WHO contribution in Iraq

Evaluation report

World Health Organization

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Abbreviations

AISPO	Association for Solidarity among People
APM	activity plan module
AMR	antimicrobial resistance
BO	business operation
BWP	biannual work plan
CCA	Common Country Analysis
CCCM	Camp Coordination and Camp Management
CO	Country Office
CLA	Cluster Lead Advisor
CMD	communicable diseases
CCPM	cluster coordination performance monitoring
CCS	country cooperation strategy
COR	corporate functions
DSTWG	Durable Solutions Technical Working group
DHIS-2	District Health Information Software
DOH	Department of Health
DDI	Division of Data, Analytics and Delivery for Impact
ECHO	European Civil Protection and Humanitarian Aid Operations
EWS	Early Warning System
EIOS	Epidemic Intelligence from Open Sources
EWARN	Early Warning, Alert and Response Network
EMRO	WHO Regional Office for the Eastern Mediterranean
EmONC	emergency obstetric and new-born care
ERG	Evaluation Reference Group
FGDs	focus group discussions
FTS	financial tracking service
GOI	Government of Iraq
GPW	General Programme of Work
GLASS	Global Antimicrobial Resistance and Use Surveillance System
HeRAMS	Health Resources and Services Availability Monitoring System
HC	Health Cluster
HDPN	Humanitarian – Development– Peace Nexus
HGIS	Health Geographical Information System
HIV	human immunodeficiency virus
HMIS	Health Management Information System
HQ	headquarters
HR	human resources
HRP	humanitarian response plan
HSY	health systems
HTO	Humanitarian Transition Overview
ICU	Intensive Care Unit
ID	identity documents
IDP	internally displaced person
IHF	Iraq Humanitarian Fund
IHR	international health regulation
INGO	international non-governmental organization
IOM	International Organization for Migration
IMU	Information Management Unit
IPC	infection prevention and control
ISIL	Islamic State of Iraq and the Levant
JCC	Jordan Crisis Coordination Centre
JEE/IHR	Joint External Evaluation/ International Health Regulation
KIIs	key informant interviews
KPI	key performance indicators
KRG	Kurdistan Regional Government
KRI	Kurdistan Region of Iraq
LTA	long-term agreement
M&E	monitoring and evaluation
MCH	maternal and child health
MHPSS	mental health and psychosocial support
MoH	ministry of health
OCR	outbreak, crisis response and scalable operations
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD DAC	Organisation for Economic Cooperation and Development – Development Assistance Criteria
OSC	output score card
NCD	non-communicable diseases
NGO	non-governmental organization
PCR	polymerase chain reaction
PEN	WHO package of essential noncommunicable (PEN) disease interventions for primary health care
PHCMI	primary health care measurement and improvement

PHL	public health laboratory
PME	project management and evaluation
PPE	personal protective equipment
PSEA	protection from sexual exploitation and abuse
PwDs	persons with disabilities
RBM	results-based management
RCCE	risk communication and community engagement
RMM	response monitoring module
RMNCAH	reproductive maternal, new-born, child and adolescent health
RO	regional office
3RP	Regional Refugee and Resilience Plan
RT-PCR	reverse transcription-polymerase chain reaction
SAG	strategic advisory group
SDG	Sustainable Development Goals
TAG	Transition Advisory Group
TPM	third party monitoring
TOT	training of trainers
TWG	technical working group
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children Fund
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNDCSF	UN Sustainable Development Cooperation Framework
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
USD	United States Dollar
US	United States
USG	ultrasound sonography
WB	World Bank
WCO	WHO Country Office
WHE	WHO Health Emergencies Programme
WHO	World Health Organization
WR	WHO Representative

Glossary

WHO support modalities. The WHO Thirteenth General Programme of Work (GPW 13) identifies four modalities to support Member States strategically, depending on the health system maturity: *policy support* (high-level advocacy); *strategic support* (guidance for health system); *technical support* (guidelines, standard operating procedures); and *health service delivery support* to fill gaps (1). The first three are considered normative support, the last operational support.

Health emergency. Actual or imminent threat with the potential to cause widespread illness. Natural or human-made, e.g. bioterrorism, epidemic disease, infectious agent or biological toxin. One pillar of the WHO GWP13 is '1 billion more people better protected from health emergencies', through: 1) building and sustaining resilient capacities to prevent health emergencies; and 2) ensuring that populations affected by emergencies have access to life-saving health services (1). The WHO Health Emergencies Programme works to research, prevent and manage epidemic-prone diseases; to strengthen and expand systems to detect, investigate and assess potential threats to public health; and to respond to and manage emergencies. In humanitarian settings, WHO staff and operational partners may act as health-care provider of last resort (2).

Humanitarian crisis. A *generalized* emergency that affects the well-being of a group of people. Humanitarian crises involve high levels of mortality or malnutrition, but beyond health issues can include lack of shelter, personal safety and food security. Causes are human-made (war, political unrest, displacement) or natural disasters (floods, droughts, storms). Crises can be acute or protracted and complex, requiring a multisectoral, coordinated response (3). The *humanitarian crisis in Iraq* is large and volatile. Conflict has destroyed livelihoods and infrastructure, and many people have been threatened, displaced and injured. Iraq's health system has faced challenges as a result of shortages in basic and essential health services, weakened infrastructure and limited supplies and health workforce (4).

Executive summary

1. Introduction

Background

Evaluations of WHO's contribution at country level are included in the biennial WHO--wide evaluation workplans, approved by the WHO Executive Board. Such evaluations focus on the results achieved at country level, using the inputs from all three levels of the Organization. They also assess WHO's contributions against the country's public health needs, the objectives formulated in the WHO General Programme of Work (GPW) and key country-level strategic instruments, including Country Cooperation Strategies (CCS), WHO Country Office (WCO) biennial workplans and national health strategies. The evaluations document good practices and provide lessons that can be used in the design of new in-country strategies and programmes.

The Republic of Iraq is a middle-income country recovering from decades of socio-political upheaval, from a humanitarian crisis that peaked around 2017 with millions of internally displaced people (IDPs) and refugees living in camps and from the impact of the COVID-19 pandemic. Considering the current transition towards long-term development and the pending arrival of a new WHO Representative, this evaluation is timed to ensure optimum utility in strategic planning for WHO.

Purpose and scope

The dual purpose of this evaluation of WHO's contribution in Iraq is to enhance *accountability for results* towards external and WHO stakeholders, as well as to *strengthen organizational learning* for informed decision-making going forward. The timeframe for this evaluation is 2019–2023. The intended users of the evaluation are internal (at all WHO levels) and external (counterparts, partners and donors).

Object of the evaluation

The object of the evaluation is WHO's contribution at country level in Iraq, focusing on both health system development and health emergency interventions that took place in the period under review. The total budget utilization of the WCO in the period 2019–2023 was US$ 218 224 830. A key priority for WCO between 2019 and 2023 has been supporting the Federal Ministry of Health in the implementation of the National Health Policy, although the vast majority of funding was dedicated to health emergency service delivery for IDPs, refugees and host communities, in collaboration with the Ministry of Health in the Kurdistan region of Iraq (KRI), as well as responding to the COVID-19 pandemic. WHO is part of the UN Country Team and works under the UN Sustainable Development Cooperation Framework (UNSDCF) 2020–2024.

Methods and limitations

The evaluation team opted for a non-experimental design, combining a theory-based and participatory approach. During the inception phase, a Theory of Change was constructed and used as an analytical framework for the evaluation (see Annex 1). The team also developed an evaluation matrix (see Annex 2) with evaluation (sub)questions, data sources and methods. The approach was forward-looking, appreciative and participatory, resulting in several sense-making sessions with key stakeholders. The methodology was qualitative, using document review (over 150 documents), key information interviews and focus group discussions (104 respondents, of which 81 were male and 26 female), and seven site visits in Ninawa, Dohuk and Basra. Evidence was verified through pre-departure feedback sessions, triangulated and analysed. Findings were validated, and lessons and recommendations were co-created in an online workshop with Evaluation

Reference Group stakeholders (see Annex 9). Minor limitations included possible selection bias in sites to visit and stakeholders to interview, and response bias due to the presence of WHO Evaluation staff during interviews. The latter was mitigated by explaining the independence of the WHO Evaluation Office and confidentiality principles to respondents.

Photo credit: WHO; WHO inaugurates new triage unit for acute care in East Emergency Hospital in Erbil - December 2022

2. Key findings

Effectiveness of WHO support in supporting Iraq's health system

WHO inputs and outputs reflect a variety of support modalities and interventions. Since 2019, by far the larger part of WHO interventions has consisted of health emergency support, including on the COVID-19 response, and relatively less for health system development through policy, strategic and technical support modalities. Health emergency outputs include material and technical support for health service delivery for IDPs and host communities; reconstruction and infrastructure support for referral health services; and procurement, warehousing and supply of medicines and health technologies. As chair of the Inter-Agency Standing Committee Health Cluster, WHO also coordinated health partners and provided key information on service access. Since 2019, WHO health system support outputs have included (but have not been limited to) digitization and district health information software DHIS-2, disease surveillance, and support for national disease strategies design and policy implementation, for example on Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH). WHO Regional Office and headquarters technical and funding inputs helped the Country Office to support health sector partners.

Yet despite ample anecdotal evidence of WHO outputs and achievements, the evaluation was not able to quantify the *effectiveness* of WHO in Iraq in strengthening the health system, that is, in making progress towards intended results. The main reason is that WHO Iraq did not agree with the Iraqi MoH on a CCS, which typically specifies how inputs and outputs lead to higher level results, and provides indicators, timelines and targets. Besides, current reporting of progress towards WHO corporate outputs and outcomes is disjointed and does not generate clear information on progress towards targets.

That said, various progress reports for donor-funded projects demonstrate that agreed intervention-specific milestones were achieved, and key informants (KIs) express general satisfaction about WHO support, especially in terms of leadership for health emergency during COVID-19 (which remains out of the CCS scope) and health emergency service delivery in camps.

Relevance of WHO support and interventions

Assessing the relevance of WHO support to Iraq faces a similar challenge. On the one hand, government counterparts consider WHO generally responsive to their requests for technical assistance. Health workers and communities alike consider WHO support for health services to be responsive to their needs. The design of individual interventions also generally includes a needs assessment, and WHO supports various national assessments of health services and health needs. However, WHO lacks a comprehensive health sector needs assessment or situation analysis that could help develop a responsive and relevant *overall* WHO country support strategy in Iraq. Moreover, internal and external stakeholders question whether WHO is working to its comparative advantage, given some of Iraq's health system needs and opportunities, for example around universal health coverage (UHC) and climate change. Finally, the WHO country office has been struggling to adjust its focus in the new reality of reduced humanitarian funding (and needs).

