impact Assessment Report; Global Action Canada; UNFPA Multi-Country Response to the Syria Crisis: Syria, Turkey cross-border operations into Syria, Lebanon, Iraq and Jordan. May 2018. UNFPA (2018): Impact Assessment Report; Sida; UNFPA Multi-Country Response to the Syria Crisis: Syria, Turkey cross-border operations into Syria, Lebanon, Iraq and Jordan. May 2018.

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 experienced in conducting large surveys, and a lack in capacity in data analysis. 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 volatility in Iraq has made it difficult to reach agreement on conducting nation-wide surveys, whereas access to some geographic areas is restricted for security reasons, which hampers conducting surveys there. Cooperation with national and international NGOs was therefore important as were at times able to access insecure areas.

Gender equality and human rights principles

EQ 7) To what extent did the UNFPA Iraq CO make good use of its human, financial and technical resources, as well as of different partnerships, in pursuing the achievement of the expected results articulated in the CP (2016-2019)?

FINDINGS SUMMARY

UNFPA CP components in Iraq are responsive to gender, in that they promote gender inclusion principles for the development of adolescent girls and young women and men, promoting opportunities and equal treatment for all young people, young women and men alike.

The CP supported the rights-based approach of universal access of vulnerable populations living in humanitarian situations to reproductive health information and services, family planning and to the response to GBV and other harmful practices. The CP furthermore promoted an inclusive approach by generating knowledge on how to include vulnerable groups such as adolescent girls, youth, women and GBV survivors in SRH and GBV programming. The assessments supported by the CP generated knowledge on inequities in access to information and services by GBV survivors, and the studies and surveys planned for 2019 will provide information on adolescent girls and boys and youth. This facilitated and will further facilitate advocacy by UNFPA with government for increased attention and resources for these vulnerable groups in humanitarian and development settings.

Gender equality

Ensuring universal access to SRH and reproductive rights is included in the targets of the SDGs, as well as efforts to end all forms of discrimination against all women and girls, ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action, and strengthen relevant national institutions for building capacity at all levels, in particular in developing countries, to prevent violence and combat terrorism and crime. Gender equality and the empowerment of women and girls are one of the thematic pillars of UNFPA and one of the outcome- and output areas of the Iraq CP Document and CP Action Plans.

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

The CP output indicators aim to measure performance of UNFPA-supported services and activities to promote RH and FP access, taking into consideration the legal framework in Iraq which does not allow SRH access to unmarried adolescents and youth, and the cultural context in Iraq which does not look favourably on providing SRH information and services to unmarried adolescents and youth. The indicators also measure advancement in interventions aiming to reduce and respond to violence against women and girls. The CP indicators are not disaggregated by sex. On the other hand, the WizMonitor programme monitoring system collects data disaggregated by age and sex.

The CPE could find no evidence of CP efforts to provide space for women in the design and implementation of the CP support.

Human rights

The right to sexual and reproductive health is a universal human right. Yet, for biological and social reasons, women and girls are uniquely affected by decisions taken concerning control of reproduction and sexuality. Adolescent girls, for example, from the moment they reach puberty, are more likely to face threats to their sexual and reproductive well-being including from sexual violence, coercion into child marriage or denial of access to the information and services that would enable them to maintain their sexual and reproductive health. Furthermore, certain population groups among them are subjected to exclusion and discrimination when it comes to their exercise of human rights in relation to their sexual and reproductive health and well-being.[110]

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 right to universal access to primary health care and safe deliveries as well as the right to SRH and reproductive rights. Similarly, by supporting the provision of GBV and youth interventions for vulnerable and marginalised populations, the CP contributed to ensuring the rights of women, adolescents and youth to access these services, to fight violence against women and girls, to reduce discrimination against women, and to the empowerment of young girls and boys and of women. UNFPA Iraq furthermore supported the Government to review, document and report on various international human rights related commitments - such achievements against the ICPD Programme of Action, the Convention on the Elimination of Discrimination against Women (CEDAW) - which monitor country's advance in reducing maternal mortality, promoting SRHR, reducing teenage pregnancies, ending child marriage, eliminating GBV and FGM, etc.

In this way, the CP supported the population as rightsholders to participate and access essential services, and supported the Government as duty-bearer to provide those essential services and to review, document and report on various human rights related commitments. UNFPA supported 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.

During the CPE interviews, UNFPA staff and Y-PEER volunteers confirmed that young people were included in consultations by the CO for the design of the CP Document, through the Y-PEER organisation which is youth-led and youth-centred. UNFPA made efforts to include young people in the implementation of some CP activities, mainly by supporting Y-PEER to conduct awareness-raising amongst young people, and inviting Y-PEER to attend thematic meetings. UNFPA's efforts to strengthen links between Y-PEER and government and civil society IPs were limited. There was no systematic involvement of Y-PEER volunteers in the implementation of interventions by civil society IPs, except for in the case of Harikar in Dohuk. Y-PEER were amongst the stakeholders identified by the CO to be consulted during the CPE.

Until the end of 2018, the CP had not started integrating people with disability into its programming, unlike other UN agencies, such as IOM, which have developed a disability inclusion strategy. In 2019, the UNFPA M&E system was updated to include the target group of people with disability. Until mid-2019, the CP had not conducted or supported any assessments and studies focusing on generating knowledge on inequities of access by vulnerable groups to SRH and GBV information and services.

4.5 Efficiency

EQ 8) To what extent did UNFPA make good use of its human, financial and technical resources, as well as of different partnerships, in pursuing the achievement of the expected results articulated in the CP (2016-2019)?

[110] UNFPA (2019): A Guide in Support of National Human Rights Institutions: Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Wellbeing.

FINDINGS SUMMARY

The total CP expenditure during 2016-2018 was USD 108.5 million, more than double the estimated CP resource needs when the CPD was developed in 2015. This made the Iraq CP the highest spending UNFPA Country Programme in the world.

42.9% of UNFPA regular resources and 57.7% of external (donor) resources was spent on Output 1 (RH); 14.3% of regular resources and 39.5% of external resources on Output 3 (GBV) programming; 13% of regular resources and 2.4% on Output 2 (youth).

The CO performed well in CP financial management: the implementation rate of the CP budget was high (89%) and the office achieved corporate compliance.

CP implementation was affected by frequent delays, caused by the political volatility and changing security situations in many areas of CP operations, which resulted in UNFPA and IPs having to delay and re-programme planned activities. The political context in Iraq with "1 country – 2 systems" in combination with serious security issues, access and mobility restrictions and level 3 emergency situation make for a difficult working environment which takes up staff time and energy.

The UNFPA field offices in Erbil, Dohuk and Sulaymaniyah contributed to the success of CP achievements. As the humanitarian situation became more acute, the CO and IPs were able to recruit additional international and national staff with experience in working in humanitarian emergencies, which allowed for a rapid CP response and deployment to affected areas.

The system used by UNFPA Iraq for quality assurance of CP implementation was not formalised or applied across the programmes. Programmes did not use standardised approaches or technical guidelines to guide programme implementation by IPs, such as a guideline on the minimal standards of a UNFPA-supported youth centre or women's centre. Apart from the Standard Operating Procedures (SOPs) developed for GBV case management and the Adolescent Tool Kit, no other guidelines were introduced or developed by UNFPA. Also, the team found no evidence of systematic data collection of indicators on quality indicators nor systematic data analysis. This resulted in variations in standards in programme implementation between locations and IPs.

Regarding CP monitoring, a major challenge was that the CP results framework is only partly able to demonstrate programme results. A number of CP output and output indicators do not capture the main achievements of the CP's focus on humanitarian service delivery during the first years of implementation. Furthermore, the UNFPA CO teams did not use the CP results framework and its CP results tracking tool for monitoring of CP results.

The CO M&E Specialist developed and established an innovative online programme monitoring system called WizMonitor, which has been rolled out to CO teams and IPs. The UNFPA Regional Office is interested in rolling out this tool to other countries in the region.

Financial resources

UNFPA financial records show that the total actual CP expenditure for the period January 2016 to December 2018 amounted to USD 108.5 million. This was an extraordinarily large amount for UNFPA and more than double the estimated resource needs of USD 40.9 for the 4 year CP period in the CP Document of 2015 and nearly double the estimated resource needs for 2016-2018 in two CPAP documents (see section 3.3). This expenditure level has made the Iraq CP the highest spending UNFPA Country Programme in the world.

Table 11: CPD Actual Expenditures by Outcome Area for the period Jan. 2016 to Dec. 2018

Expenditure per CP Outcome Areas	Regular Resources	Other resources	Total	% of total
Outcome 1: Sexual & Reproductive Health	1.50	60.50	62.00	***57.1%***
Outcome 2: Adolescent and Youth	0.50	2.50	3.00	***2.8%***
Outcome 3: Gender Equality and women empowerment	0.50	41.50	42.00	***38.7%***
Outcome 4: Population Dynamics	0.50	0.50	1.00	***0.9%***
Programme Coordination & Assistance (PCA)	0.50	-	0.50	***0.5%***
Total USD million	**3.50**	**105.00**	**108.50**	***100.0%***

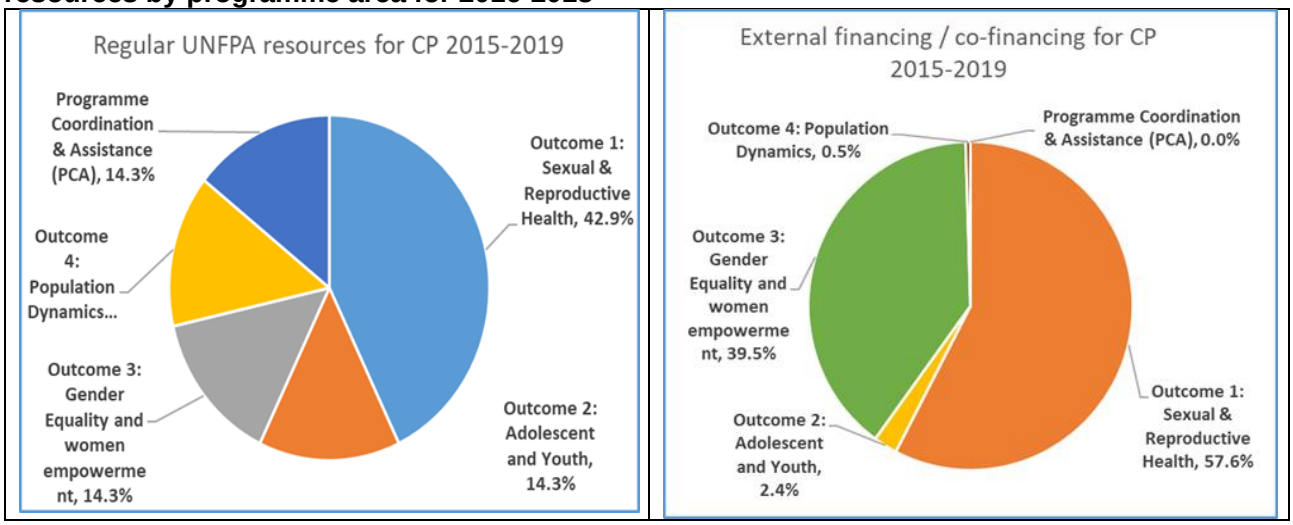
Source: UNFPA Iraq Country Office (2016).

Table 12: CP expenditure compared to CPAP budgets by Outcome Area for the period Jan. 2016 to Dec. 2018

CP Outcome Areas	Regular Resources			Other resources			TOTAL		
	Budget	Expen-diture	*% expendi-ture over budget*	Budget	Expen-diture	*% expendi-ture over budget*	Budget	Expen-diture	*% expendi-ture over budget*
Outcome 1: Sexual & Reproductive Health	1.40	1.50	*107%*	27.00	60.50	*224%*	**28.40**	**62.00**	***218%***
Outcome 2: Adolescent and Youth	0.90	0.50	*56%*	7.00	2.50	*36%*	**7.90**	**3.00**	***38%***
Outcome 3: Gender Equality and women	0.60	0.50	*83%*	31.00	41.50	*134%*	**31.60**	**42.00**	***133%***
Outcome 4: Population Dynamics	1.40	0.50	*36%*	1.40	0.50	*36%*	**2.80**	**1.00**	***36%***
Programme Coordination & Assistance (PCA)	0.60	0.50	*83%*	-	-	*0%*	**0.60**	**0.50**	***83%***
Total USD million	**4.90**	**3.50**	***71%***	**66.40**	**105.00**	***158%***	**71.30**	**108.50**	***152%***

Of the total expenditure of USD 108.5 during 2016-2018, 96.7% (USD 105 million) was mobilised from external donor sources. Figure 5 shows that during 2016-2018 42.9% of UNFPA regular resources were spent on the implementation of Output 1 (RH), whereas expenditure on Output 2 (youth) and Output 3 (GVB) was similar (14.3%). Of funding provided by external resources (donors), 57.7% was spent on Output 1 (RH), 39.5% on Output 3 (GBV) and only 2.4% on Output 2 (youth) and 0.5% on Output 4 (population).