Sustainability of WHO interventions and results

The sustainability of WHO interventions and their results was assessed as mixed. In general, normative health system support is sustainable, as strategies and systems have a long-term horizon and WHO capacity-building generally relies on training-of-trainers approaches. However, the health services for internally displaced populations are unlikely to be sustained beyond WHO support. The post-humanitarian transition process since 2017 has been challenging for WHO (and other humanitarian actors) for several reasons, including the effects of the COVID-19 pandemic, the protracted nature of insecurity and sectarian tension, and differences in local governance attitudes, leaving the federal government unable to take responsibility to sustain health services. Besides, recent infrastructure support projects are unlikely to be sustainable as they lack funding for maintenance and running costs.

Coherence of WHO internally and within the UN system

The coherence of WHO support as part of the UN system has been good, not only as chair of the health cluster during the humanitarian crisis but also in playing its part in developing the UN Sustainable Development Cooperation Framework (UNSDCF). Coherence with the three levels of WHO is mixed – whilst the Country Office is effectively liaising between government counterparts and the Eastern Mediterranean Regional Office (EMRO), some EMRO and headquarters information requests or technical assistance offers are considered supply-driven instead of needs-based.

Implementation efficiency of WHO support

The evaluation found mixed evidence on the efficiency of WHO implementation processes. Financial and human resource management appear to be strong in the Country Office, but dependency on humanitarian funding remains high. This source of funding will end in 2024, yet the Country Office lacks a resource mobilization strategy to mitigate this – or a human resource transition strategy, though an ongoing functional review[1] may help. Implementation is generally timely, despite reported delays consequent to the Regional Office and headquarters' due diligence and quality assurance systems. Significantly, the evaluation found that results-based management (RBM) is weak and generally not functioning as a management tool for the country team. This reflects gaps in the corporate RBM system, as identified in recent corporate evaluations, and is largely beyond the control of the Country Office.

[1] The evaluation team did not have access to the draft Functional Review report; the topic is out of scope for this analysis.

3. Conclusions and recommendations: key issues for WHO Iraq

The evaluation first presents an overarching conclusion on the set of evaluation criteria and questions. It then also gives conclusions and recommendations on three strategic issues for the WHO Country Office that were identified in discussion with key stakeholders and further outlined during a workshop to co-create conclusions and recommendations. These include developing a fit for purpose CCS; measuring progress; and transitioning responsibly out of ongoing health emergency work.

Overall conclusions regarding the evaluation criteria

Conclusion 1. WHO has delivered many relevant and substantive achievements in Iraq, but with little evidence on effectiveness and mixed evidence on sustainability.

In the absence of a WHO CCS that contains a needs assessment, priority strategies and a result framework, it is hard to confirm the relevance and effectiveness of WHO interventions since 2019. While WHO emergency health service support responds to the health needs of some of the most vulnerable populations, it is unlikely to be sustained. WHO normative support for health systems strengthening is more sustainable. While coherence within the UN system is good and WHO is appreciated for its specific normative expertise, coherence within the three levels of the Organization is mixed, partly resulting in delays and complex monitoring and evaluation systems. The biggest threat to WHO support in Iraq is the adjustment needed for it to remain relevant and effective, as Iraq's health sector needs change from health emergency support to health systems support.

The evaluation concludes that in the period under review, WHO has supported Iraq mainly with health emergency responses and universal health coverage, and to a lesser extent with health systems strengthening interventions. Unmet needs for health system strengthening exist in the areas of (further) digitization; UHC, especially primary health care (PHC) and health financing; addressing the health impacts of climate change; and systems for health emergency prevention and response.

Developing a vision: balancing health system and health emergency support

Conclusion 2: Although WHO largely attends to the health needs of the people in Iraq, it has not developed a systematic situational analysis of the priority health needs. WHO also largely addresses the needs of the government, yet it has not agreed on health system priorities with the MoH (findings 1,3–7).

Conclusion 3: Despite many substantive achievements, it is hard to determine effectiveness or impact, as WHO results are poorly defined, and there is no theory of change that clearly outlines a set of coherent interventions leading to specific outcomes and contributing to the triple billion goals (findings 1–6,16).

Conclusion 4: There is little synergy between the operational work from Erbil office and the health system work from Baghdad office. Health services in camps and infrastructure support for referral services are unlikely to be sustained post-WHO support, whereas WHO upstream policy and strategic and technical support tends to be more sustainable (findings 1,3,5,6,8–11).

Conclusion 5: In an emergency-prone setting like Iraq, "transition out of emergency work" may imply a false dichotomy, as health systems strengthening includes

strengthening systems for health emergency preparedness and response (findings 1,3,5,6,8).

The year 2024 is an excellent opportunity for the Country Office to define a longer-term strategy, as a new WHO Country Representative will be appointed in the first quarter. Also, the government is in the process of developing a national health policy and has requested WHO support; the UN country team is developing a five-year sustainable development cooperation framework based on a country situation analysis that includes health challenges; and WHO is developing a new General Programme of Work.

Recommendations to develop a strategic vision for Iraq

1. WHO Country Office should develop a CCS aligned with the national health strategy and the UNSDCF. (high urgency)
2. WHO Country Office should undertake an assessment of national health sector support needs aligned with and informing the national strategic planning process. (high urgency)
3. WHO Country Office should incorporate all support (operational as well as normative) for health emergency preparedness and response under one strategic objective (for example in line with GPW13 Pillar '1 billion more people better protected from health emergencies' and with the forthcoming GPW14 high-level outcome 5.2. 'Preparedness, readiness and resilience for health emergencies enhanced'). (medium urgency)
4. WHO Regional Office should support strategic planning, including situation analysis and CCS development. (high urgency)

Monitoring and demonstrating progress towards results

Conclusion 6: The findings and conclusions of the recent WHO Corporate RBM evaluation apply to Iraq, whereby there is no enabling environment for meaningfully monitoring and reporting progress towards results in a way that supports the Country Office in demonstrating such progress (findings 2,5,16).

Conclusion 7: Country Office progress reporting is labour-intensive and time-consuming, consists of many products for various audiences, and yet at aggregate level fails to communicate progress towards milestones (findings 2,5,16).

Conclusion 3 is also relevant for a discussion on monitoring progress, namely that despite many substantive achievements, it is hard to determine effectiveness or impact, as WHO results are poorly defined, and there is no theory of change.

Whilst it is the responsibility of WHO headquarters to improve the results-based management system at all levels of the Organization, the Iraq Country Office is in a good position to improve its own monitoring and evaluation. A CCS typically contains a theory of change as well as a result framework with indicators, targets and timelines. A high-level result framework can inform monitoring and evaluation systems for specific interventions, and vice versa.

Recommendations to improve measuring results

5. WHO Country Office should develop a CCS that contains a theory of change and result framework with specific indicators and targets. (high urgency)
6. In line with the recommendations of the WHO Corporate RBM evaluation, especially 5, 7 and 8, the WHO Secretariat and EMRO should work to create an enabling environment for measurement and learning, by simplifying the monitoring and reporting system and encouraging a culture of learning and evaluation in country offices.

7. The WHO Country Office should, in the meantime, report annually based on the CCS result framework *in one single* report and develop additional documents for any additional audiences (such as donor or media) as needed. (medium urgency)

Responsible disengagement from health emergency work in Iraq

Conclusion 8: As the humanitarian crisis is winding down and national priorities and needs change, the ongoing transition of support towards health systems and disengagement from health emergency work needs to find a balance between doing it quickly but also responsibly towards those still affected (findings 1,5,8).

Conclusion 5 (above) is also relevant for responsible disengagement, namely 'In an emergency-prone setting like Iraq, "transition out of emergency work" may imply a false dichotomy, as health systems strengthening includes strengthening systems for health emergency preparedness and response'.

The transition process has been challenging as the crisis was complex and protracted. Responsible disengagement requires paying consideration to all aspects that help or hinder national and local counterparts in sustaining interventions. In Iraq, the timing of the transition and cluster de-activation was short and abrupt in retrospect, partly reflecting the shifting priorities of humanitarian donors. A phased approach to the de-activation of health clusters might have enabled a smoother process. The evaluation team found that urgent humanitarian needs and human rights violations remain, disasters are likely to re-emerge, and the capacities and willingness of national counterparts to lead sectoral coordination is low. Responsible disengagement requires a look at humanitarian, development and peace efforts in parallel, rather than through a narrow transition of sectoral or health services. WHO could learn from the Iraq Protection Platform, which provides strategic guidance, advice and technical support to the UN and actors supporting UN's humanitarian and development efforts on key protection issues, and, when relevant, joint advocacy to relevant public institutions.

Recommendations for responsible disengagement from health emergency work:

8. The WHO Country Office should advocate with counterparts to strengthen public health care services and expand these to reach and address the needs of marginalized people, including IDPs, refugees and other persons of concern, particularly those in hard-to-reach areas such as camps. (high urgency)
9. The WHO Country Office should establish coordination mechanisms at strategic level to make sure that high-level advocacy and engagement take place on core and emerging issues that have been transitioned from WHO to national counterparts, so as to ensure that these counterparts fulfil the responsibilities that have transitioned to them in a suitable and non-discriminatory manner. (high urgency)

10. The WHO Country Office should advocate with other UN agencies for continued funding to support the residual health emergency needs of those who are most vulnerable. It should also advocate for pooled funding towards humanitarian development interventions. (high urgency)

Photo credit: WHO; Environmental surveillance for poliovirus in Iraq - May 2022

1. Introduction

1.1 Background and context

1.1.1 Sociopolitical context

Iraq, with a gross domestic product of US$ 207.89 billion in 2021, qualifies as an 'upper middle-income country' (5). Since the 2003–2017 war, the country has been pursuing a major state reform under a new constitution as well as dealing with an ongoing and complex armed conflict (6). Prolonged conflict over the past four decades has resulted in political/geographical fragmentation, a deepening divide between the state and its citizens and growing social unrest (6). Mass protests in 2019 and elections in 2023 brought to power a government that initially operated without budget (7, 8). Growing climate risks could further exacerbate this precarious situation (7). In 2019 the government launched the "Future we want" Iraqi Vision 2030 for sustainable development, which includes amongst its core priorities efficient and inclusive health care system goals, and a National Development Plan (2018–2022). It is guided by four main pillars: laying the foundations for good governance and associated components; developing the private sector as a vital anchor for progress and development; post-crisis reconstruction and development of affected provinces; and reducing multidimensional poverty in the provinces (9). Iraq consists of 18 governorates, including three governorates in a semi-autonomous region, the Kurdistan region of Iraq (KRI).

1.1.2 Health situation

Iraq's health statistics are typical for the region, with a trend towards noncommunicable diseases. (NCD) *(10)*. Of its population of over 40 million as of 2020, most (70%) live in urban areas. NCDs account for over 56% of total mortality, mainly cardiovascular diseases, cancer, diabetes mellitus and road traffic accidents. Neonatal and maternal conditions remain a leading cause of death for females, and road injuries and interpersonal violence for younger age groups. Multiple diseases outbreaks have overwhelmed the health system's capacity, thus increasing vulnerability to further outbreaks of other communicable diseases. The average death rate attributable to natural disasters (based on data from 1997–2016), is 4.9 deaths or 0.02 per 100 000 inhabitants (6). The WHO Country Office reports that population growth and the accelerated growth of health care costs are a challenge for the health sector. In addition, climate change has a major impact on the health and well-being of the population, as Iraq has been exposed to heat waves, drought and sandstorms.[2]

Table 1 Leading causes of death, Iraq 2019 (rates per 100 000 inhabitants)(11)

Females	Rate	Males	Rate
Ischemic heart disease	84.4	Ischemic heart disease	101.6
Stroke	53.5	Stroke	52.3
Neonatal conditions	30.4	Road injury	39.7
Diabetes mellitus	20.1	Neonatal conditions	38.8
Kidney diseases	15.8	Interpersonal violence	20.6
Road injury	14.5	Diabetes mellitus	17.6
Lower respiratory infections	12.8	Kidney diseases	16.4

[2] Country Office presentation, quoting from Health system functional review 2010, Health system review 2016, Health financing review 2019, Pharmaceutical profile review 2020, UHPR 2022.

Congenital anomalies	10.8	Lower respiratory infections	15.4
Breast cancer	9.2	Exposure to mechanical forces	14.4
Interpersonal violence	8.1	Congenital anomalies	13.6

Health inequalities are influenced by factors such as war, conflict and economic conditions. Health service indicators vary between rural and urban communities. Women, disabled people and the elderly face access barriers to primary health services, and crises like the conflict against the Islamic State of Iraq and the Levant (ISIL) and COVID-19 have further exacerbated health inequalities (12). In 2021 Iraq was categorized as a country at great risk of becoming a humanitarian crisis context, as per the INFORM Risk Index (13). The protracted conflict situation in Iraq has left people in a vulnerable situation, lacking access to basic services, including health, water and sanitation, psychosocial and protection services and opportunities to sustain a living. Iraq is also increasingly struggling with a shortage of water and frequent droughts, which indirectly affect the health of its people (14).

1.1.3 Health sector policies and systems

There are two Ministries of Health; the Federal Ministry based in Baghdad and a Ministry of Health based in KRI. The KRI MoH is dependent on federal funding for operations and adheres to national health policies but is operationally independent.

A review and revision of the National Health Policy is planned for 2024. The MoH has developed a National Health Policy (2014–2023) and four-year National Health Strategic Plan (2018–2022) (6). Key objectives align with the National Development Plan 2018–2022 and the Vision 2030 and Sustainable Development Goals (SDGs): 1) improving and modernizing the health system, 2) enhancing the health prevention system, 3) developing the health information management system, 4) strengthening the mechanisms for health delivery, 5) applying administrative governance in the health sector, 6) reducing communicable and NCDS, 7) reconstructing and rehabilitating terrorism-affected health infrastructures, and 8) strengthening health systems financing (ibid., pp. 206–207). The Iraqi Constitution mandates the state to protect health and provide social security. Iraq is a signatory to various international declarations and agreements, including World Health Assembly declarations, the SDG agenda, the WHO Framework Convention on Tobacco Control, the International Health Regulations 2005 and other binding instruments. These include gender equality instruments such as the Convention on the Elimination of All Forms of Discrimination Against Women (6).

Decades of conflict and instability, exacerbated by the COVID-19 pandemic, have affected Iraq's health system. Various reviews have identified challenges to the health system in Iraq, some of which also emerged during initial consultations for this evaluation.[3]

1. Health policy development is inconsistent and implementation of decentralization slow. There were frequent changes in MoH leadership in Baghdad in the period 2019–2023: three different ministers, plus a period of an acting minister. There is also political tension between the central government and KRI.

2. Out-of-pocket expenses for health are rising, and financial protection is lacking. The general government expenditure on health as a percentage of general government expenditure is 2.2%.[4] WHO estimated out-of-pocket expenditure as a percentage of total health expenditure in 2019 to be 51% (6). Recent (2021) legislation aims to promote health insurance to reduce the cost of catastrophic health expenditures for citizens.

[3] Country Office presentation, see footnote 18

[4] Country Office presentation, quoting WHO Global Health Expenditure data https://apps.who.int/nha/database.

3. The focus is on secondary and tertiary care as opposed to PHC, and PHC programmes are fragmented. The PHC system in Iraq consists of primary health centres at district level (on average 20 per district) with a district health centre staffed by doctors and nurses (on average 7 district health centres per province). Specialized family health doctors act as front-line doctors and refer patients to hospitals if needed.[5] Primary health centres require a small registration fee and fees for specific diagnostics services, but medicines are free, if available.

4. There is an imbalance in health worker supply and demand. The departure of many skilled health professionals is limiting access to quality basic health care. Physician density stands at 9.3 per 10 000 population, and nursing/midwifery staff at 22.5 per 10 000 population (6).

5. Access to medicines is shrinking, as there is significant reliance on large-scale importation of medicines and medical equipment.

6. There is poor health management information systems, disease surveillance, monitoring and planning, including reliance on paper-based systems.

7. The role of the private sector in achieving UHC is unregulated and unclear. Iraq has 295 public sector hospitals in 20 governorates and 155 registered private sector hospitals, mainly in larger cities.[6] The recent (2021) health insurance legislation encourages the market for private health insurance.

1.1.4 Transition from emergency and rehabilitation to development status

Iraq is currently transitioning from emergency state to rehabilitation and development status. Five years after the end of military operations against ISIL, the humanitarian situation has significantly improved, with a decrease in the number of people in need of humanitarian assistance from 11 million in 2017 to 2.5 million in 2022 (15). More than 81% of all six million people ever displaced have returned following the closure of most of the IDP camps (15). This has coincided with the deactivation of the humanitarian cluster system starting at the end of 2021 and the handing over of key components of the humanitarian joint response to line ministries at the end of 2022.[7] The COVID-19 pandemic and response have delayed the handover of health services from humanitarian partners to the government. Humanitarian funding has also significantly declined over the recent years, mirroring the change from humanitarian to development status; it is projected to be further reduced. Government of Iraq is expected to progressively assume responsibility of providing for the health needs of remaining displaced populations, albeit with reduced international assistance.

The UN system and development partners support Iraq's humanitarian, development and peace efforts. The UN Sustainable Development Cooperation Framework 2020–2024 (16) articulates the following strategic priorities, all of which impact on health and WHO's mandate: 1) achieving social cohesion, protection and inclusion; 2) growing the economy for all; 3) promoting effective, inclusive and efficient institutions and services; 4) promoting natural resource and disaster risk management, and climate change resilience; and 5) achieving dignified, safe and voluntary durable solutions to displacement in Iraq.

1.2 Objective of the evaluation

WHO has been present in Iraq since 1991 and supports both the MoH in Federal Iraq and the one in KRI. WHO maintains liaison offices in the MoH in Baghdad and in Erbil. WHO also currently has 3 sub-offices (Dohuk, Sulaymaniyah and Basra) based in Directorates of Health, in Governorates with camps for IDPs and refugees (see Fig. 1).

[5] Country Office presentation.
[6] Country Office presentation.
[7] Note to the EDG on transition, January 2023.

Photo credit: WHO; High-level delegation of WHO visits Iraq to boost health system - March 2022

Figure 1 WHO Iraq office locations

Source: WHO GIS Centre for Health

WHO Iraq does not have a longer-term CCS; instead priorities are set through biennial workplans and specific project documents. The most recent CCS ended in 2017. Since then, the Country Office has drafted but never finalized an overall CCS that reflects GPW13 outcomes and outputs. As a result, Country Office priorities and objectives are not formally specified, nor is there a result framework. Instead, the Country Office develops biennial workplans and budgets to reflect planned interventions for selected GPW13 outputs.[8] Besides, the Country Office has developed a variety of projects funded by humanitarian donors, which contain specific results.

WHO interventions in Iraq include technical, strategic and policy support for national health programmes, plus operational support for health emergencies. Firstly, the core normative support includes technical, strategic and policy support for health system strengthening to government counterparts on various issues (DHIS-2 support, UHC preparedness), disease programmes (Maternal and Child Health strategy, HIV technical assistance) and policy support (national health strategy, health financing). Secondly, health emergency support includes financial and technical assistance for health services in camps, plus operational support for the national COVID-19 response. The Country Office also provides infrastructure support for rehabilitation and reconstruction of PHC or referral services. Thirdly, WHO implements procurement and supply chain management for medicines and health technologies (in support of health emergency work). In Iraq, primary targets for WHO normative interventions are national counterparts, including health policy-makers or programme managers in counterpart ministries; secondary targets for operational intervention are health workers and implementing partners.

The Country Office modus operandi for health emergency support is similar across various projects and donors. It typically consists of 1) contracts with local non-governmental organization (NGO) partners to provide PHC services among refugees and IDPs, with a particular focus on the northern areas of KRI; 2) supply of mobile clinics, ambulances, laboratory equipment and medicines to health services targeting IDPs in or outside camps; 3) support for running costs for the operation of mobile medical clinics; 4) capacity-building of health staff in PHC centres, and 5) support for infrastructure rehabilitation of vital referral departments in hospitals (maternity, accident and emergency).

There has been a significant reduction in humanitarian funding for WHO in Iraq. Country Office resources peaked in the 2016–2017 biennium due to humanitarian funding for the health emergency work (see Table 2)[9]. Over the same period, the budget for core (normative health systems) work of the Country Office remained relatively stable at around US$ 10 million per biennium (see Table 3). The financial implications include a reduction of overall country budget, as most of the programme funding was for health emergency work: as much as 95% of expenditure in the 2018–2019 biannual budget (see Table 1). Country Office leadership identified maintaining the Country Office budget and capacity as a major challenge.