Figure 5: CP spending of regular UNFPA resources and other / external financing / co-financing resources by programme area for 2016-2018



Source: UNFPA Iraq Country Office (2019)

In terms of disbursement of funds, the UNFPA country programme in Iraq reached an average financial implementation rate of 89% over the period from January 2016 to December 2018, as shown in table 13 below. The implementation rates of CP Implementing Partners (IPs) showed more variation. Table 15 in Annex 4 shows that annual implementation rates varied from 33% for some IPs in some years to 99% for other IPs in other years.

Table 13: CP implementation rates of the UNFPA Iraq CP from January 2016 to 31 December 2018

Programme Components	2016	2017	2018	Overall implementation rates per programme area
Sexual Reproductive Health	72%	88%	86%	**85%**
Adolescent and Youth	92%	91%	80%	**86%**
Gender Based Violence	96%	92%	85%	**90%**
Population and Development	82%			**82%**
Program Coordination and Monitoring	94%	99%	86%	**93%**
Program Administration	86%	94%	101%	**95%**
All Components	**86%**	**90%**	**87%**	**89%**

Source: UNFPA Iraq Country Office (2019)

UNFPA and implementing partners made efforts to economise programme costs by holding meetings and workshops in existing agency premises, and by compacting the number of meeting days and increasing use of remote meeting technology (video calls). The CP also contributed to economies of scale through the international procurement by UNFPA of reproductive health products (including contraceptives), thus contributing to achieving low prices for products in conformity with UNFPA quality standards. However, most of the contraceptives and reproductive health supplies made available to health facilities were provided in the shape of UNFPA kits. As discussed in section 4.4, health authorities and facilities were only able to use 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.

Administrative resources

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. Iraq (particularly the Baghdad area) is one of most high-risk UN duty stations worldwide. The UNFPA CO and IPs should be commended for having managed to implement the programme in a highly challenging environment.

Human resources

As the humanitarian situation became more acute, the CO was able to recruit additional international and national staff with experience in working in humanitarian emergencies, which allowed for a rapid response and deployment to affected areas. In addition, the existing CO staff which had previously worked on development-oriented programmes were also reallocated to humanitarian programming. The Iraq CO recruited most of the staff directly and did not benefit much from the UNFPA emergency human resource surge facility.

Most UNFPA CO staff in Iraq are hardworking and committed. The evaluation team found that the workload is not distributed equally amongst staff. Furthermore, some programmatic staff was charged not only with the overseeing and managing their programme activities but also with leading active and important cluster working groups. This was the case of the RH programme staff which did not recruit a full-time coordinator of the RH sub-working group. This may have contributed to the interruption in UNFPA's coordination of the RH sub-working group (see section 4.7). The senior management team (SMT) is aware of this challenge and is currently conducting a workload distribution to make some changes. Field office staff in Dohuk and Sulaymaniyah contributed to the success of CP achievements, which is highly appreciated by UNFPA and IPs. The evaluation team found that field office staff have at times felt undervalued. In late 2018, the staff positions of international field office coordinators in Dohuk and Sulaymaniyah were discontinued without adequate technical handover, guidance or supervision being provided to the national staff tasked to take over the field office coordinator positions.

Technical resources (expertise)

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 sometimes seemed lengthy. The CO received useful technical support from the Arab States Regional Office (ASRO) in Cairo, the regional humanitarian hub in Jordan, UNFPA HQ in New York and the PSB procurement office in Copenhagen.

The evaluation team observed that the system used by UNFPA Iraq for quality assurance of CP implementation was not formalised and applied across the programmes. The programmes did not use standardised approaches or technical guidelines to guide programme implementation by IPs, such as for example a guideline on the minimal standards for a UNFPA-supported youth centre or women's centre. Apart from the Standard Operating Procedures (SOPs) developed by UNFPA and partners for GBV case management by non-medical facilities, which by the way are basic and do not describe all the aspects of the GBV response, and from the Adolescent Tool Kit, no other guidelines were introduced or developed by the CP. Also, the team found no evidence of systematic data collection of indicators on quality indicators nor systematic data analysis. This resulted in variations in standards in programme implementation between different locations and between IPs in Iraq. An external challenge to the CP is that the financial crisis in the Kurdistan Region of Iraq limited government resources available to support social sectors and activities, and resulted in lower government staff motivation and irregular supervision by relevant government authorities.

Knowledge management
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 limited and not systematic. This is a lost opportunity as a number of interventions supported by UNFPA in Iraq were mentioned by stakeholders interviewed as examples of best practice and it would be useful to document these while the main actors are still around. An exception here is the documentation of the rapid response approaches used by UNFPA and partners during the Mosul liberation. In 2018 UNFPA Iraq 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 consisted mainly of the traditional report formats, whereas the CP did not systematically produce policy briefs – a more useful format for policy advocacy - on proposed best practice. Thus, the link between production of strategic information and influencing policy development has so far not been strong during the current CP. It is not too late to document lessons learned, best practices 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.

Innovation
The UNFPA CP in Iraq supported a number of innovative approaches. In terms of programme planning and delivery, the prepositioning of emergency supplies and implementing partners with response capacity represented the first such effort undertaken by any UNFPA Country Office in the world and allowed for increased responsiveness to humanitarian emergencies that were expected to occur. Rehabilitation by UNFPA of hospital buildings destroyed during the conflict allowed to quickly re-establish functional service provision capacity and was apparently also a first in the region. Using larger international NGOs such as Qandil to channel funding to and monitor implementation by government institutions and smaller local NGOs was possibly also an innovation. In terms of programme management, the Iraq M&E Specialist contributed to innovation by developing a new programme monitoring tool called "WizMonitor" described below.

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 delays in IPs receiving programme funding which affected programme efficiency (see section 4.5). At times, late communication by UNFPA to IPs on events organised or decisions taken contributed to ineffective planning by IPs. Governmental and civil society IP staff interviewed considered UNFPA procurement procedures to be generally lengthy, except during acute emergency periods. During the period of acute emergency, the operations staff managed to support the programme and achieving all planned activities within the time period planned while under enormous pressure. UNFPA HQ authorized the Country Office to apply fast-track procedures for administrative and procurement processes, which helped to accelerate

processes. The CO received useful support from the Regional Office, PSB and HQ through rapid responses to procurement requests and other queries.

Fund disbursements were processed on time, except for when they were delayed due to late signing of annual workplans or due to late submission by IPs of financial reports over the previous period. All IPs interviewed mentioned delays in signing annual workplans at the start of each calendar year as a challenge for their internal planning, recruitment and procurement forecasting systems. IPs also mentioned that UNFPA tended to change the annual working plans during the year. While this may enable the CP to respond to emerging priorities or to strategic decisions, the changes resulted in uncertainty and in lack of predictability for IPs managing their programmes and staff. Another challenge is the quarterly disbursement system operated by UNFPA (in contrast to other UN agencies), which in Iraq caused delays in disbursements with transfers frequently being received by IPs only in the 2nd or even 3rd month of the quarter. This system is time-intensive and cumbersome for both UNFPA and for IPs. In 2019 UNFPA introduced the system of quarterly workplans for some civil society IPs, due to uncertainty of funding for the supported programme interventions. IPs interviewed remarked that this system resulted in a high administrative workload and uncertainty for staff contracted through the CP.

Programme management, monitoring and evaluation

UNFPA Iraq performed well on corporate compliance. Procurement targets were met and financial audits took place as planned, including audits by international firms on selected IPs. So far, almost all audits were unqualified, which is an indication of good financial management performance by the CP. An exception was the audit of one of the departments of the regional MoLSA in KRI. As a result, while waiting for the KRG to respond to audit recommendations and for the audit being cleared, UNFPA had to suspend its IP contract with the Kurdish MoLSA and provide any remaining support through a civil society IP. As shown in table 15 in Annex 4, a large part of programme resources – ranging between 28% in 2018 to 55% in 2016 - was executed directly by UNFPA through the Direct Execution modality. The remaining resources were executed through contracts with counterpart Implementing Partners through the National Execution modality based on Annual Workplans.

Weaknesses in the CP operations management include the fact that during the first CP years no management audits were conducted. The UNFPA operations team also reported that their team is not systematically informed and consulted by programme staff in the planning of programmes and in development of funding proposals. This represents the risk of programme proposals not including adequate budgets for staff, M&E, communication and operations.

CO officials interviewed reported that programme financial monitoring by the CO through IP spot-checks was regular. The high emphasis within the UNFPA financial management system on programme expenditure is necessary to ensure that resources mobilised from UNFPA and partners are used, but results in a perverse incentive for maximising expenditure independent of quality of service delivery.

UNFPA built capacity of IPs in monitoring and reporting, resulting in better quality IP financial reports (completeness, data quality and supporting documents) and less delays in report submission. An external challenge was the turnover of government and NGO staff which resulted in loss in capacity and required UNFPA to continuously train newly appointed staff in programme and financial management and in reporting to UNFPA.

A major challenge faced by the UNFPA Iraq CO was the continuing insecurity and volatility, as well as political/sectarian conflicts, which limited access to and mobility in a number of areas in the country and made it difficult to provide services and conduct monitoring and evaluation activities. The security situation also increased the cost of CP service provision and monitoring. The security situation, in combination with political/sectarian conflict and the corruption in the public system also made any system strengthening efforts more challenging. The political crisis in Iraq has hampered the development of national strategies and mechanisms. The situation with “one country – two systems” means that UNFPA had to work with two different governments in the same country, each with different laws, regulations, and strategies for the programme areas. The lack of coordination between public and private sectors in the country hinders the effectiveness of implementation of any policy. These challenges make for a challenging working environment which takes up staff time and energy.

PSEA

UNFPA is leading the network on Protection from Sexual Exploitation and Abuse (PSEA), established in 2016, on behalf of the UN Country Team and Humanitarian Country Team. The network, which is co-led by other UN agencies, aims to strengthen the prevention of and response to SEA cases amongst humanitarian agencies in Iraq.[111] UNFPA recruited a full-time coordinator for the network. The network developed national BCC materials in four languages and is working closely with the 119 hotline centre to receive case complaints. The CP supported the establishment of the network and PSEA mainstreaming among all (humanitarian) coordination clusters. Through its IPs the CP furthermore ensured capacity building of 320 staff from over 100 organisations including government, UN agencies, civil society organisations and communities on PSEA.

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. The network established conducted awareness-raising of counterparts, implementing agencies, beneficiaries and communities on their right to PSEA and on the reporting mechanism established by the UNCT in Iraq. The CPE team saw evidence of information provided to service users through posters located in facilities and structures visited. However, the contribution of the capacity building of implementors supported by the CP to strengthening the prevention of and response to SEA has not been documented so far.

Monitoring and Evaluation

The Country Programme has a Results-Based Management tool in its Results Framework, which includes outcome indicators and output indicators, baselines for 2015 and final targets for 2019. A major challenge is that the results framework is only partly able to demonstrate programme results. The outputs and output indicators – particularly for outcomes 1 (SRH), 2 (adolescents and youth) and 4 (population and development) – do not capture the main achievements of the output areas as they do not reflect the CP's almost exclusive focus on humanitarian service delivery during the first years of implementation. The evaluation team find that it is a missed opportunity that the CP has functioned during the entire CP period without the CP indicators and targets being revised to ensure that they better capture the performance of the CP. During the development of the new UN Sustained Development Cooperation Framework in 2019, UNFPA is playing an active role and heading the inter-agency M&E framework to ensure that UNFPA's work is fully integrated into the framework.