Table 2 Budget allocation for WHO Country Office

Biennium	Total budget allocation (US$)
2012–2013	24 338 234
2014–2015	82 117 620
2016–2017	153 231 080
2018–2019	117 794 642
2020–2021	57 035 430

[8] Biennial workplans consist of several separate worksheets, reflecting planned activities and estimated costs for selected GPW13 outputs. There is no narrative report.

[9] Country Office presentation.

2022–2023[a]	51 342 794

Table 3 Iraq Programme financing and utilization

Programme	2018–2019		2020–2021		2022–2023	
	Financing	Utilization	Financing	Utilization	Financing	Utilization
Total	**121 508 057**	**115 482 004**	**63 583 664**	**61 958 456**	**50 361 495**	**40 784 370**
GPW13 (core)	8 017 120	8 022 075	10 508 554	9 892 298	8 600 181	5 978 307
Emergencies	113 490 937	107 459 929	52 875 593	51 872 301	41 635 314	34 710 230
Special Programmes			199 517	193 857	126 000	95 834

1.3 Purpose, objectives and scope of the evaluation

The main purpose of this evaluation of WHO's contribution in Iraq was twofold. First, to enhance *accountability for results* towards external and WHO stakeholders (including, inter alia, governing bodies, Member States, donors and Iraqi partners and the Iraqi people, as well as the WHO Regional Director for the Eastern Mediterranean, the WHO Representative in Iraq, the WHO Emergencies Programme and other programmes in the Regional Office) through an impartial and comprehensive assessment of the results of WHO's work in Iraq. Second, the evaluation aimed to *strengthen organizational learning* for informed decision-making processes, particularly in the design, resourcing and implementation of new in-country strategies and programmes going forward.

Considering the current transition from health emergency to long term recovery and development, the timing of this evaluation is critical. The evaluation aims to ensure optimum utility in feeding into the development of a new CCS (CCS) and National Health Development Plan.

The evaluation objectives were:

1. to assess achievements against the objectives formulated in country-level strategic instruments and the corresponding expected results developed in the Country Office biennial workplans, while pointing out the challenges and opportunities for improvement;
2. to assess past successes, challenges and lessons learned from WHO's work so as to support the WHO Country Office and partners in developing and resourcing the next strategic instruments and to refine WHO operational planning mechanisms; and
3. to assess communication and coordination approaches across the three levels of the Organization and in-country stakeholders, to identify the strengths and areas for improving WHO's modalities of technical assistance as well as case studies that demonstrate strong co-ownership, collaboration and good use of funding.

The timeframe for the evaluation was 2019–2023. This includes the last three biennia, and corresponds to WHO's GPW13 period of implementation, as well as pre, intra and post-COVID-19 phases of the response. The geographical scope included initiatives implemented in all five WHO Iraq sub-offices where relevant.

[a] Note that the budget allocation for the current biennium 2022–2023 is an ambition. During the evaluation, out of the allocation, US$ 9.7 million were received, US$ 16.9 million in the pipeline, and US$ 12 million under development.

The scope of the evaluation covered both health emergency and developmental interventions undertaken by WHO in Iraq. That included activities which took place to support the implementation of the National Health Policy, as framed in relevant strategic instruments such as the UN Sustainable Development Cooperation Framework and (in the absence of a WHO CCS) the WHO Country Office biannual workplans. The focus of the evaluation was at policy level and programme level and covered specific operations (such as the COVID-19 response). This evaluation focused mainly on the health sector, with cross-linkages to collaborating sectors like finance, security and education, in case such links were relevant for the work of WHO.

The intended users of the evaluation were internal (WHO at all levels) and external (counterparts, partners and donors). The interest of various users is presented in Table 4 below. A new WHO Representative to Iraq is expected to take office in early 2024 and will be the most important user of this report (in conjunction with the pending Country Office Functional Review).

Table 4 Users of the evaluation

Internal	Role and interest in the evaluation
WHO Country Office Iraq	The evaluation results are to inform the design and implementation of the next country strategy as well as future interventions.
WHO Regional Office and Regional Committee for the Eastern Mediterranean	Ensuring that WHO's contribution at country level is relevant, coherent, effective and efficient. Evaluation findings and best practices aim to be directly useful to inform other country offices in the region as well as regional approaches to health.
Headquarters management	Headquarters management oversees the strategic analysis of country-level strategic instruments and their implementation and is responsible for promoting the application of best practices in support of regional and country technical cooperation.
Executive Board	The Executive Board has a direct interest in being informed about the added value of WHO's contribution at country level, best practices and challenges.
External	
Government of the Republic of Iraq	As a recipient of WHO's action, the government has an interest in the partnership with WHO and in seeing WHO's in-country contribution to health independently assessed. Will be engaged in the Evaluation Reference Group, validation, stakeholder workshop and use of evaluation.
UN Country Team	It is in the UN Country Team's interest to be informed about WHO's achievements and to be aware of the best practices in the health sector. WHO contributes to UN strategic frameworks as part of the UN Country Team.
Donors and partners	Donors have an interest in knowing whether their contributions have been spent effectively and efficiently and whether WHO's work contributes to their own strategies and programmes.
All individuals in Iraq	The evaluation will look at how WHO heeds equity and ensures that all population groups are given due attention in the various policies and programmes. WHO must ensure that its in-country action benefits all population groups, prioritizes the most vulnerable and does not leave anyone behind.

2. Methodology

2.1 Evaluation criteria and questions

This evaluation looked at relevance, coherence, effectiveness, efficiency and cross-cutting issues. Its questions were formulated based on the Organization for Economic Cooperation and Development's Development Assistance Criteria. However, not all these criteria were included because not all are equally important for the purpose and objectives of this evaluation. Additional cross-cutting areas were added to assess gender, human rights and equity. The evaluation was guided by the following key evaluation questions under its terms of reference.

Table 5 Evaluation questions

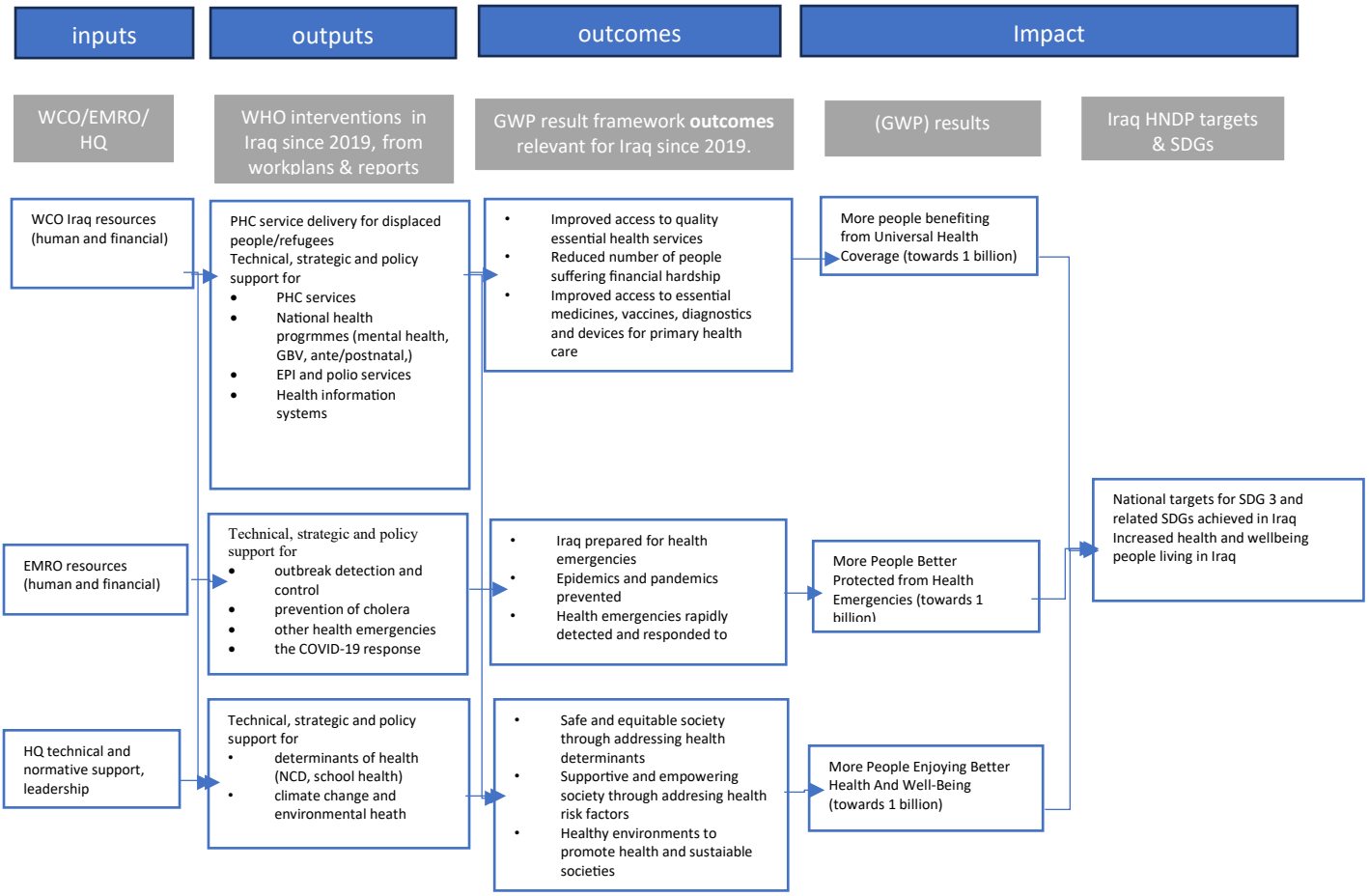
Evaluation criteria and questions	Sub-questions
Relevance	
1. To what extent are WHO's objectives and interventions relevant to the context and the evolving needs and health rights of the Iraqi population, including IDPs, as well as country and regional partners and institutions' needs, policies and priorities, and will continue to be so if circumstances change?	1.1 To what extent have WHO's *objectives* (including any adjustment of objectives) and interventions responded to Iraq's beneficiaries' needs and rights, including those of the most marginalized populations, as well as the country's and partners' policies and priorities?
Coherence	
2. To what extent are WHO interventions coherent and demonstrate synergies and consistency with one another as well as with interventions carried out by other partners and institutions in Iraq?	2.1 To what extent are WHO interventions aligned internally between its Country Office, Eastern Mediterranean Office and headquarters, as well as with WHO GPW13 and its result areas? 2.2 To what extent are WHO interventions aligned with the policies and priorities of country and regional partners (such as UNSDF) and institutions and with other sector-specific policies (such as SDGs)? 2.3 What has been WHO's comparative advantage in Iraq, especially in relation to other UN agencies, and what adaptations and refinements are needed to improve its positioning?
Effectiveness	
3. To what extent were WHO results (including contributions at outcome and system level) achieved or are they likely to be achieved and what factors influenced (or not) their achievement?	3.1 To what extent were programme outputs (including any adjustment) delivered and did they contribute to: (a) progress towards the stated programme outcomes (b) the reduction of inequalities and exclusion related to socio-economic and environmental determinants of health? 3.2 What factors influenced their achievement or non-achievement, and to what extent has WHO demonstrated a reasonable contribution at the outcome or health system level?