The UNFPA Iraq international M&E Specialist developed a useful Country Programme Action Plan Planning & Tracking Tool in Excel, which lists the outcome and output indicators for each programme areas on a separate sheet. The CO used 2 versions of these tools: one for the first CPAP for 2016-2017 and one for the second CPAP for 2018-2019.[112] The tool enabled the CO to track implementation progress during the 2 years of the CPAP in question. However, by focussing on 2 years only, it does not show progress during the entire 4-year CP period and does not encourage coherence during the full CP period. Furthermore, by inserting the outcome areas in 4 separate sheets, the tool perpetuates the separation of the 4 CP programme areas and does not promote integration and cross-fertilisation between programme areas and between programme teams. The CPAP Planning & Tracking Tool does not automatically calculate the percentage of achievement against the target or a traffic light colour indicator, which would be useful to quickly show performance against the CP indicators. From interviews with UNFPA staff it has become clear that the CO programme team did not regularly use the CPAP tracking tool to check their performance and to take programmatic decisions.

An achievement in the CP M&E system is the new online programme monitoring system called WizMonitor, developed and established by the M&E Specialist in 2018. The system captures a large variety of data on programme implementation by IPs and allows the user to see achievements by

[111] No publishing organisation (no date): PSEA engagement.

[112] UNFPA (2017): CPAP Planning and Tracking Tools for 2016-2017. Updated to December 2017.
UNFPA (2019): CPAP Planning and Tracking Tools for 2018-2017. Updated to June 2019.

geographic location and check implementation progress against targets.[113] This has resulted in detailed data being available for monitoring implementation results of UNFPA activities in Iraq. IPs interviewed find the system sometimes quite work intensive. The UNFPA Regional Office is interested in introducing the WizMonitor system for programme monitoring in other countries in the region.

Resource mobilisation

EQ 9) To what extent was the UNFPA Iraq CO efficient in mobilising resources – human, financial and technical – for a timely response to the emerging humanitarian needs?

FINDINGS SUMMARY

The UNFPA Iraq financial resource mobilisation efforts have generated impressive results, particularly in the areas of RH and GBV response in humanitarian settings. The CO managed to mobilise over USD 105 million from donors for its programmes between early 2016 and late 2018. With this, the UNFPA Country Programme Iraq became the largest UNFPA programme globally during the 2016-2018 period.

Interestingly, whereas the majority of donor funding to UNFPA Iraq is earmarked to specific programmes/ interventions, UNFPA Iraq also managed to secure unearmarked multiannual core funding to its CP from one donor.

The CP succeeded in mobilising additional human resources for the CP through redeployment of existing staff and direct external recruitment. Technical resources in the programme and operational areas were mobilised from UNFPA Regional Office, HQ and PSB.

The achievements of the Financial resource mobilisation (RM) by UNFPA Iraq have been remarkable, particularly in the areas of RH and GBV response in humanitarian settings. Since the start of the CP in January 2016, UNFPA Iraq managed to mobilise over USD 105 million from external sources, nearly the entire amount of expenditure during this period. With this, the UNFPA CP in Iraq became the largest UNFPA programme globally.

During the CP period, resources were mobilised from a large number of donors, including: Australia, Belgium, Bill & Melinda Gates Foundation, Canada, Children's Investment Fund Foundation (CIFF), Denmark, European Union, Finland, France, Friends of UNFPA, Iceland, Ireland, Italy, Japan, Korea, Kuwait, Liechtenstein, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, The RMNCH Trust Fund, Slovenia, Spain, Cataluña Region of Spain, Sweden, Treehouse Investments, United Kingdom, United Nations Central Emergency Response Fund (CERF), UNDP, UNOCHA, UNOPS, Winslow Foundation and private individuals (through the UNFPA website).

Table 14 below shows that the largest external partners of the UNFPA CP in Iraq are Canada, the European Union and OCHA. 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. Table 14 shows that external partners were most interested in supporting RH and GBV interventions during the acute emergency period. 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 core funding to the CP, which UNFPA Iraq can use where it sees fit.

However 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 RH services and 400,000 persons with GBV services.[114]

[113] IPs and UNFPA programme staff are linked online to the WizMonitor system. IPs enter data and generate detailed reports on their entries at IP level. UNFPA staff use WizMonitor to manage IP entries, generate any data as deemed necessary for their programmatic needs such as to check and verify progress reports submitted to the system, or for reports to senior management, ASRO/HQ or donors, check and verify progress reports submitted to the system. UNFPA programme coordinators uses the WizMonitor as a source to report to the UNFPA Strategic Information System (SIS) quarterly. The WizMonitor is also used by M&E team to check progress reports, report to CO quarterly updates, provide SitReps and report to donors. Senior management uses the system to identify programme indicators with low performance.

[114] https://iraq.unfpa.org/en/news/people-japan-stand-women-iraq-us-13-million-contribution-unfpa

Table 14: Summary of external resources mobilised during 2016-2018

Donor	Programme Area	Amount
Australia	Budget support to CP	$5,573,114
Canada	Outputs 1, 2, 3; Progr. Admin, Progr. Coordination / M&E	$21,790,866
Denmark	Outputs 1, 2, 3; Progr. Admin, Progr. Coordination / M&E	$1,605,398
European Union	Outputs 1, 3; Progr. Admin, Progr. Coordination / M&E	$21,845,698
Finland	Outputs 2, 3; Progr. Admin	$439,270
Germany	Outputs 1, 2, 3; Progr. Admin, Progr. Coordination / M&E	$983,609
Japan	Outputs 1, 2, 3; Progr. Admin, Progr. Coordination / M&E	$8,519,716
Netherlands	Outputs 1, 2	$205,716
Norway	Outputs 1, 2, 3, 4; Progr. Admin, Progr. Coordination / M&E	$3,817,084
OCHA	Outputs 1, 2, 3; Progr. Admin, Progr. Coordination / M&E	$17,808,555
South Korea	Outputs 1, 3; Progr. Admin, Progr. Coordination / M&E	$1,433,507
Spain	Outputs 1, 2	$160,253
Sweden	Outputs 1, 2, 3; Progr. Admin, Progr. Coordination / M&E	$5,287,462
UNDG	Outputs 1, 2, 3, 4; Progr. Admin, Progr. Coordination / M&E	$147,995
UNDP	Outputs 1, 2, 3; Progr. Admin	$241,900
USA	Outputs 1, 2, 3, 4; Progr. Admin, Progr. Coordination / M&E	$14,120,836
TOTAL (USD)		**$103,980,978**

Source: UNFPA Country Office

In late 2018, the UNFPA CO developed a draft financial Resource Mobilisation strategy for 2018-2020, which was finalised in 2019.[115] UNFPA Iraq also produced quarterly programme updates, which are used as donor briefings. The evaluation team feel that for these quarterly updates to be useful to donors, they should focus on programme achievements instead of on donor visits.

As described in section 4.5 on efficiency, the CP succeeded in mobilising additional human resources for the CP through redeployment of its existing staff in combination with direct external recruitment. Technical resources in the programme and operational areas were mobilised through assistance from UNFPA Regional Office, HQ and the procurement division PSB.

Operations staff interviewed observed that they are not systematically informed and consulted from the beginning by programme staff in the planning of programmes and activities and in the development of funding proposals. As a result, project proposals have been submitted to partners and donors without adequate inclusion of budgets for staff, communication, M&E, operations costs, security costs, etc. The evaluation team observed that the understanding of some CO staff on donor policies and procedures is limited. CO staff do not understand the difference between various funding modalities (budget support, programme support, project support). This was also noticed by donor partners, who observed during the interviews that at some occasions CO staff had not followed correct donor procedures.

Partnerships

EQ 10) To what extent was the UNFPA Iraq CO able to establish and maintain different partnerships to ensure good use of its comparative strengths in the achievement of the outcomes of the CP (2016-2019)?

FINDINGS SUMMARY

UNFPA has established strong working relations with a number of government counterparts in key sectors. This contributed to commitment by these sectors to support priority interventions promoted by the CP. Relations with other non-IP government agencies were less developed. Partnerships with civil society Implementing Partners were also strong. IPs find UNFPA a responsive and flexible partner, but observed that UNFPA had not facilitated much information and experience exchange between IPs working in the same programme area. This was a missed opportunity for CP IPs to learn from each other, replicate best practice, form stronger links and also to motivate IP staff.

[115] UNFPA Iraq (2018): Draft Resource Mobilisation Strategy – UNFPA in Iraq. November 2019.

In terms of partnerships with government, UNFPA maintained strong working relationships with a number of Ministries at central, regional and governorate level, as described in section 4.4. UNFPA participated in and supported annual planning processes of a number of government partners, such as the Kurdistan High Council of Women's Affairs. UNFPA partnerships with government focused on those government institutions and specifically on the departments within those institutions who are the Implementing Partners of UNFPA. As a result, partnerships with other Ministries such as the Kurdish Ministry of Youth and Sports, were not well-developed and opportunities for engagement and advocacy with them – such as for example during the organisation of thematic meetings – were missed.[116] Furthermore, UNFPA's routine practice of leaving the liaison with government officials to the UNFPA focal points for the specific government IPs, was not always understood and well received by senior government officials. Senior 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 and at times affected the Ministries' willingness to cooperate with UNFPA. Until recently, the UNFPA youth team did not engage much with the Regional Ministry of Youth 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.

Stakeholders in camp sites reported to the CPE team that during field visits, UNFPA staff generally went directly to the activity sites, often to accompany donor representatives, and rarely make courtesy calls to camp management or to IP offices. Thus, opportunities were lost for strengthening partnerships and learning about what was going on the ground. As mentioned above, the limited engagement by UNFPA with government authorities in the establishment and management of women's and youth centres contributed to limited (technical) ownership by the government of these initiatives.

In terms of partnership with civil society organisations, UNFPA Iraq focussed mainly on its civil society implementing partners, most of whom are national or international NGOs. Collaboration with local and international NGOs was essential due to their capacity for service delivery. During the past years, UNFPA's civil society IPs did 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. UNFPA 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 South-Central Iraq. Similarly, QANDIL was contracted to support local NGOs both in Kurdistan and South-Central Iraq. Both organisations supported some capacity building in monitoring and financial management capacity of their sub-contracted agencies. UNFPA did not request them to provide technical capacity building of their subcontractors. Some stakeholders interviewed expressed their concern about the (lack of) technical capacity of some of the smaller civil society IPs of the UNFPA CP.

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. IPs reported that UNFPA contributed to capacity building of local IPs in term of policy development, programme management, narrative / programmatic and financial reporting, and data collection and to some extent, documentation and communication products.

IP staff interviewed stated that during the past years UNFPA staff generally liaised with IP staff on an 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 the same location. There was limited exchange of experience with organisations internationally, nor sharing by UNFPA staff on developments in programme areas within Iraq or abroad. This was a missed opportunity for the CP IPs to learn from each other, replicate best practice, form stronger links and also to motivate IP staff. The new senior management has made some changes in this respect and has reportedly organised 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

[116] Interviews with staff from UNFPA CO, Ministries and partners.

closure of facilities and handover processes. IPs also reported that some UNFPA programme staff communicate with them in a rather direct and directive way.

4.6 Connectedness

EQ 11) To what extent did humanitarian activities of the UNFPA Iraq CO support or contribute to the transitioning towards longer-term (i.e. developmental and/or resilience-related) goals of the affected populations?

FINDINGS SUMMARY

Due to its initial focus on humanitarian service delivery, the CP's capacity strengthening efforts during the first 2.5 years were limited. The manuals and tools developed by the CP (GBV SOPs, Adolescent Girls Toolkit) and associated capacity building of government staff at governorate and service delivery will assist authorities' ability to provide routine RH and GBV services to populations during the recovery period and during the transition into the development of the country.

Since mid-2018, the CP started transitioning towards resilience and recovery programming by moving away from direct support to service provision. This included efforts to hand over service delivery to local authorities in stable areas, and increased high-level policy engagement with government as well as preparations for generation of data to facilitate long-term planning and advocacy. Handover of service delivery was not always well prepared and communicated to partners.

Capacity development was one of the programme delivery mechanisms defined in the CP, with the objective to contribute to the resilience of Iraqi government and civil society counterparts to enable them to be better prepared for future emergencies and to transition into a post-conflict and development-oriented phase. Due to the CP's initial focus on humanitarian service delivery, there were some capacity strengthening efforts but these were not as extensive as planned in the CP Document of 2015. To some extent CP interventions strengthened the capacity of central and regional government departments responsible for overseeing UNFPA's mandate areas, particularly GBV and other harmful practices, as well as the capacity of governorate level departments to provide emergency assistance in the areas of RH and GBV to populations in humanitarian settings. The manuals and tools developed by the CP (GBV SOPs, Adolescent Girls Toolkit) and the capacity building of government staff at governorate and service delivery levels – for example in the model GBV survivor centre – will assist authorities to provide routine RH and GBV services to populations during the recovery period and the transition into development. The CP also strengthened capacity of central level women's institutions and statistics organisations – to develop their strategic and operational annual plans and mobilise. Partners interviewed stated that the CP contributed to strengthening the capacity of government institutions and civil society partners supported to respond to the current and future crises and thus augmented their resilience to risks (such as recurrence of emergencies, decrease in funding from UNFPA, etc).

As mentioned above, 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 technical capacity building of government health workers and of technical IP staff on the application of the CMR protocol and the use of the GBV SOPs. 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. Stakeholders observed that capacity building of civil society IPs contributed to increasing their technical capacity to deliver services in UNFPA mandate areas during acute emergency and recovery periods. However, CP resources allocated to IP capacity building were limited. This was a particular challenge when IPs such as TAJDID and QANDIL were requested to sub-contract smaller local NGOs and CBOs. The CPE team also found that UNFPA was not always effective in ensuring that adequate staff- particularly service providers - benefitted from trainings.

Since 2018, the CP started its transition towards resilience and recovery programming by moving away from direct support to service provision. This included efforts for handing over service delivery to local authorities in stable areas. This was in line with decisions taken by the UN Humanitarian Country Team, evidenced by suggestions in the UN Humanitarian Response Plans from 2017 onwards that agencies hand over health facilities in camps to health authorities through a pre-defined phase-out approach that

includes support and capacity building.[117] For example, by the end of 2018, UNFPA and IPs had handed 40 out of 112 RH facilities over to governorate DoHs, which closed most of them.

The evaluation team found no evidence that the CP implemented a phased handover approach with consistent capacity building 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. The evaluation team found evidence of some mid-term planning for handover to counterparts or local institutions for women's centres starting from mid-2018 and discussions with DOLSA to coordinate this,[118] but no evidence of planning the phase out or handover of youth centres. The evaluation found no evidence of any system for capacity building to ensure adequate handover of women's centres or youth centres to counterparts to prepare them in advance. Stakeholders expressed the opinion that the CP did not always apply adequate planning for responsible transition and handover to counterparts or local institutions. CP capacity strengthening efforts of the institutions taking over the services seem to have been conducted on an ad-hoc basis instead of adopting a coherent systematic approach using an institutional development plan. In general, interventions designed and established by the CP did not include exit strategies. 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's centres. 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 staff working in other departments. DoH staff interviewed reported that since the phase-out of the incentives, staff motivation to provide FP services has decreased.

With the arrival of the new CO senior management team from mid-2018 onwards, the emphasis of the CP changed towards facilitating the transition towards an increased development focus in the programme. This is evident from the CO's increasing efforts in high-level policy engagement with government, supporting government in developing new policies and strategies (such as the FP Strategy) and generating important data to facilitate long-term planning (such as the Adolescent Survey and the Population Census). CO staff interviewed also mentioned their plan and efforts to increase support to capacity strengthening of government counterparts and civil society organisations, as well as to strengthen participation of adolescents and youth in policy dialogue.

4.7 Coordination

EQ 12) To what extent did the UNFPA Iraq CO contribute to the functioning and consolidation of the UN Country Team (UNCT and HCT coordination mechanisms and to national coordination mechanisms?

FINDINGS SUMMARY

UNFPA contributed to the functioning of the UN Country Team and Humanitarian Country Team by leading the UN RH working group, the GBV sub-cluster and the Adolescent Girls Taskforce. Stakeholders interviewed found these mechanisms useful as they facilitated exchange of information between implementors as well as identification and addressing of gaps and bottlenecks. The GBV sub-cluster and Adolescent Girls Taskforce furthermore developed tools useful for standardisation of methods used for service delivery and awareness-raising. UNFPA furthermore participated in other UN coordination mechanisms and collected data and contributed these to various UN databases. Stakeholders interviewed appreciated UNFPA´s efforts in leading these mechanisms, although at times the regularity and/or inclusiveness of the coordination mechanisms led by UNFPA could be improved. The CP documented the achievements of the GBV sub-cluster, such as its contribution to timely deployment of GBV services, effective usage of resources and inter-agency joint responses for enhanced service availability during the Mosul crisis. The CP did not document the contribution by the RH working group and other UNFPA-led coordination mechanisms to achieving CP objectives.

UNFPA is lead of the Reproductive Health Working Group and the GBV Sub-Cluster. Stakeholders interviewed generally found the RH working group, which is a sub-group of the UN Health Cluster, a

[117] UN (2017): Humanitarian Response Plan, Iraq, 2017. February 2017.

[118] UNFPA (2019): Phase out of WCCs in Iraq, April 2019.

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 effectively coordinating the RH working group. Despite this issue being raised by the UN Health Cluster at the level of the UNCT, the RH working group has not resumed its regular meetings at the time of the CPE field visit to Iraq. Members of the RH working group observed that that group had improved information exchange and coordination between members, reduced duplication between service providers, facilitated the identification of bottlenecks and gaps and enabled a quick response to address the bottlenecks and gaps. The CPE team did not find evidence on whether the group had reduced / avoided wastage of resources.

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. The GBV sub cluster in Iraq established local GBV working groups in almost all Iraqi governorates.[119] It functions as a mechanism to coordinate activities, exchange information and identify gaps. The sub-cluster is not involved in monitoring whether the standards set are being implemented by government and partners. UNFPA has the mandate to lead on GBV interventions within the UN family and recruited a full-time GBV sub-cluster coordinator, which has facilitated availability for engaging in the coordination of the sub-cluster. The GBV sub-cluster played a key role in coordinating the GBV humanitarian response during Mosul operations in 2017, by coordinating the preparation of contingency plans and facilitating prepositioning of human resources and supplies.[120] When the response started, the sub-cluster and working groups ensured timely GBV responses and daily reporting. This contributed to timely deployment of GBV services, effective usage of existing resources and inter-agency joint responses for enhanced service availability.[121] The sub-cluster also coordinated GBV preparedness plans for response to other geographic areas, for ex. for Sinjar governorate in 2018.[122] The GBV sub-cluster together with the GBV case management working groups, the adolescent girls taskforce and the shelter working groups (established in 2019) currently function as coordination platform for all GBV providers and actors in the country. Through the sub-cluster, the CP supported the development of a referral pathway and facility / service mapping. The sub-cluster also produced guidance notes for its members and established a system to monitor the performance of its members in terms of awareness-raising, service provision and capacity building.[123]

Stakeholders interviewed appreciated the expertise of UNFPA in this area and the technical contributions made by UNFPA to the activities of the sub-cluster. The service mapping, referral pathways and Standard Operating Procedures coordinated and developed by the sub-cluster were all found to be useful. RH sub-working groups and GBV working groups were created in several governorates in Kurdistan, which stakeholders interviewed found useful and reported to have facilitated information exchange, coordination of activities and identification of gaps and challenges.

UNFPA is also co-lead of the Adolescent Girl Taskforce, established by UNFPA and UNICEF Iraq in 2016.[124] It is an active working group of UN agencies and civil society partners, focussing on producing and rolling out the Adolescent Girls toolkit amongst civil society partners and some government institutions such as youth centres. The taskforce played a considerable role in raising awareness on the issues of adolescent girls and capacity building of partners on Adolescent Girls toolkit to create

[119] Iraq Gender-Based Violence Sub-Cluster (no date): Summary of GBV SC Achievements (2017-2018).
United Nations Protection Cluster Organigramme (no date).

[120] UN 2016): Inter-Cluster Operational Planning Exercise 16 October 2016.
Iraq Gender-Based Violence Sub-Cluster (no date): Preparedness for the Protection of Women and other vulnerable groups ahead of MOSUL.

[121] Iraq Gender-Based Violence Sub-Cluster (no date): Summary of GBV SC Achievements (2017-2018).

[122] UN (no date): Preparedness for Possible Displacement of Civilians from Sinjar area.

[123] GBV Sub-Cluster Iraq)2016): Iraq GBV Sub-Cluster Strategy for 2016.
GBV Sub-Cluster Iraq (2017): Guidance Note for Reporting on GBV Sub-Cluster Activities in ActivityInfo.
No publishing organisation (no date): Guidance on Survival Sex for Humanitarian Community in Iraq.

[124] UNFPA-UNICEF (2019): Interagency Task Force on Adolescent Girls, Iraq; Terms of Reference.

awareness on protection and SRH issues of girls in communities. It ensured regular coordination among partners on adolescent girls' programmes in communities. UNFPA as one of the co-leads conducted vigorous evidence-based advocacy on the issue of child marriage and GBV. Members of the taskforce interviewed by the CPE team feel that the taskforce was useful to draw attention to the importance of targeting adolescent girls as a highly vulnerable group during humanitarian crisis and to coordinate the implementation of the Toolkit. However, they also observed that the focus within the taskforce is mostly on the GBV prevention and response, and not sufficiently on other aspects affecting adolescents and girls, such as SRH and life skills, empowerment, etc.

National sector coordination mechanisms in Iraq at national and governorate level are not strong. This is particularly the case for adolescent and youth programming. Within the UN system, several clusters touch upon youth activities. Consequently, coherence between the IPs implementing activities targeting adolescents and youth in IDP and refugee camps is limited. In the absence of a UN youth cluster or youth working group Iraq, youth coordination has been conducted through the Adolescent Girl Taskforce. Development partners are currently considering establishing a large adolescents and youth working group which would also cover adolescent boys as well as youth of both sexes.

As mentioned in section 4.4, coordination by UNFPA with partners before and during the handover and phasing out of RH services, women's centres and youth centres has not been adequate, with UNFPA at times taking its decisions on a unilateral basis and not timely sharing of its intentions. This resulted in opportunities for responsible transition being lost. 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 is Dohuk governorate where - as an exit strategy and development mechanism – UNFPA and its IP Harikar decided to place Department of Youth focal points in the youth centres. Some stakeholders interviewed expressed the opinion that UNFPA Iraq's style of leadership of joint initiatives was at times uni-directional and not sufficiently inclusive. A few stakeholders expressed their opinion that in some instances UNFPA coordination staff seemed to represent their own agency when liaising with external parties rather than acting as representative of a multi-agency effort. UNFPA furthermore contributed to the functioning of the UNCT and HCT coordination mechanisms through attending meetings, contributing to data collection and developing reports. Staff from partner UN agencies observed that there was room for improvement in the participation by UNFPA in working groups not led by UNFPA.

On an individual level, UNFPA generally cooperated well with other UN agencies in the design and implementation of interventions, particularly for interventions that were part of a joint project or where funding was linked. Examples of this is the cooperation with WHO on the sharing of PHC and RH clinics and with UNICEF in the Adolescent Girls Taskforce. On the other hand, UNFPA did not systematically invite other relevant UN agencies when it organised meetings with government and civil society on programmatic issues. The operations team of UNFPA 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, which contributed to sharing of operations resources and procedures. UN agency staff interviewed appreciate the willingness of the new UNFPA Representative to cooperate and share information with other UN agencies. The previous UNFPA senior leadership seemed more focussed on working alone, which at times contributed to the impression of competition amongst UN agencies for resources, rather than emphasising joint intervention delivery.

The UNFPA CP produced a number of communication products, including programme brochures, summaries, humanitarian fact sheets, reports, donor briefs and audio-visual materials, which give an excellent representation of the interventions. The UNFPA Iraq website regularly published success stories and documents produced by UNFPA in Iraq and at global level.[125] Engagement by UNFPA in social media increased in recent years.