Evaluation criteria and questions	Sub-questions
	3.3 What has been the added value of regional and headquarters contributions to the achievement of results in Iraq?
Efficiency	
4. To what extent did WHO interventions deliver, or are they likely to deliver results in an efficient and timely way?	4.1 To what extent do WHO interventions reflect efficient economic and operational use of resources, including in response to new and emerging health needs that require adjustment or re-prioritization of interventions? 4.2 To what extent are the internal controls and RBM systems adequate to ensure efficient operational and timely allocation of resources and adequate measurement of results, including in changing circumstances?
Sustainability	
5. To what extent has WHO contributed towards building national capacity and ownership for addressing Iraq's humanitarian and development health needs and priorities, especially as Iraq transitions to development status?	5.1 To what extent has WHO supported Iraq's national longer-term goals and a resilient, shock-responsive health systems, including building national capacity in view of ongoing and future health needs (including emergencies)? 5.2 To what extent have WHO interventions supported national ownership for health system strengthening, as well as the national capacity to deliver on and achieve the results as planned in the relevant national health policies and strategies? Is there evidence that the benefits will be sustained over time?

2.2 Detailed methodological framework: approach and methods

The evaluation was designed to be utilisation-focused in assessing the effectiveness of the WHO interventions between 2019 and 2023 against their intended aims. During the inception phase, the evaluation team and evaluation reference group agreed a Theory of Change (see Fig. 2 and Annex 1) to serve as an analytical framework for the evaluation, explaining how WHO interventions in Iraq are coherent, relevant and efficient and contribute to impact level results at WHO and Iraq level. With a strong focus on utilization, the approach of the evaluation was participatory, appreciative and forward-looking. The team engaged with the principal users of the evaluation report – WHO Country Office and Regional Office, focal points in ministries and departments, and UN partner organizations in Iraq.

Figure 2 Theory of change for WHO Iraq



The evaluation team used an evaluation matrix as the core guide to its work. The evaluation matrix (see Annex 2) defines specific questions and sub-questions, plus indicators to assess each sub-question. It also indicates data collection methods and data sources, so that data can be triangulated. The matrix reflects inputs from the evaluation questions in the terms of reference, documentation review, stakeholder interviews and discussions with the Evaluation Reference Group.

Data collection methods reflect the qualitative nature of the evaluation and make triangulation of findings and evidence possible.

1. ***Document review* (see Annex 5 for bibliography).** The evaluation team undertook a detailed desk review of programme-related documents shared by WHO, in addition to other relevant documents gathered from internal and external stakeholders. Programme documents from WHO included proposals and plans, donor progress reports, partnership agreements and financial records. The evaluation team recognized potential limitations to the use of resources, such as official statistics and third-party monitoring data. This included issues of reliability and accuracy as well as difficulty in accessing such data, particularly on sensitive issues relating to vulnerable target groups and domestic violence information.

2. ***Stakeholder interviews*[11].** This was the main form of primary data collection. A list of interview questions was drafted and agreed in the inception report (see Annex 3). The evaluation therefore used a combination of individual and group interviews. Individual interviews were useful in providing detailed information and opinions, whereas group interviews also provided insights into the processes of decision-making or implementation. Purposive sampling methods (17) were used, with support from the Country Office counterpart to ensure that the evaluation included individuals who were most relevant to the evaluation. All interviews were treated as confidential by the evaluation team. Care was taken to ensure make interviewees feel comfortable to express their opinions, by ensuring confidentiality. Interviews were conducted in person where possible and online where needed. Interviews were held in English or Arabic.

Table 6 Stakeholder characteristics (KIIs only)

Category		Location		Gender	
WHO staff	40	Global	8	male	81
Counterpart (MoH)	43	Regional	9	female	26
Implementing partners	6	Baghdad	52		
donors	4	Erbil	28		
UN partners	10	Basra	2		
Others[a]	4	Duhok	3		
		Ninawa	3		
		Sharia camp	2		
total	**107**		**107**		**107**

3. ***Written submissions*.** Two KIs who could not be interviewed in person for reasons of time or language provided written submissions on the KII questions.

4. ***Focus group discussions*.** Data was collected through focus group discussions to generate good practices and lessons to improve future programming, as permitted within the country mission timeframe. Selection of sites was purposive and agreed with WHO and partners to ensure maximum lessons, a broad range of perspectives from beneficiaries of WHO support, both direct (service providers, implementing partners) and indirect (users of WHO supported health

[11] List of stakeholders were removed to keep their identities confidential.

[a] Higher Council of Medical Specialties, community leader, Association for Solidarity among People, European Civil Protection and Humanitarian Aid Operations.

services, male and female IDPs/refugees and host communities). In total, six focus group discussions were held across four locations (see Table 7).

Table 7 Focus group discussions

Governorate	Location	# participants	Gender	Status	Type
Ninawa	Tal Marak Clinic	6	Males	Host Community	Beneficiaries
	Tal Marak Clinic	7 (5 M, 2 F)	Mixed	Host Community	Clinic Staff
Dohuk	Sharia Camp	5	Female	IDP	Beneficiaries
	Sharia Camp	5 (2 M, 3 F)	Mixed	Host Community + IDP	Clinic Staff
Basra	Basra University	3	Males	Host Community	Teachers
	Public Health Department	2 (1 M, 1 F)	Mixed	Host Community	Staff

The team conducted a two-week country mission to Baghdad and Erbil. This mission provided an opportunity to gather information through stakeholder interviews, gather contextual information and complement the literature review with additional documentation. The mission started with a briefing with the Country Office. National consultants supported the Evaluation Team. An in-country feedback session on the main emerging findings was organized at the end of the mission.

Data analysis. The evaluation team triangulated all information collected, compiling data structured by evaluation question, sub-question and indicators. With the evaluation grid fully populated, the team undertook a thematic analysis of emerging themes per evaluation (sub-)question. Evaluation findings were then drawn up only after thorough cross-checking and triangulation of all information for each evaluation question. This ensured that answers were based on solid and cross-checked evidence. Qualitative data from the interviews and focus groups was analysed thematically. Gender, age and disability were regularly investigated with other characteristics to better understand the intersectional contributions of the interventions on participants.

Data quality management. The evaluation matrix and KII guidelines were important tools to ensure data quality. One (bilingual) team member assured the quality of data collected by the national consultants in focus group discussions. National consultants received an online training before the country missions and daily support during the data collection phase. The national team also undertook reflexivity exercises[13] on the data collected, and data provided by the field team were later triangulated with evidence from KIIs and documentation review.

Validation and finalization. Based on the cross-checked evaluation findings, the team formulated tentative answers to the evaluation questions and lessons learned. At the end of the country visit, the evaluation team debriefed the WHO teams in Erbil and Baghdad on preliminary findings, providing an opportunity to fact-check these findings and identify any remaining data gaps. After the data analysis phase and prior to the finalization of the recommendations, the acting WHO Representative organized a *co-creation workshop* with key counterparts in-country to discuss the findings and conclusions of the evaluation team and co-create recommendations. The aim of the workshop was to ensure buy-in and commitment for all relevant parties to the evaluation's conclusions, lessons and recommendations. This participatory approach of jointly reviewing findings and co-creating lessons and recommendations was also important to ensure the commitment of the WHO Country Office and Regional Office towards the evaluation recommendations (see Annex 9 for workshop outputs). Finally, the evaluation team provided practical operational recommendations for future adjustments and actions.

[13] Reflexivity was carried out through recognizing how the evaluator's social identity (which includes, for example, gender, age, ethnicity, social status) may influence interview dynamics and responses as well as judgements made when synthesizing findings.

2.3 Limitations of the evaluation and mitigation strategies

The evaluation has some limitations that were mitigated. The main ones are:

1. The field level data collection was dependent on the WHO focal points in Basra, Ninewa and Duhok. The evaluation team worked closely with WHO focal points to arrange for focus group discussions with participants who were most relevant to the current context and receiving current services provided by WHO. For that reason, there may have been some variations in the target groups. However, the evaluation team made sure that the overall sample across the different locations was reflective of a diverse range of beneficiaries receiving different services from WHO.

2. The evaluation team were not able to visit Syrian refugee camps; however, sites were visited in IDP locations and locations in the host community that were used by Syrian refugees.

3. Due to an escalation in the security situation in Baghdad, the evaluation team was not able to conduct face-to-face interviews on one of the days of the in-country mission. However, the evaluation team was able to hold interviews with KIs remotely instead.

4. The WHO Evaluation team was present during the interviews, which may have resulted in social desirability bias in stakeholder responses. Statements at the beginning of each interview about the independence of the WHO evaluation team in relation to the WCO and about confidentiality and anonymity reduced this bias to some extent.

2.4 Ethical considerations

Due diligence was given to effectively integrating good ethical practices and paying due attention to robust ethical considerations in conducting this evaluation of WHO's contribution in Iraq. In adherence to UNEG norms and standards for evaluation (18) and WHO guidance, the evaluation does not reflect personal or sectoral interests, and the team (including national consultants and WHO staff accompanying the team) displayed professional integrity and respected informants' right to confidentiality and local beliefs, customs and sociocultural environments. No harm was done in relation to interviews, interactions generally and reporting of findings in this report. During the evaluation, the team aimed for the welfare of participants and staff involved, through human-rights based and gender equality approaches with relevant standards and principles (19). The suitability of all field staff to work with vulnerable adults and children was assured, and all staff acknowledged and adhered to WHO's Policy on preventing and addressing sexual misconduct (20).

2.5 Gender, equity, disability and human rights inclusion

The evaluation team ensured that *equity, ethnic minorities, human rights, gender and disability issues* were addressed by several means. The documents review paid specific attention to how equity issues have been addressed at the planning, implementation, monitoring and evaluation stages of WHO contributions. Some sub-questions within the evaluation matrix were population disaggregated; focus group discussions with health service beneficiaries were gender disaggregated for this purpose. Group interviews with health clinic, WHO and ministry staff were mixed in terms or gender, profession and ethnicity and carefully managed by the evaluation team to mitigate equity dynamics.

Finally, equity dimensions were reflected in relevant interviews, through probing questions on equity concerns related to specific interventions, including support for service delivery. During data analysis the evaluation team assessed the

implications of WHO's interventions for equity and gender equality, including through legislation, norms and standards, policies or programmes in all areas and at all levels. Considerations regarding equity in health were also examined to assess the extent to which WHO and partners addressed health inequities through the various interventions implemented (21).

Photo credit: WHO/Chloe Sharrock; January 2023, Erbil, Iraq

3. Findings

This chapter provides the key findings of the evaluation, including the evidence base to substantiate them. Using the Theory of Change as the analytical framework, the chapter first provides an overview of the wide range and scope of WHO interventions undertaken in Iraq since 2019. The chapter then presents key findings for the evaluation questions and explores 1) if and how the achievements of the WHO Country Office translated into intended results (effectiveness); 2) if the interventions respond to priority needs (relevance); 3) how likely they will persist as humanitarian funding decreases (sustainability); 4) if and how interventions align between WHO offices and within the UN system (coherence); and 5) implementation issues related to cost-effectiveness and measuring progress (efficiency).

3.1 WHO achievements in Iraq since 2019

Finding 1. WHO has provided support to the Government of Iraq through a variety of strategies and interventions in the period 2019–2023. WHO support is well recognized and appreciated by all stakeholders interviewed.

3.1.1 WHO support for health systems

The core of WHO's normative work in Iraq uses three support modalities as per the GPW13: technical, strategic and policy support for stronger health systems, policies and governance. WHO Country Office presentations and progress reports highlight the following achievements in health system strengthening:

Health systems support is the responsibility of one dedicated technical officer whose focus is on health information, UHC and NCDs. Support interventions as presented to the evaluation team by the Country Office cover a variety of issues and approaches, including: 1) assessment for the EMRO "PHC Measurement and Improvement" (PHCMI) project; 2) development of Humanitarian-Development-Peace Nexus profile of Iraq 2021; 3) a rapid health governance mapping; 4) a hospital sector profile for Iraq; 5) capacity-building of the national health account team on disease costing; 6) facilitating MoH participation in workshops for strengthening local production capacities; 7) a training of trainers on supply chain management for health facilities in Basra, Kirkuk and Mosul; 8) support to pharmacy department monitoring and evaluation system; and 9) facilitating MoH implementation of WHO Global Antimicrobial Resistance and Use Surveillance System.

Health information systems (HIS) and digitization are a focus of WHO support. WHO support as presented to the evaluation team by the Country Office included: 1) a joint EMRO/MoH assessment of the HIS in Iraq in 2019, which identified a need for a national strategy (including the private health sector) and DHIS-2 roll out, including infrastructure (22); 2) Iraq's participation in the EMRO Network of Institutions for Evidence and Data to Policy; 3) a consultation with MoH, WHO, UNICEF, the World Bank and partners on Health Management Information System (HMIS) strengthening in 2021; 4) agreement on a roadmap for investment in Health Management Information System, adoption of DHIS-2 and establishment of a national higher committee for Health Management Information System in 2022; 5) training of 250 MoH cadre on data management through DHIS-2, and 6) operationalizing the immunization programme module, with additional modules planned to be added (such as tuberculosis, Maternal and Child Health).

The emphasis of the Country Office Information Management Unit (IMU) has gradually shifted from health emergency information support to health system support. The Information Management Unit consists of six staff (including 4 data assistants) plus a DHIS-2 consultant. As presented to the evaluation team by the Country Office, Information Management Unit products for country wide health systems in the evaluation period included, besides DHIS-2, 1) a Health Resources and

Services Availability Monitoring System (HeRAMS)[14] for all Iraq, resulting in a dashboard and six reports (2022) on operational status, general clinical services, sexual and reproductive health services, child health services, communicable disease services, NCD & mental health; 2) a COVID-19 dashboard; 3) development of Health Geographical Information System and dashboard; and 4) an RMNCAH online dashboard. For internal functions, the Information Management Unit produced information products for the WHO medical technology and pharmaceutical procurement units.

Communicable disease surveillance and outbreak management is traditionally a strong focus of WHO support, reflecting the fact that Iraq is prone to outbreaks of several diseases, especially with climate change, including annual cholera outbreaks and a current Congo-Crimean Haemorrhagic Fever outbreak. WHO support as presented to the evaluation team by the Country Office included: 1) implementation of an early warning, alert and response network [15], an early warning disease surveillance system for outbreak prone diseases (cholera, measles, Congo-Crimean Haemorrhagic Fever (CCHF) etc.) until 2023; 2) technical assistance for incorporation of event-based surveillance[16] into the national surveillance system[17] since 2023; 3) establishment of epidemic intelligence from open sources [18] to complement communicable disease surveillance; 4) capacity-building for outbreak investigation, data management, analysis and case management; 5) laboratory support, including digitization, training and supplies; 6) support for data submission for the Pandemic Influenza Protocol; 7) procurement and provision of vaccine, medicines and laboratory supplies; 8) training on infection prevention and control and antimicrobial resistance (AMR), and 9) water quality monitoring.

Health promotion through risk communication and community engagement has become an important area of WHO support, boosted by the COVID-19 response. WHO support activities included: 1) support for a national risk communication and community engagement strategy 2024–2030; 2) a national risk communication and community engagement taskforce; and 3) the development of a 2024–2027 national action plan. Activities have so far focused on mass

Photo credit: WHO; Iraq team visit to Babylon governorate, Iraq – May 2022

[14] The Health Resources and Services Availability Monitoring System (HeRAMS), a WHO system that collates information on essential health resources and services, is readily available to decision-makers.

[15] The Early Warning, Alert and Response Network (EWARN) is a network of health partners which collect and report surveillance data on selected epidemic-prone diseases.

[16] Event-based surveillance is the organized and rapid capture of information about events that are a potential risk to public health through formal and informal channels.

[17] The national communicable disease surveillance system is based on weekly reporting from all health services on reportable diseases.

[18] The Epidemic Intelligence from Open Sources (EIOS) initiative is a collaboration between WHO and public health stakeholders around the globe to strengthen public health intelligence by creating a unified all-hazards, One Health approach to early detection, verification, assessment and communication of public health threats using publicly available information. It is managed by WHE.

awareness for routine immunization and mass gathering for religious pilgrimage, social media campaigns, engaging religious and tribe leaders, health workers and volunteers.

3.1.2 WHO support for technical and/or vertical health programmes

WHO normative support for vertical programmes is mostly technical and strategic. The scope of this work is mainly national and addresses the following national programmes.

Support for NCD prevention and management drew until recently on a dedicated technical officer but is currently the responsibility of the health systems officer. WHO support as presented to the evaluation team by the Country Office focused on: 1) national strategy development (the national NCD strategy 2013–2017 was extended to 2018–2022) and participation in the NCD steering committee; 2) assessment of NCD services in Iraq; 3) annual assessment of national key monitoring indicators of NCD; 4) assessment of Iraq's cancer control capacities and needs; 5) including NCD in the regional PHCMI initiative; 6) capacity-building in the context of WHO's Personal protective equipment [19] and HEARTS[20] initiative; 7) training for local NGOs and media on tobacco tactics; 8) contribution to the global status report on road safety 2022, and 9) a survey for a number of people with disabilities, plus a rapid assessment of assistive technology for disabilities.

WHO support for polio eradication was downsized from 2019 to 2023, and the focus shifted, reflecting the change in needs. As presented to the evaluation team by the Country Office, staff numbers were reduced from 25 to 3, and the budget from US$ 922,000 to US$ 186,000.[21] The shift was from polio surveillance to vaccine preventable diseases (measles, rubella) and training of EPI officers for surveillance. COVID-19 vaccination roll out was included in the 2021 annual plan (see below).

WHO supported the national Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) programme with strategy, technical and material support. Support activities as presented to the evaluation team by the Country Office include: 1) review and revision of the national RMNCAH Strategy 2023–2030 in collaboration with UNICEF and UNFPA, of the National School Health Strategy and the national Nutrition Strategy 2023–20230; 2) updating RMNCAH guidelines and training packages in line with WHO recommendations, and training of health care providers; 3) digitization of maternal and perinatal death surveillance and development of emergency obstetric and new-born care and reproductive health digital dashboard; 4) qualitative assessments and policy surveys; and 5) procurement of supplies and lab kits.

Support for mental health and domestic violence services increased in the period since 2019. At the national level, WHO supported 1) the MoH Technical Working Group on mental health, including technical assistance for the mental health strategy, domestic violence strategy, suicide prevention and drug abuse.[22]

WHO provided policy support for social determinants of health, climate change, One Health and water, sanitation and hygiene () interventions. As presented to the evaluation team by the Country Office, WHO supported the MoH in developing a climate change health strategy and national action plan, including an early warning system for climate sensitive health hazards. WHO advocated for a One-Health approach and multisectoral actions among different ministries.

WHO provided policy and technical support in antimicrobial resistance prevention. Achievements include support for: 1) developing the national action plan; 2) infection prevention and control trainings at the governate level; 3) microbiology laboratories for AMR surveillance; 4) antimicrobial stewardship teams for improved antibiotic use, in collaboration with the Syndicate of Pharmacists; and 5) developing a curriculum for medical/nursing/pharmacist students and promoting the WHO Antibiotic Book.

[19] WHO package of essential noncommunicable disease interventions for PHC.
[20] WHO technical package providing a strategic approach to improving cardiovascular health.
[21] Country Office presentation.
[22] Mental Health and Substance use programme/ Annual report 2023: WCO Iraq Mental Health activities in 2023.

3.1.3 WHO support for health emergencies responses

WHO operational support for health service delivery in IDP camps has been reduced since 2019 as part of the transition. This support consisted of 1) contracting local NGOs[23] to provide PHC services (through static and mobile clinics) to refugees and IDPs in locations without functioning health services, especially in northern areas of KRI; 2) supplying mobile clinics, ambulances, laboratory equipment, and medicines to health services targeting IDPs in or outside camps; 3) building the clinical capacities and skills of health staff in PHC centres located across five governorates; and 5) training health care providers to support domestic violence survivors from IDP and refugees populations (Annual Report, WHO Iraq, unpublished observations, 2023).