[125] https://iraq.unfpa.org/en/news
UNFPA Iraq (2019): Factsheet: UNFPA Humanitarian Response in Iraq 2018 -2019. Draft.
UNFPA Iraq (2019): Factsheet: Reproductive Health Humanitarian Response in Iraq - 2018 -2019.
UNFPA Iraq (2019: Factsheet: Gender-Based Violence Humanitarian response in Iraq - 2018 -2019.
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UNFPA Iraq (2019): UNFPA Iraq, Quarterly Update. Issue nr 4, January, February, March 2019.

5 CONCLUSIONS

5.1 Strategic level

1. The 3rd UNFPA Iraq Country Programme (CP) for 2016-2018 was relevant in responding to emerging humanitarian priorities defined by the United Nations HRPs, and focussed mainly on addressing the needs of populations identified by the international community as most vulnerable, namely IDPs, returnees and refugees in areas affected by conflict and post-conflict situations in Iraq. The CO was highly responsive to changing humanitarian RH and GBV response needs of populations affected, and was able to modify CP support delivery mechanisms in order to increase access to insecure and volatile areas. This responsiveness is appreciated by stakeholders interview, who acknowledge UNFPA as a champion for reproductive health and rights and for the fight against gender-based violence and other harmful practices, including in humanitarian situations. In 2018, with the humanitarian crisis becoming less acute, the CO shifted the CP focus to facilitate a transition towards a greater development emphasis. UNFPA Iraq has demonstrated added value in the areas of its technical expertise and mandate, which are recognised and appreciated by stakeholders. UNFPA's technical expertise and comparative advantage has allowed it to act as a facilitator, playing an intermediary role between national counterparts and partners in UNFPA¡s mandate area. The CO has added value in engaging in policy dialogue, particularly regarding health and wellbeing for adolescents and youth and to a more limited extent also on sensitive themes such as right of adolescents and young people and unmarried persons to SRHR information and services. (Origin: EQs 1, 2, 3, 4, 7)

2. The CP targeted its humanitarian response to populations identified by the UN Humanitarian Country Team (HCT), namely women and girls of reproductive age, GBV survivors and adolescent girls and boys and youth in humanitarian settings - including the marginalised populations comprised of former wives and children of ISIL fighters - particularly those living in camps accessible by the humanitarian community. During the first three CP years (2016-2018), the UNFPA-supported interventions reached a total of six million persons in 83 camp sites and host populations. The bulk of the CP humanitarian support was provided to populations living in camps in the three governorates of Dohuk, Erbil and Sulaymaniyah located in the Kurdistan Region of Iraq (KRI), which housed the majority of the IDPs, refugees and returnees, and from which humanitarian support was also provided to vulnerable populations in the neighbouring governorates of Ninewa (following the liberation of Mosul and surrounding areas), Diyala and Kirkuk, and in Baghdad governorate, from which support was provided to areas affected by IDPs, refugees and returnees in the governorate of Anbar. (Origin: EQ 5)

3, The CP effectively takes into account gender equality and human rights principles: it promotes gender inclusion principles for the development of adolescent girls and young women and men, promoting opportunities and equal treatment for all young people, young women and men. The CP supported the universal access of vulnerable populations living in humanitarian situations to reproductive health information and services, family planning and to the response to GBV and other harmful practices. It furthermore promoted an inclusive approach by generating knowledge on how to include vulnerable groups such as adolescent girls, youth, women and GBV survivors in SRH and GBV programming. Gender equality and the empowerment of women and girls are one of the thematic pillars of UNFPA and one of the outcome- and output areas of the Iraq CP Document and CP Action Plans. The assessments supported by the CP generated knowledge on inequities in access to information and services by GBV survivors, whereas the studies and surveys planned for 2019-2020 will provide information on adolescent girls and boys and youth. This facilitated and will further facilitate advocacy by UNFPA with government for increased attention and resources for these vulnerable groups in humanitarian and development settings. (Origin: EQ 7)

4. The CP contributed to some degree to strengthening the government's ability to provide RH and GBV services to populations during humanitarian crisis and recovery periods, as well as during the country's transition to a greater development focus. Due to its initial focus on humanitarian service delivery, the CP's capacity strengthening efforts were limited until mid-2018. The manuals and tools developed and rolled-out by the CP were related to the GBV and youth programming, such as the GBV SOPs and Adolescent Girls Toolkit, which were highly appreciated by implementors interviewed for their usefulness and contribution to standardisation of approaches. The CP did not document the degree of capacity building of government and implementing partners. The shift in focus of the CP in 2018 was demonstrated by moving away from direct support to service provision (including

efforts for handing over service delivery to local authorities in stable areas) towards increased emphasis on high-level policy engagement with government and on generation of data for planning and decision making. (Origin: EQ 11)

5. UNFPA-led coordination mechanisms contributed to coordination of programme implementation between implementors and with government and other partners and to the development of common approaches and tools and increasing effective usage of resources. UNFPA furthermore contributed to the functioning of the UN Country Team and Humanitarian Country Team through its leading of the UN RH working group, the GBV sub-cluster and the Adolescent Girls Taskforce. Stakeholders interviewed found these mechanisms useful as they facilitated exchange of information between implementors as well as identification and addressing of gaps and bottlenecks. The GBV sub-cluster and Adolescent Girls Taskforce furthermore developed tools useful for standardisation of methods used for service delivery and awareness-raising. Coordination with other UN agencies was strong, particularly when funding for interventions was linked. Stakeholders interviewed appreciated UNFPA´s efforts in leading the coordination mechanisms, although at times the regularity and/or inclusiveness of the mechanisms could be improved. The CP documented the achievements of the GBV sub-cluster, such as its contribution to timely deployment of GBV services, effective usage of resources and inter-agency joint responses for enhanced service availability during the Mosul crisis. The CP did not document the contribution of other coordination mechanisms such as the RH working group and Adolescent Girls Taskforce (co-)led by UNFPA. (Origin: EQ 12).

5.2 Programme level

6. The UNFPA CP was effective in providing quality RH services to women and girls of reproductive age living in IDP and refugee camps and highly responsive to evolving emergency situations. UNFPA Iraq's rapid RH and GBV response to the Mosul crisis was internationally recognised as a best practice example for provision of RH services in emergency situations: it includes provision of emergency reproductive health services on frontlines and strengthening of referral pathways through maternity hospitals, mobile and static delivery rooms, and mobile and static reproductive health clinics in camps and host communities. The rapid response was facilitated by pre-positioning of emergency in supplies, materials, training of staff in advance and strong cooperation with UN partners and IPs. Beneficiaries interviewed by the evaluation team expressed their appreciation of the maternal health services received. The CP did not document the contribution by the programme to awareness of, access to and utilisation of RH services amongst targeted populations. Male engagement in the awareness-raising on FP and RH information was not strong. Management of the high-value RH kits by the CP was not efficient, which resulted in a part of kit items being returned to Department of Health medical stores or wasted. From mid-2018 onwards, the CP was effective in shifting the focus of the RH programme towards development-oriented interventions, such as increased engagement and advocacy with government on key policy issues, such the development of a new Family Planning policy. This was successful as the government has established a FP policy working group. Following handover by the CP of RH services to government, health facility staff interviewed stated they noticed a decrease in FP services provided in camps. (Origin: EQs 5, 11)

7. The CP was highly effective in providing GBV response services to survivors in humanitarian settings and in hard-to-reach areas, in many of which no GBV response capacity had existed previously. The CP was effective in supporting capacity building of government and civil society staff on GBV prevention and response, as well as in developing and rolling out service delivery norms and tools. These efforts reportedly resulted in strengthening the GBV response by government and civil society facilities and in promoting minimum quality standards and standardisation across providers, although these results were not documented by the CP. The CP also contributed to capacity building of government women's authorities at central level, who are now able to coordinate gender and GBV issues, lead policy development and mobilise resources. Engagement of men and boys was not systematic nor well developed. The CP and GBV sub-cluster support to GBV service mapping, documentation of referral pathways and of vulnerability of GBV survivors and data on survivors have contributed to institutionalise the GBV response in Iraq. Efforts by UNFPA to ensure consistency and minimum quality standards in the development and use of BCC materials by IPs were limited. Despite the considerable resources allocated to providing GBV awareness raising and services, the CP did not document their impact on GBV survivors and other women and girls, boys and men in the camps and community attitudes on violence against women and girls, child marriage and women's empowerment. Since mid-2018 the UNFPA CO has shifted

CP focus away from direct service provision by initiating the handover of women's centres to authorities and partners. The CP is currently supporting the replication in other governorates of the model GBV survivor centre established in Dohuk. (Origin: EQs 5, 6, 11).

8. In spite of limited resources being allocated to the youth programme compared to the RH and GBV programme areas, the CP was effective in supporting life skills teaching and SRH and GBV awareness-raising of adolescents and youth in humanitarian settings, as well as through youth volunteer outreach throughout the country. These efforts achieved the objective to provide age- and gender-responsive and inclusive programmes contributing to the protection, health and development of young women, young men, girls and boys within humanitarian settings. The CP did not document changes in knowledge, skills and attitudes amongst adolescents and youth who attended the youth centres and in attitudes towards young girls attending schools and marrying young. Interestingly, using women's centres was an effective way to reach adolescent girls for awareness-raising on SRH and GBV, and for GBV response programming. The development and roll-out of the Adolescent Girls Tools kit in cooperation with UNICEF contributed to unifying approaches between UN agencies and partners and standardising tools used by government and its partners in Iraq when working with adolescent girls. CP capacity building efforts targeted to government staff on youth issues were limited, whereas capacity building efforts of civil society organisations focussed on CP IPs. From mid-2018 onwards, the UNFPA youth team has shifted its focus to developing a coherent youth programme, with increased emphasis on strengthening cooperation and advocacy on youth issues with central and regional authorities and on developing a national youth agenda. The recruitment of an international UNFPA Youth Specialist also demonstrates the increased CO commitment to its youth programme. (Origin: EQs 5, 6, 11)

9. Due to low priority placed by the CO on population dynamics programming during the humanitarian crisis in the first CP years, allocation of financial and human resources to this CP output were reduced. The CP was therefore not effective in achieving the CP objectives defined in the CP, and generation of data and capacity strengthening efforts of government on population issues were limited. Since late 2018, the CO has revitalised its Population Dynamics programme efforts by resuming advocacy with government on key issues such as the National Population and Housing Survey planned to take place in 2020 and assisting government in preparations for it. The recruitment of the international UNFPA Population and Development Specialist demonstrates the increased CO commitment to its population programme. (Origin: EQs 5, 6, 11)

10. In spite of a highly challenging operational environment and the CP resource needs being extremely high, the CO performed well in terms of CP programme management, financial management and corporate compliance, while the Iraq CP became the highest spending worldwide during 2016-2018. UNFPA Iraq was extremely effective in its resource mobilisation efforts, managing to raise USD 105 million for its 2016-2018 programme, making the Iraq CP the largest resource mobilisation effort globally ever for the organisation. UNFPA's operational set-up allowed for rapid CP response and deployment to affected areas and contributed to CP achievements. However, CP implementation suffered from delays due to political volatility and changing security situations, requiring frequent CP reprogramming. Whereas the CP applied a quality assurance system in its GBV response through the formulation and rolling out of minimum service standards, quality assurance systems across RH and youth programmes were not effective, lacking formalisation and uniform application, which resulted in variations in standards in programme implementation between locations and IPs. In CP monitoring, the CP results framework was only partly able to demonstrate programme results as some CP output and output indicators do not capture the CP's achievements in humanitarian service delivery. The CO teams did not use or updated the CP results framework and its CP results tracking tool for monitoring of CP results. The CO established an innovative online programme monitoring system used by CO teams and IPs. However, documentation by the CP of achievements, best practices and lessons learned was not strong. UNFPA established strong working relations with government counterparts and civil society IPs in key sectors at central and regional level, which led to government commitment to supporting priority CP interventions. Relations with non-IP government agencies were less developed. IPs interviewed found UNFPA a responsive and flexible partner, but observed that UNFPA had not facilitated much information and experience exchange between IPs which is seen as a missed opportunity for IPs to learn from each other and replicate best practice. (Origin: EQs 8, 9, 10)

6 RECOMMENDATIONS

This chapter presents the recommendations that are linked to the findings and conclusions shown in the previous sections and that constitute the set of actionable proposals for the next CP for 2021-2025.

6.1 Strategic level

RECOMMENDATION 1: The next UNFPA Iraq Country Programme 2021-2025 should focus on youth programming as a cross-cutting issue while ensuring that within the four programme areas also the focus is always on ensuring that systems and services supported reach adolescents and young girls, as well as other highly vulnerable groups.

Priority: High **Target level:** Country Office **Based on conclusions:** 6
Operational implications
For the new CP, UNFPA should work with Government to push for the implementation of the Youth Strategy. This would include the CP increasing focus on reaching adolescents and youth in all its programme components, with the objective of increasing the access of adolescents and young people to health (including SRH) and GBV information and services and to life skills education and peace building, and of increasing their participation and empowerment. This would enable UNFPA to continue to build on its comparative advantage in these areas going forward into the new programme. To achieve this, UNFPA should prioritise multisectoral approaches and programmes, involving priority sectors of health, education, youth & sports, health and gender, with strong advocacy and engagement with government authorities (central and municipal) and partners on key issues. Programmes should where possible be implemented through inter-agency cooperation with UN agencies and in close cooperation with civil society partners.

RECOMMENDATION 2: The current and new CP should continue moving towards an increased focus on resilience, recovery and long-term development objectives. This will include continuing to move away from support to direct service delivery once responsible transition is ensured, and increasing emphasis on systems strengthening in a coordinated manner across programme areas, in combination with advocacy and engagement with government authorities on key issues. This should be accompanied by an acceleration of the documentation of the achievements, best practices and lessons learned from the current CP as well as knowledge generation, collection and dissemination, so that the CP can use the data and best practices to advocate with government, influence policy development and promote replication where appropriate, and so that other countries can learn from Iraq's example.

Priority: High **Target level:** Country Office **Based on conclusions:** 5, 6, 7, 9
Operational implications
The CO should increase engagement with central, regional and governorate level authorities in the key mandate areas of UNFPA, including with those Ministries and agencies which are not IPs of the CP but which are important players for the achievement of the CP objectives. In the current and upcoming Country Programme, UNFPA Iraq should continue to phase out support to direct service delivery, except where new approaches are being piloted, or where populations are affected by new humanitarian and emergency situations. These new approaches should be adequately documented from the beginning. During the phase-out it will be important for UNFPA to ensure responsible transitions for all services which are to be discontinued, through robust transition planning over several months accompanied by detailed formal documented technical handovers and related capacity building efforts. For the new CP, UNFPA should from the beginning ensure that exit strategies are developed for all programme interventions to be supported and that these are agreed with IPs and included in IP Work Plans. This would contribute to greater connectedness of the CP moving between humanitarian, resilience and development efforts. It would also contribute to optimising the sustainability of CP achievements and to limiting the substitution effect of UN agencies and civil society organisations replacing government in service provision.
Systems strengthening efforts by the CP should increasingly focus on strengthening of systems, including policies, guidelines, procedures and tools. This should include capacity building of CO and GEEW partner staff on technical issues and on programme planning, results-based management,

quality assurance, M&E and reporting. The CP should also increase opportunities for exchange of information and experiences between IPs and partners working in the same area inside the same country and abroad, including through south-south cooperation. The CO and its partners should develop a capacity building strategy for the CP period in order to optimise the strengthening of capacities of strategic partners and sharing of knowledge and experience with and between partners. The current and new CP should increase emphasis on knowledge generation, collection and dissemination, including innovation, with the objective of influencing policy development and national programme implementation. Knowledge generation should enable UNFPA to fulfil its UN role of influencing policy development and implementation by contributing to Getting Research Into Policy and Practice (GRIPP). Better knowledge products will also facilitate resource mobilisation with partners. This should include the production of policy briefs and materials for advocacy with government and engaging in national coordination mechanism to promote policy development and replication of best practices. National academic institutions can play a useful role in knowledge generation and documentation. This implies that the CP should plan for and ensure adequate CP budgets to support documentation of best practices and intervention models, knowledge generation and communication. Best practices to be documented include the impact of women's centres and youth centres and awareness-raising efforts on the level of knowledge, skills and attitudes of direct beneficiaries as well as on attitudes in camps and other targeted communities. The CP could also document the impact of the provision of RH and FP services and information in the targeted areas.

RECOMMENDATION 3: UNFPA should further strengthen coordination with IPs, government counterparts, sister UN agencies, academic institutions, civil society organisations, other stakeholders and donors through regular meetings and circulation of regular written updates on programmes and achievements.

Priority: High **Target level:** Country Office **Based on conclusion:** 9

Operational implications

The current and new CP should strengthen and increase inter-agency coordination with likeminded UN agencies, including for interventions which are not funded or implemented jointly. Partnerships with UN agencies will also be useful to leverage the expected results in government commitments, through the provision of technical assistance under the premise of multi-sectoral coordination.

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, working to strengthen relationships between members and synergies between agencies and programme efforts. Coordination should also focus on maximising opportunities for joint working and resource mobilisation. Strengthening and working through national coordination mechanisms and their respective technical working groups is an excellent way for UNFPA and its partners to lobby for and promote government ownership on priority issues, while at the same time strengthening national capacity. In order to facilitate the transition to development, UNFPA could support the strengthening of government ownership of all coordination mechanisms which touch on UNFPA's mandate, both at national level and in the governorates where UNFPA is active.

6.2 Programme Level

RECOMMENDATION 4: UNFPA should increase emphasis on strengthening national capacity for SRH, FP, GBV, youth services and population data, while advocating for greater government budget allocation for these programmes.

Priority: Medium **Target level:** Country Office **Based on conclusion:** 5, 6, 7, 9

Operational implications

UNFPA should support the strengthening of government capacity to provide better quality SRH, FP, GBV and youth services to populations living in camps and host communities. This should be based on the documentation of best practices supported by UNFPA and partners (such as the RH service model supported in PHC services in humanitarian settings, the youth centres and women's centres) and advocacy with relevant government authorities for replication of the best practice models into host community across the country. The CO should strengthen its provision of technical support to counterpart government institutions in the revision and development of relevant national policy

documents and in their implementation. The CP should also support the capacity of civil society organisations to provide key services, to adequately contribute to national and local policy dialogues and to represent and involve communities in decision making processes.

RECOMMENDATION 5: The CP should strengthen the national capacity for knowledge generation and data analysis in Iraq, particularly regarding population dynamics, as well as the national system for monitoring of country progress on post-ICPD agenda and performance, including the ICPD-related SDG indicators.

Priority: High **Target level:** Country Office **Based on conclusion: 8**
Operational implications
The CP should support the government in the production of population data, such through the organisation of the Population and Housing Census and analysis of census data. Furthermore, the CP should promote and further support the development of data literacy within government at central, regional and governorate levels. The CP should also increase the breadth and depth of data dissemination, so that data is more accessible and used more for policies and programming by Government and partners.
In the spirit of leaving no one behind, it is important to know as much as possible about key vulnerable groups, to understand which groups have benefited from certain interventions, which have not and to identify key problems. The disaggregation of data should apply to ally national surveys.

RECOMMENDATION 6: UNFPA should continue to strengthen CP management, quality assurance and monitoring and evaluation, in a way that promotes systematic cooperation between programmes areas and their integration as well as standardisation of approaches between programmes and implementing partners.

Priority: High **Target level:** Country Office **Based on conclusion: 9**
Operational implications
UNFPA should implement a quality assurance mechanism to programmatic coherence across the country and ensure minimal quality standards for its CP implementation by IPs. This QA system should be closely linked to the monitoring system.
The CO should strengthen its practice of basing programme interventions on needs assessments, operational research and participatory consultations with stakeholders. The CO should also review the CP and CPAP every 6 months to ensure that its content and Results Framework still adequate reflect the focus and content of the CP implementation. When the CP implementation focus changes due to emerging developments, such as a major humanitarian crisis, the CPAP and Results Framework should be adapted to ensure that they remain relevant and enable UNFPA and partners to adequately demonstrate the CP achievements. The CP interventions should also include interventions that allow for the systematic documentation of the achievement by the CP of its objectives and indicators.
In awareness-raising and behaviour change communication the CP should ensure consistent standardised messaging.

ANNEXES

Annex 1 – Bibliography

Annex 2 – Terms of Reference of the Evaluation

Annex 3 – Mapping of partners consulted

Annex 4 –IP implementation rates

ANNEX 1 – BIBLIOGRAPHY

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ANNEX 2 – EVALUATION TERMS OF REFERENCE

UNFPA IRAQ COUNTRY PROGRAMME (2016 – 2019)
EVALUATION TERMS OF REFERENCE

INTRODUCTION AND BACKGROUND INFORMATION

UNFPA uses evaluation to aid accountability for development results, foster learning in order to improve development and implementation of interventions, and to contribute to knowledge and good practices in the sector. In consonance with UN system wide declarations and resolutions on evaluation practices, the UNFPA evaluation policy makes provision, and encourages the conduct of Evaluation in the organization.
This evaluation will be conducted in order to enable the country office have robust information on the programs and interventions it has implemented in the last few years and to use this information to improve on the focus and strategies of the next cycle of programs. The primary audience of the evaluation will be the UNFPA CO in Iraq, its implementing partners, including the relevant agencies of the Iraq government and other development partners in the country.

Importantly, this Country Programme Evaluation (CPE) would be the first to be conducted in a nearly-wholly humanitarian context for any CPE of such magnitude in the organization. Therefore, the organization plans to ensure that this evaluation documents critical guides and recommendations that should be adhered to when conducting CPEs for humanitarian programs in UNFPA.

The population of Iraq increased from 8 million in 1965 to an estimated 38 million in 2017. This rapid growth is fueled by a high total fertility rate, currently estimated at 4.2, a low contraceptive prevalence rate (modern methods) at 33.6 percent and a relatively high life expectancy at birth 67.6 years for males and 70.9 for females. The majority of the population of Iraq (69.9 percent) lives in urban areas. Since 2014, the sudden escalation of the conflict in Iraq has caused several successive massive waves of displacement, with a total of 3.2 million internally displaced persons. More than 90 percent of internally displaced persons live within host communities, particularly within the Kurdistan Region, which has seen a population increase of 30 per cent over the last two years. In addition, 250,000 Syrian refugees are still hosted within Iraq. The population influx, the lack of adequate health professionals and structural damage to facilities have contributed to the decreased capacity to deliver timely and high-quality services, and has put significant strain on existing social services, including reproductive health services.

Between 1990 and 2013, the maternal mortality ratio declined from 117 deaths per 100,000 live births to 35.7 per 100,000 live births. Over 90per cent of deliveries were with a skilled birth attendant and over 75per cent were in a health facility. Despite these positive trends, the Millennium Development Goal (MDG) target was not achieved; recent conflict-related access issues are expected to reverse or stall this progress. An assessment carried out by Ministry of Health in 2014, revealed that currently only 25 facilities have the capacity to deliver emergency obstetric and neonatal care (EmONC). Iraq is at a demographic turning point, with 60 per cent of the population under the age of 25, it has one of the most 'youthful' populations in the world. Young people's access to formal education and health services, including sexual and reproductive health services, is negatively affected by the years of conflict and displacement. One in three young persons in the age group 15-29 is illiterate, with a marked gender difference between young women and young men (36.2 percent and 22.4 percent, respectively).

The 2014 Human Development Report ranks Iraq 120 out of 187 countries, with a gender inequality index estimated at 0.54. Iraqi women and girls are subject to domestic violence, 'honor' killings, early and forced marriages and human trafficking. Domestic violence is common, with 46 percent of currently married women exposed to at least one form of spousal violence. Although the legal age of marriage is 18 years for both men and women, 21 percent of young women aged 15-19 years and 5.5 percent under the age of 15 are married. In the Kurdistan Region, 43 percent of women aged 15-49 years have experienced some form of female genital mutilation, despite the fact that the practice is criminalized.

Conflict and displacement have acutely increased the vulnerability of women and put them at higher risk of violence, including sexual exploitation. The 2015 Iraq Humanitarian Response Plan estimates that approximately 630,000 women are in need of protection assistance. Female-headed households are particularly vulnerable due to their precarious economic and social situation. A disturbing negative coping mechanism emerging from the conflict situation is the increased incidence of child-marriages. The existing service structure has been overwhelmed and the standardized protocols for gender-based violence services, including reporting and case management, are largely absent. Iraq's institutions have suffered from the attrition effects of conflict, challenging their ability to formulate policies, design programs and deliver services, including in the areas of population, gender and reproductive health. While the capacity of statistical institutions has recently improved, Iraq has limited capacity to provide up-to-date and disaggregated data for evidence-based policymaking. With the demographic changes in Iraq over the past two years, there is a need to revisit national and sectoral strategies that were designed based on the 2012population-based survey.