WHO chaired the health cluster for the humanitarian response, for coordination among MoH and health partners. Firstly, as the health cluster chair, WHO produced data and technical guidance to support implementation of health services. The Country Office Information Management Unit supported 1) the early warning, alert and response network (EWARN)[24] and developed an online dashboard, monthly snapshots, and infographics on disease reports; 2) an online and interactive dashboard on nationwide health services availability for various target populations, [25] including monthly infographics and infographics on specific issues (such as camp profiles, specific services and expected camp closures); and 3) a Cluster Coordination Performance Monitoring (CCPM) report. Second, the health cluster supported donors to monitor implementation. Key achievements included 1) monitoring missions for the Iraq Humanitarian Fund to monitor progress; 2) training on reporting to the Response Monitoring Module and Activity Plan Module for the Humanitarian response plan 2022; 3) the Iraq Health Cluster Dashboard to monitor the health emergency response; 4) the Financial Tracking Service to monitor humanitarian funding; 5) support for the Iraq information centre to address cases referred to health partners; and 6) protection from sexual exploitation and abuse training to health partners (23).

During the COVID-19 pandemic, WHO provided operational, technical and strategic support to the national response. WHO direct support included: 1) technical assistance to departments of health and universities through training sessions, webinars and updated guidelines,[26] including training of trainers for various health workers; 2) surveillance and contacts tracing support; 3) supplies, including personal protective equipment for frontline workers, oxygen concentrators for intensive care unit and test kits for labs; 4) training of trainers for lab specialists on COVID test analysis and reporting; 5) support for a national risk communication and community engagement strategy, various campaigns for awareness (2020) and mass vaccination (2021), volunteer training and IEC messages and materials; 6) support for Basra University for research and development of viral transport media during the acute shortage, as well as model patient isolation chambers for infection prevention among health workers; and 7) an assessment of health services for domestic violence survivors during COVID-19.[27] Focusing on humanitarian settings, WHO chaired the *Iraq Health Cluster COVID Task Force*, where achievements include 1) coordination between and a platform for partners to communicate with the MoH; 2) monthly static infographics on all COVID-19 activities (24); 3) facilitation of the Iraq Humanitarian Funds COVID-19 allocation for partners; and 4) multisectoral collaboration in the COVID-19 response, such as quarantine and isolation areas in camps for IDPs (25), training to identify and refer potential cases of domestic violence (26), and text messages through the Iraq Information Centre.

[23] The main Iraqi NGOs contracted as implementors, for both emergency health service delivery and as infrastructure support across the country, mainly in KRI, are Dary and Heevie.
[24] A network of humanitarian health partners to collect and report surveillance data on epidemic-prone diseases, as an early warning system for disease outbreaks.
[25] Health Cluster 4W Monitoring Interactive Dashboard 2018
[26] Presentation Country Office team
[27] Mental Health and Substance use programme / Annual report 2023: WCO Iraq Mental Health activities in 2023.

WHO provided infrastructure support to establish referral specialist services in governorates with high numbers of refugees and IDPs. This included: 1) operation theatres of the Reconstructive Surgery & Burn Hospital, equipment at Shar hospital, medicines, medical supplies, ambulances and mobile clinics in Sulaymaniyah; 2) additional intensive care unit beds, oxygen concentrators and ambulances for the COVID-19 hospital in Sulaymaniyah; 3) a paediatric intensive care unit at Heevi paediatric hospital, a paediatric department in Akre paediatric and maternity hospital and an oncology care centre in Duhok; and 4) expansion of the emergency department and a neonatal care unit in the maternity hospital in Erbil.

Photo credit: WHO; Erbil warehouse, December 2022

3.1.4 WHO internal support functions for health emergency responses

A WHO supply chain unit is responsible for procurement and supply chain management of pharmaceutical products for WHO interventions.[28] The unit procures, stores and delivers pharmaceutical or health technology products to WHO supported partners: in the period since 2019, it made 567 deliveries worth almost US$ 21.5 million.[29] The unit of 14 staff manages a warehouse, co-located with the KRI MoH warehouse. Business management systems are WHO corporate systems and fall under the WHO Health Emergencies Programme. **The WHO grant management unit was established under the emergency programme for proposal development, resource mobilization and reporting to donors and managing subcontracts with implementing partners**[30]. The unit has now moved to the Baghdad office where, as the 'planning and programme management unit', it has a broader mandate for programme planning and management.

[28] Country Office presentation and visit to WHO warehouse in Erbil.
[29] Ibid.
[30] Country Office presentation.

3.2 Effectiveness

This chapter explores to what extent WHO results (including contributions at outcome and system level) were achieved or are likely to be achieved and what factors influenced (or not) their achievement (Evaluation Question 3). This involved three specific questions.

1) To what extent were programme outputs delivered, and to what extent did Country Office outputs contribute to progress toward the stated Country Office outcomes?
2) What has been the added value of regional and headquarters contributions to the achievement of results in Iraq?
3) What factors influenced their achievement?

Finding 2: Despite many WHO achievements in Iraq, it is hard to determine effectiveness, outcomes or impact, as WHO results are poorly defined.

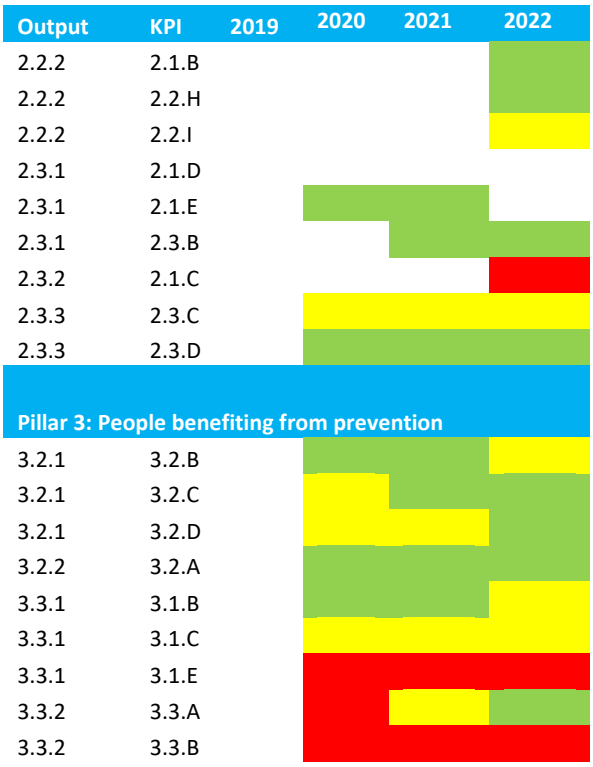
WHO's progress cannot be assessed without stated objectives, including targets and timelines, but for WHO in Iraq there is no such document. A CCS has not been developed since 2017, and although biennial workplans contain a selection of GPW13 outcomes and outputs, these are not documents with targets and timelines. Moreover, biennial workplans are aspirational and do not contain activities that are funded by donors outside the workplan (meaning most of the health emergency work) nor the objectives and targets agreed for such donor-funded activities. There is no theory of change for WHO'S work in Iraq that could explain how WHO outputs contribute to higher level results, such as stronger health systems or health outcomes.

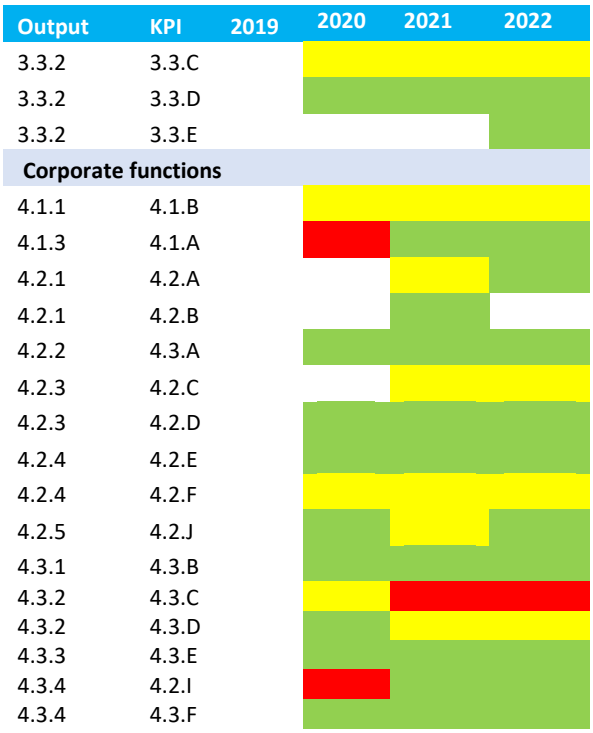
Output level progress has been satisfactory and improving since 2019. The Country Office reports annually to the WHO Regional Office on 31 GPW outputs that are selected in the biennial workplan (see below under Efficiency for discussion of the reporting system). Annual progress reports to the Regional Office and to its Programme Planning, Budget, Monitoring and Evaluation Unit staff indicate that, over the years, the comprehensiveness of reporting has increased from 1 to 57 KPIs, and the proportion of KPIs with good progress has risen from 1 to 30. That said, assessment of progress is not external but self-reported by relevant Country Office staff, so there may be some bias. Table 8 provides an overview of the improvement in reported progress (see Annex 6 for detail on the actual GPW13 outputs).

Table 8 . Output level performance[31]

Output	KPI	2019	2020	2021	2022
Pillar 1: People with access to health services					
1.1.1	1.1.F				
1.1.1	1.1.G				
1.1.2	1.1.D				
1.1.2	1.1.E				
1.1.2	1.1.I				
1.1.3	1.1.A				
1.1.3	1.1.B				
1.1.3	1.1.C				
1.1.4	1.1.J				
1.1.5	1.1.K				
1.2.1	1.2.A				
1.2.2	1.2.B				
1.3.1	1.3.B				
1.3.1	1.3.H				
1.3.2	1.3.E				
1.3.2	1.3.F				
1.3.3	1.3.D				
1.3.3	1.3.C				
1.3.4	1.3.G				
1.3.5	1.3.A				
3.1.1	1.1.H				
Pillar 2: People protected from health emergencies					
2.1.1	2.1.A				
1.1.3	2.2.D				
2.1.1	2.1.F				
2.1.2	2.1.G				

[31] Colour coding as per EMRO reporting guidelines: red (unsatisfactory); yellow (in progress); green (achieved).