CONTEXT

UNFPA began its assistance to Iraq in 1971, via a range of population and family planning projects. These interventions were suspended in 1991 under the UN sanctions regime and resumed in 1995 with a set of major humanitarian interventions focusing on RH and FP services. During the relief phase of the 2003 crisis, UNFPA distributed pre-positioned relief supplies including reproductive health kits, and provided medical supplies and equipment. In August 2003, UNFPA conducted an assessment of RH needs in Iraq and since 2004, UNFPA supported reproductive health, gender-based violence and youth development interventions countrywide, in accordance with its mandate.[126]

Subsequent to the 2003 bombing of the United Nations premises in Baghdad, the UNFPA office was based in Amman, Jordan, with a limited presence in Iraq. From 2011, however, UNFPA increased its presence year-on-year, in accordance with the 2011-2014 CPD, which indicated a gradual UNFPA move back to Baghdad, with a sub-office in the city of Erbil, capital of the KRI.

UNFPA's first Country Programme Action Plan (CPAP) for Iraq covered the period 2011-2014, and thus its development predated and did not anticipate the Syrian conflict. It focused on the priorities within the 2011-2015 UNDAF, with an associated budget of US$30 million for the five-year programme period, articulated within the 2011-2014 Country Programme Plan.[127] Due to the emerging protracted nature of IDPs and refugee crisis, the 2011-2014 CPD was extended in 2014 for one year, and in 2015 a new CPD for 2016-2019 was published, with significant attention to the ongoing crisis and the likelihood of it extending for the foreseeable future. Specific areas of focus articulated in the CPD are:

- Focus on RH/GBV service preparedness plans in the event of escalation of the crisis;
- Capacity strengthening of maternity centres, referrals from camp clinics to outside maternity centres and to the tertiary RH facilities;
- Strengthening/supporting capacity of health provider accountability & quality of care standards;
- Targeting young vulnerable people;
- Recognize and support the role of non-governmental organizations (NGO) in filling humanitarian service delivery gaps, and standardize of their services, particularly for GBV;
- Address host community needs;
- Strengthening referral systems and state institutions to support to GBV survivors.[128]

The second Country Programme (2016-2019) is being implemented through two Country Programme Action Plans (CPAP). The initial Action Plan (2016-2017) focused heavily on the humanitarian context to provide targeted support to internally displaced persons, host communities and refugees. The second CPAP (2018-2019) currently

[126] UNFPA Country Programme Action Plan, 2011-2015
127 UNFPA Country Programme Document, 2011-2015
[128] Ibid.

under way is still heavily leaning towards humanitarian service delivery but is expected to build linkages with the development context through strategies of recovery and resilience.

In line with UNFPA's corporate goal, the Iraq programme is aiming at achieving universal access to sexual and reproductive health and rights through delivery of four interlinked outputs:

- 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.
- 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.
- 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.
- 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 programme is being delivered through five modes of engagement with service delivery featuring prominently to reach the most vulnerable populations especially refugees and IDPs with reproductive health and gender-based violence services capacity. In the second CPAP, capacity development, knowledge management, advocacy, policy dialogue and advice as well as partnerships and coordination, including South-South and triangular cooperation, are expected to be more prominent.

OBJECTIVES AND SCOPE OF THE EVALUATION

The purpose of this evaluation is to assess the contribution of UNFPA to the Iraq humanitarian and development priorities. This exercise will generate findings and lessons that will be of use for UNFPA at global, regional and country levels.
The specific objectives of the evaluation are:

- Assess relevance of the programme and progress in the achievement of outputs against what was planned (effectiveness) in the country programme document (CPD) and/or its action plan (CPAP), as well as efficiency of interventions and sustainability of effects;
- Assess responsiveness of the CO to changes/additional requests from national partners caused by an evolving country context
- Assess alignment of CPAP with the UN Development Assistance Framework (UNDAF) and the Humanitarian Response Plans and role of UNFPA country office as an active contributor to the UN coordination mechanisms in the country
- To draw lessons from UNFPA past and current Iraq programme and propose recommendations for future programs.

The scope of the evaluation is to cover activities implemented from January 2016 to mid-2018 targeting all government and NGO partners involved in the CP implementation. In addition, geographical scope of the evaluation will cover those regions both in the Kurdistan Region (Duhok, Suliemania, Erbil) and in the Central South Region (Diyala, Baghdad, Najaf, Ninewe) including those regions with high flow of internally displaced persons and refugees where UNFPA programming was implemented to respond to humanitarian emergency.

EVALUATION CRITERIA AND QUESTIONS

The evaluation will use internationally agreed evaluation criteria, drawn from UNEG norms and standards, OECD/DAC and the ALNAP criteria for the evaluation of humanitarian action, including: relevance, effectiveness, efficiency, coherence, connectedness, coordination.
Attention will be given to gender, age, protection and accountability to affected populations.

The below list of indicative evaluation questions and themes, structured around the above-mentioned evaluation criteria, will be refined by the evaluation team at inception stage. Please note that the final list of evaluation questions should not exceed ten (10). Based on the final list of evaluation questions, the evaluation team will prepare an evaluation matrix, linking questions with associated assumptions to be assessed, indicators, data sources and data collection tools.

- **Relevance**
  - To what extent were the objectives of the UNFPA programme in Iraq adapted to identified humanitarian and development needs?
  - To what extent was UNFPA able to adapt its strategies and programmes over time to respond to changes in the context?
- **Coverage**
  - To what extent did UNFPA interventions reach the population groups with greatest need for reproductive health and gender-based violence services, in particular, the most vulnerable as defined by HCT?
- **Effectiveness**
  - To what extent did the UNFPA programme in Iraq contribute to an increased access to and utilization of quality reproductive health, including maternal health services, for the target population in Iraq?
  - To what extent did the UNFPA programme in Iraq contribute to the prevention of and response to gender based violence for the affected population?
  - To what extent did the implementation of the UNFPA programme in Iraq take into account gender equality and human rights principles?
    - What is the main UNFPA added value in the country context as perceived by national stakeholders?
- **Efficiency**
  - To what extent did UNFPA make good use of its human, financial and technical resources, as well as of different partnerships, in pursuing the achievement of the results expected from programme in Iraq?
  - To what extent has the country office successfully used the establishment and maintenance of different types of partnerships to ensure that UNFPA can make use of its comparative strength in the achievement of the country programme outcomes across all programmatic areas?
- **Coherence**
  - To what extent was the UNFPA programme in Iraq aligned with 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;
- **Connectedness**
    - 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?

- **Coordination**
    - To what extent has the country office contributed to the functioning and consolidation of UNCT and HCT coordination mechanisms?

METHODOLOGY AND APPROACH

The evaluation team will design the evaluation methodology (including data collection methods and tools), which will be presented in the inception report.
The evaluation will use secondary qualitative and quantitative data, complemented with primary data collection as necessary and feasible.

At a minimum, the approach will comprise but not limited to:

- A reconstruction of the **theory of change** underlying UNFPA's programme
- A **document review** as well as an **analysis of the available administrative and financial data** pertaining to the portfolio of activities conducted by UNFPA within the evaluation period
- A thorough gender responsive **stakeholder analysis**, including a beneficiary typology;
- The conduct of **key informant interviews** and **focus group discussions**;
- Direct observation through **field visits**.

Additional data that can enrich evaluation process will be welcomed given reasonable timeframe. Particular attention will be paid to triangulation of information, both in terms of data sources and methods and tools for data collection.

EVALUATION PROCESS AND DELIVERABLES

The evaluation will unfold in four phases (not counting the preparatory phase) and lead to the production of the following deliverables:

- An inception report (including, among others: the reconstructed theory of change of the UNFPA Iraq programme; the stakeholder mapping; the final list of evaluation questions and the associated evaluation matrix; a detailed methodological approach with a work plan and a timeline for the data collection and the reporting phases);
- A completed evaluation matrix, accompanied with the evaluation team's preliminary findings;
- A draft final report (two versions of the draft final report are often required);
- A final report, including findings and recommendations to inform future planning processes.
- A key deliverable of this evaluation is the guide on conducting CPE in humanitarian settings (Based on the consulting team's experience) – Approaches and good practices including potential pitfalls that could be avoided in future CPEs to ensure the organization has a recognised path to conducting similar CPEs in humanitarian context.

Besides the above-mentioned documents, the evaluation team will produce Powerpoint presentations respectively for:

- Debriefing meetings at the end of the field visit
- Evaluation reference group meetings

All deliverables will be in English.

WORK PLAN/ INDICATIVE TIMEFRAME

Phase/milestone	Timing	Responsible
Preparatory phase • Drafting of ToR • Establishment of the evaluation reference group (ERG) • Procurement • Contract signature	January – February 2019	UNFPA Iraq Country Office / ASRO
Inception phase • Initial document review • Stakeholder analysis • Initial key informant interviews (KIIs) • ERG meeting • Inception report	March 2019	Evaluation Team
Data collection phase • Extended desk review • Field visits • Debriefing meeting at the end of field visit • Filled evaluation matrix / preliminary findings • ERG meeting	April-May 2019	Evaluation team
Reporting phase • 1st draft final report • Quality assessment, review and feedback • Stakeholder workshop on recommendations • 2nd draft final report • Final evaluation report	May- June 2019	Evaluation team / UNFPA *Iraq Country Office*
Management response, dissemination and follow-up phase • Preparation of final management response document • Posting the evaluation report, evaluation quality assessment and the management response on UNFPA website	June 2019 – July 2019	Iraq Country Office, PD and Evaluation Office

COMPOSITION AND QUALIFICATIONS OF THE EVALUATION TEAM

The evaluation team is expected to be composed of 4 people, as follows:

- 1 experienced **team leader**, with at least 8-12 years of experience working in the humanitarian sector, including previous experience leading major evaluations of humanitarian assistance. Work experience in any of the UNFPA thematic areas, Gender Based Violence (GBV) or Sexual and Reproductive Health (SRH) is required.
- 3 **evaluators**, each with at least 6 years of experience working in the humanitarian sector, as well as significant evaluation experience. Work experience in any of the UNFPA thematic areas: Reproductive Health (RH), Population and Development (PD), Gender Based Violence (GBV) or Adolescent and Youth (AY) is required.

The evaluation team will collectively bring the below expertise and experience:

- Extensive evaluation experience of policies, strategies and programmes and of complex conflict situations, internal displacement, refugee programmes and transition settings;
- Experience with and institutional knowledge of development and humanitarian UN and NGO actors, the inter-agency mechanisms, such as OCHA funding, and the IASC;

- Familiarity with the Transformative Agenda (Leadership, Coordination, Accountability to Affected Populations);
- Extensive knowledge of humanitarian law and principles, and experience with using human rights and gender analysis in evaluations;
- Good understanding of UNFPA mandate and processes;
- Technical expertise in (i) sexual and reproductive health; (ii) gender equality; (iii) emergency preparedness and response;
- Extensive regional expertise, and solid knowledge of the regional issues;
- Excellent analytical skills;
- Excellent communication skills (written, spoken) in English;
- Good communication skills (written, spoken) in Arabic and/or languages spoken in the region and countries covered is desirable.

REMUNERATION AND DURATION OF CONTRACT

The calculation of workdays is assuming a 5-day work week.
Repartition of workdays among the team of experts will be the following:

- 46 workdays for the International Consultant /Evaluation Team Leader
- 34 workdays for each of Evaluation National Consultant;

The repartition of workdays per expert and per evaluation phase is the following:

	TL	Expert 1	Expert 2	Expert 3
Design phase	10	6	6	6
Field phase	19	19	19	19
Reporting phase	26	20	20	20
Total days	55	45	45	45

Workdays will be distributed between the date of contract signature and the end date of evaluation.
Payment of the Evaluation Team will be made in three tranches, as follows:

1. First Payment (20 percent of total) – Upon UNFPA's approval of design report
2. Second payment (40 percent of total) – Upon the submission of the first draft evaluation report; and
3. Third payment (40 percent of total) – Upon UNFPA's acceptance of the final evaluation report.

Daily Subsistence Allowance (DSA) will be paid per nights spent at the place of the mission following UNFPA DSA standard rates. Travel costs will be settled separately from the consultant fees in line with UNFPA consultancy policy.

MANAGEMENT AND CONDUCT OF THE EVALUATION

The Country Programme Evaluation will be conducted in accordance with the above Work Plan/ Indicative Timeframe. Overall guidance to the CPE will be provided by the Iraq UNFPA Representative with support of the Evaluation Reference Group. The UNFPA Country Office M&E Specialist will serve as the Evaluation Manager.

The Evaluation Reference Group is composed of representatives from the UNFPA Country Office in Iraq, the national counterparts, and the UNFPA Regional M&E Adviser and other relevant colleagues of the regional office.

The main functions of the Reference Group will be:

- to discuss the terms of reference drawn up by the Evaluation Manager;
- to provide the evaluation team with relevant information and documentation on the programme;
- to facilitate access of the evaluation team to key informants during the field phase;
- to discuss the reports produced by the evaluation team;
- to advise on the quality of the work done by the evaluation team;
- to assist in feedback of the findings, conclusions and recommendations from the evaluation into future programme design and implementation.

The Evaluation Manager will be the M&E Specialist in the UNFPA CO in Iraq, and she/he will support the team in designing the evaluation and will provide ongoing feedback for quality assurance during the preparation of the design report and the final report. The UNFPA CO Evaluation Manager will produce the evaluation quality assurance (EQA) for the final draft evaluation report and the final evaluation report in consultation with the RO M&E Adviser. *The Regional M&E Advisor will be responsible for the approval of the Inception Report, and clearance of the final draft of the evaluation report*, and send the final report and EQA to the HQ Evaluation Office. The UNFPA CO Evaluation Manager will ensure dissemination of the final evaluation report and the main findings, conclusions and recommendations.

UNFPA CO will provide the evaluation team with all the necessary documents and reports and refer it to web-based materials. UNFPA management and staff will make themselves available for interviews and technical assistance as appropriate. The CO will also provide necessary additional logistical support in terms of providing space for meetings, and assisting in making appointments and arranging travel and site visits, when it is necessary. Use of office space and computer equipment may be provided if needed.

QUALITY ASSURANCE AND ASSESSMENT

The UNFPA CO Evaluation Manager will use the UNFPA Evaluation Quality Assessment (EQA) grid in consultation with the RO M&E Adviser, for the quality assurance of the draft final evaluation report. Upon receipt of the final evaluation report, UNFPA Evaluation Office at HQ will conduct an independent assessment of the Evaluation Report in line with its organization procedures and tools.

DISSEMINATION

The intended audience for the evaluation results is the decision-makers within UNFPA as well as national counterparts, government agencies, and other stakeholders within and outside of Iraq. Evaluation findings, conclusions and recommendations will be made available for the use of above-mentioned audience. In addition, other UN agencies working in Iraq may use evaluation findings for their strategic planning and or review processes.

ANNEX 3 – LIST OF STAKEHOLDERS CONSULTED

Below is a list of the stakeholders consulted during the evaluation of the 2nd UNFPA Country Programme evaluation in Iraq (2016-2019).

UNFPA COUNTRY OFFICE IN IRAQ

UNFPA Iraq programme and operational staff of the main office in Baghdad plus the field offices in Erbil, Dohuk and Sulaymaniyah, including:

- Representative,
- Deputy Representative,
- International Operations Manager,
- Operations staff,
- Programme staff for the teams of Reproductive Health, Gender, Youth and Population,
- M&E team,
- Security specialist.

OTHER UNITED NATIONS AGENCIES

- UNICEF, including:
  - Head of Field office in Erbil,
  - Adolescent programme officer and member of child protection sub-cluster,
  - Health specialist,
  - Gender-based violence team.
- WHO, including:
  - Deputy Representative,
  - Chair of Health cluster,
- UNHCR: Assistant Representative for Protection,
- Chair of Protection Cluster,
- UNOCHA - Head of Office,
- UN GBV sub-cluster - Chair,
- UN Health Cluster - Chair and member,
- UN Protection Cluster - Chair,
- UN Child Protection sub-Cluster - members,
- UN Youth Protection sub-Cluster - members.

EVALUATION REFERENCE GROUP (ERG) MEMBERS

- Ministry of Planning – Central Statistics Office - Director and staff,
- DCVAW – focal point for GBV,
- Kurdistan High Council of Women's Affairs – Deputy Director and staff,
- Centre for Research and Education in Women's Health, Hawler Medical University - Director,
- Qandil – Director.

GOVERNMENT

- Central Statistical Organisation – Head of Department and technical staff,
- Central Department for Women's Empowerment - Director,
- Kurdistan Regional Statistics Office – Director and Heads of Units,
- Kurdistan Regional Ministry of Health – Director of Public Health,
- Kurdistan Regional Ministry of Labour and Women's Affairs – Director,
- Kurdistan Regional High Council of Women's Affairs - Director,
- Kurdistan General Directorate for Combating Violence Against Women – GBV Focal Point,
- Dohuk Governorate Department of Health – Director and technical staff,
- Sulaymaniyah Governorate Department of Health – spokesperson for Director,
- Ninewa Governorate Department of Health - Director,
- Erbil District Department of Health- Director,

- Camp authorities in Debaga, Domiz, Mamrashan, Darashakran, Bahrka, Arbat, Ashti,
- Maternity hospitals in Dohuk, Sulaymaniyah and Mosul, and Bahrka Delivery Room-Coordinators,
- (Reproductive) Health clinics in Domiz camp (Dohuk), in Bahrka camp and Debaga camp (Erbil) and in Ashti camp (Sulaymaniyah) – Coordinators and technical staff,
- Youth centres: government youth centre in Dohuk and youth centre in Domiz 1 camp (Dohuk), youth centre in Darashakran camp, Y-peer centre in Kawergosik camp and youth centre in Bahrka camp (Erbil), youth centre in Arbat camp and youth centre in Ashti camp (Sulaymaniyah) – coordinators and technical staff.
- Women's centres: Yasamin women centre (Domiz 1 camp), Yasmin women centre/ (Mamarashan camp), Nirgz women space (Darashakran camp), Baharka women space (Baharka camp), Sham women social services (Arbat camp), Sham women social services (Ashti camp), Al-Zuhoor (Mosul) and Al-Ata women's social centre (Baghdad) as well as staff from Fallujah survivor's centre – coordinators and technical staff.

CIVIL SOCIETY

- Al-Mesalla Organisation for Human Resources Development – Director and technical staff,
- Harikar – Director and technical staff,
- Y-PEER: national coordinators and focal points in Dohuk, Erbil, Sulaymaniyah, Mosul and Anbar,
- International Medical Corps (IMC) Iraq – Dohuk Head of office and technical staff,
- Civil Development Organisation (CDO) – Director and technical staff,
- Dary Human Organisation – Director and technical staff,
- TAJDID Iraq Foundation for Economic Development – Director and technical staff,
- The United Iraqi Medical Society (UIMS) – Director and technical staff,
- Iraqi Health Access Organisation (IHAO) – Director and technical staff,
- QANDIL Swedish Humanitarian Aid Organisation)- Director,
- Zhian Heath Organisation (ZHO) - Director,
- Gender Studies Institute Organisation (GSIO) - Director,
- Women and Health Alliance International (WAHA) – Director and technical staff,
- Islamic Relief Worldwide- Director and technical staff,
- Emergency Italy – Coordinator and technical staff.

DEVELOPMENT PARTNERS

- Swedish International Development Agency (Sida), Stockholm, Sweden,
- Australian Embassy, Baghdad,
- Canadian Embassy, Baghdad.

BENEFICIARIES

- Y-PEER in Dohuk, Erbil, Sulaymaniyah, Mosul and Anbar,
- Users of Yasamin women centre (Domiz 1 camp), Yasmin women centre/ (Mamarashan camp), Nirgz women space (Darashakran camp), Baharka women space (Baharka camp), Sham women social services (Arbat camp), Sham women social services (Ashti camp), Al-Zuhoor women centre (Mosul) and Al-Ata women's social centre (Baghdad),
- Adolescent girls and boys and young people users of government youth centre in Dohuk, youth centre in Domiz 1 camp and women's centre in Mamarashan camp (Dohuk), youth centre in Darashakran camp, Y-peer centre in Kawergosik camp and youth centre in Bahrka camp (Erbil), youth centre in Arbat camp and youth centre in Ashti camp (Sulaymaniyah), Al-Zuhoor women centre (Mosul).
- Users of Reproductive Health facilities in Domiz camp (Dohuk), in Bahrka camp and Debaga camp (Erbil), and in Ashti camp (Sulaymaniyah).

ANNEX 4 – IP IMPLEMENTATION RATES

Table 15: Implementation rate per UNFPA Iraq Implementing Partner between January 2016 and December 2018

Implementing Partner	2016				2017				2018			
	Annual CP Budget in USD	Proportion of CP Budget in USD	Expenditure in USD	Imple-mentation Rate	Annual CP Budget in USD	Proportion of CP Budget in USD	Expenditure in USD	Imple-mentation Rate	Annual CP Budget in USD	Proportion of CP Budget in USD	Expenditure in USD	Imple-mentation Rate
General Directorate for Combat	$92,357	0.4%	$85,385	92%	$331,265	1%	$272,980	82%	$300,207	1%	$278,012	93%
High Council For Women's Affairs	$265,892	1%	$265,291	100%	$255,150	0.5%	$168,521	66%	$218,000	1%	$196,490	90%
Minstry of Labour and Social Affairs	$141,839	1%	$100,397	71%	$320,808	1%	$106,834	33%				
NGO Al-Mesallah	$1,095,789	4%	$1,068,248	97%	$2,487,610	5%	$2,385,519	96%	$3,402,639	9%	$2,222,494	65%
NGO Civil Development Organization	$478,627	2%	$476,829	100%	$722,928	1%	$704,446	97%	$796,541	2%	$713,553	90%
NGO Dary Human Organization	$386,671	2%	$386,671	100%	$3,935,951	7%	$2,922,660	74%	$2,281,427	6%	$2,034,955	89%
NGO Harikar	$2,039,648	8%	$1,770,803	87%	$2,832,071	5%	$2,693,302	95%	$2,714,138	7%	$2,596,768	96%
NGO International Medical Corps	$514,133	2%	$509,993	99%	$2,116,919	4%	$1,938,995	92%	$3,035,998	8%	$2,831,428	93%
NGO Intersos					$479,870	1%	$390,566	81%	$111,446	0%	$111,443	100%
NGO Iraqi Health Access Organization					$2,127,563	4%	$1,666,191	78%	$1,485,481	4%	$1,378,913	93%
NGO Islamic Relief	$278,938	1%	$213,233	76%	$547,479	1%	$526,716	96%	$659,044	2%	$375,641	57%
NGO Qandil	$911,524	4%	$903,052	99%	$1,065,542	2%	$980,329	92%	$1,668,618	4%	$1,290,037	77%
NGO Tajdid	$2,546,532	10%	$2,545,638	100%	$2,111,059	4%	$2,071,686	98%	$2,525,920	6%	$2,436,181	96%
NGO United Iraqi Medical Society	$1,402,597	6%	$1,402,597	100%	$5,221,401	10%	$4,604,132	88%	$4,278,068	11%	$4,165,396	97%
NGO UPP					$659,280	1%	$359,262	54%	$1,946,926	5%	$1,944,436	100%
NGO Women and Health Alliance	$513,678	2%	$513,678	100%	$3,339,302	6%	$2,846,560	85%	$723,800	2%	$667,779	92%
NGO Zhian	$373,654	2%	$285,739	76%	$2,618,383	5%	$2,513,294	96%	$2,116,964	5%	$1,548,730	73%
UNILO	$6,082	0%	$6,082	100%								
UNFPA	$13,437,030	55%	$10,458,476	78%	$23,052,087	43%	$21,468,241	93%	$11,226,438	28%	$9,576,676	85%
Country Program Total in USD	**$24,484,992**		**$20,992,114**		**$54,224,667**		**$48,620,233**		**$39,491,653**		**$34,368,933**	

Source: UNFPA Iraq Country Office