External monitoring reports for US government funded projects indicate good progress on outputs. Most of WHO's health emergency work is funded and monitored separately from the biennial workplan. US-Government-funded projects, which are assessed in 24 monitoring reports (13 third-party monitoring and 11 hybrid monitoring reports), have achieved agreed outputs consistently. US Government and other donor funded interventions relate to health service delivery (in camps or during the COVID-19 pandemic), health worker training, infrastructure development and technical support for Directorates of Health, for example on surveillance.

Finding 3. WHO has directly or indirectly, contributed to improved health systems in Iraq.

Whilst it is impossible to quantify outcomes or contributions from progress reports, the evaluation finds ample qualitative evidence that WHO has directly or indirectly contributed to strengthening health systems in Iraq. Examples of effective health system support mentioned by informants include 1) strategic support for various national strategies (RMNCAH, NCD, etc.); 2) technical support for development of the DHIS-2 and digitization; 3) WHO technical leadership and support for COVID-19/pandemic responses; 4) technical support for disease surveillance; and 5) various assessments of health needs and services (national health account, Health Resources and Services Availability Monitoring System, PHC measurement improvement).

Respondents identified several factors that contributed to WHO's success in Iraq, including credibility with government counterparts. WHO leadership recognizes that WHO credibility with government counterparts increases if WHO can collaborate on joint assessments, for example the Health Resources and Services Availability Monitoring System survey. That is why health information systems work is an important entry point. Very regular interaction with government counterparts is important to remain responsive and credible, and an office at the MoH is crucial. WHO established an office in KRI MoH during the COVID response.

Several factors have challenged progress, including rapid turnover of government counterparts, health programmes remaining vertical and a bias towards quick and visible results. Respondents identify the need to support cross-cutting health systems and UHC, but disease specific silos persist in both the counterpart ministries and WHO itself, with limited

collaboration. Similarly, support requests from the MoH and donor priorities reflect a bias towards visible results, curative services, infrastructure support and urban populations. An example is the WHO support for setting up specialist urban referral services (neonatal intensive care unit) whilst there is underinvestment in preventative care and PHC. This is also a challenge to WHO's equity principles, which promote UHC.

Finding 4. WHO has, indirectly, contributed to the improved health status of people in Iraq through health emergency work

Through its health emergency work, WHO has indirectly contributed to health outcomes for IPD and refugee populations (and local communities in the project areas). Since 2019, WHO has supported implementing partners to provide *PHC* services in camps for hundreds of thousands of IDP, refugees and host communities**.** WHO has also supported the improvement of *referral specialist* health services. In 2022, for example, WHO's support extended to 21 PHC centres located in camps across five governorates (Duhok, Erbil, Sulaymaniyah, Anbar and Ninawa). In Duhok and Ninawa Governorates, WHO supported PHC services in 11 IDP camps through a budget of US$ 3 097 300 (23). In addition, WHO supported the operation of nine mobile medical clinics in Kirkuk, Anbar and Ninawa governorates to ensure that hard-to-reach populations were able to access health services. WHO support for national and local COVID-19 awareness and vaccination campaigns through volunteers and implementing partners indirectly contributed to health outcomes. Finally, the WHO logistics unit has supported health service delivery by supplying infrastructure, medicines and equipment. 22 From its document review and interviews with community level informants, the evaluation team found that WHO support enabled access to health services in camps and referral sites, resulting in improved health outcomes for an estimated 1.2 million people living in 26 camps by the end of 2022 (27).

There was a general satisfaction with the work of the health cluster. This was confirmed during KIIs with WHO partners (including local, international and government stakeholders) and donors as well as cluster satisfaction surveys. Several examples to highlight the achievements of the health cluster were reported by KIIs in Duhok. These included the support provided by the health cluster to produce plans and assessments during COVID-19 and the response during the cholera and measles outbreak in Duhok, which enabled partners to provide appropriate health services.

Working through local partners and building their capacities enabled WHO to reach hard-to-reach populations and address domestic violence. WHO health emergency work focused on populations mostly left behind: IDPs and refugees, especially those dependent on humanitarian support. Even within these populations of concern, WHO supported extra vulnerable populations, such as survivors of domestic violence and people with disabilities, through initiatives for specialist health services. Working with local partners helped WHO reach hard-to-reach populations, particularly in conflict areas and areas with complex socio-economic and religious structures, as local partners were aware of local sensitivities and consulted local authorities and camp leaders prior to carrying out interventions.

The existing health cluster and prior relations between health partners and other clusters (WASH and CCCM) were critical to facilitating the response to COVID-19 in humanitarian settings. Especially as lockdowns prevented movement of staff, the involvement of the governorate-level Department of Health in the cluster meetings and its co-chairing of the cluster added value to the multisectoral collaboration (26). The health cluster also advocated with national health authorities during COVID-19 as a bridge to connect cluster partners with other UN agencies, such as UNICEF (CCPM Report Iraq, WHO, unpublished observations, 2021).

Several factors affected the ability of the health cluster to provide health services, including COVID-vaccination, to people of concern. Firstly, some local government demands were unhelpful, such as not to recruit health workers from the public sector;[32]to hand over ambulances; and not to allow humanitarian partners to move their assets from closed IDP camps to other areas. The health cluster overcame these challenges by seeking support from the UN Office for the

[32] Although this did not materialize, it resulted in concerns among health partners, as it was not possible for them to employ health workers directly.

Coordination of Humanitarian Affairs (OCHA) to advocate with the local and national government (28). Secondly, access to COVID-19 vaccines was hampered by requirements of government issued identity cards, which prevented stateless people and IDPs from accessing vaccines; long distances; and unavailability of vaccines. NGOs were initially not allowed to vaccinate people of concern, until advocacy from WHO and UNICEF resulted in approval in 2021 (29). Finally, coordination challenges affected COVID-19 quarantine in camps, causing confusion on roles and responsibilities (CCPM Report Iraq, WHO, unpublished observations, 2021) as well as gaps in advocacy according to informants and cluster satisfaction surveys (Cluster satisfaction survey, Health Cluster Iraq, unpublished observations, 2020).

3.3 Relevance

This chapter explores to what extent WHO's interventions in Iraq are relevant to the context and the health needs of the Iraqi population, including IDPs, as well as to country and partner needs, policies and priorities. It also assesses how WHO responds if circumstances and needs change.[33]

Finding 5. A comprehensive, up-to-date assessment of health sector needs does not exist.[34]

WHO in Iraq works without a CCS, which typically contains a health needs assessment and long-term strategies to respond to these needs. As mentioned above, WHO work in Iraq is guided by biennial workplans for corporate outputs (mainly on health systems) plus specific agreements for donor-funded (health emergency response) interventions. Typically, a five-year CCS articulates a needs assessment that informs WHO's long term objectives, which are subsequently translated into specific interventions and outputs as per biennial workplans and project proposals. WHO has not developed a CCS since 2017. A situation analysis and country strategy were drafted by the WHO Regional Office (1) and Country Office respectively, but it was never finalized. Reasons reported include the focus on health emergency support, COVID-19 and the rapid turnover of MoH counterparts, which prevented a participatory strategic planning process. That said, the deputy minister and the director general for public health have remained in position for longer periods. Other UN health partners, UNICEF and UNFPA were able to develop longer term country strategies but admit that their planning system is less dependent on MoH participation, that they have more budgetary control and funding and that their mandate is more focused. The Country Office prefers the next CCS, which is a requirement for the UNSDCF, to be informal, drawing on the health chapter of the UN Common Country Assessment (both were being finalized during the evaluation).

Stakeholder opinions differ on the appropriateness of a long-term strategy and objectives in a country like Iraq, as contexts and needs evolve. Current and past Country Office leadership do not consider the absence of a long-term country strategy problematic, since it allows flexibility to respond to emerging needs. This flexibility helped WHO with the response to COVID-19 and in exploring emerging opportunities to maintain funding levels as humanitarian funding is reducing. The Country Office states that strategic planning is informal, based on what is known about needs and major gaps on the one hand and the capacities and expertise of the Country Office team (supported by WHO Regional Office and headquarters expertise) on the other. The current leadership sees more utility in using the WHO Country Office biennial workplans to articulate needs and priority objectives for WHO interventions. Nevertheless, several Country Office staff consider that the absence of a broad vision and long-term strategy has resulted in a lack of clarity about WHO's mandate and vision internally and for external partners. Some staff members describe the modus operandi of the Country Office as 'identify a problem, develop a donor proposal' and call for a more strategic approach. Some UN partners argue that *especially* in a context where counterparts rotate frequently, a long-term strategy can help to stay focused and remain relevant. Government counterparts expressed mixed opinions: while technical staff appreciate the flexibility as it allows them to request support for specific issues, senior MoH leadership stated that the WHO mandate has become unclear.

[33] See evaluation matrix, evaluation question 1.

[34] Evaluation question 1.2 "To what extent have WHO's objectives (including any adjustment of objectives), and interventions responded to the country's and partners' policies and support priorities?"

Although the health needs of people living in Iraq are not systematically and comprehensively assessed, WHO has supported research to increase the relevance of services, although the rationale is not always clear. Health experts interviewed mention that emerging health needs in Iraq include the impact of climate change and the increasing importance of NCDs. WHO supported several studies and assessments, mostly undertaken in collaboration with the MoH, including assessments of health emergency response as well as on regular health systems. The evaluation found assessments on the following topics: national Health Information Systems (22) various health programmes (such as pharmaceutical systems (30), cancer care (WHO/IARC, unpublished observations, 2021), emergency care (WHO, unpublished observations, 2022) and assistive technology for disabled people (WHO, unpublished observations, 2023). The rationale for the specific assessments is not always clear, nor whether the request came from WHO regional office or headquarters (for instance the peace-health-development nexus) or from the MoH (for example cancer care). Importantly, **there is no *overall* health sector wide assessment for the country, which could serve as a basis to prioritize WHO support**. Closest is the EMRO draft 'high-level situation analysis and initial outcome prioritization of GPW13'[35] or the three-page health chapter in the 2022 UN common country assessment (31). At the same time, some MoH stakeholders admit that MoH should articulate its needs better to WHO to ensure the relevance of WHO support.

Finding 6. WHO interventions largely address the needs of the MoH of Iraq[36]

Despite the absence of a CCS, the MoH considers WHO support to be relevant and responsive to its needs. Areas of support regularly mentioned in interviews are digitization, especially DHIS-2 support, and support for the COVID-19 response, such as mass awareness campaigns, procurement and strengthening emergency services. KRI MoH staff also mentioned the WHO support for health service delivery to IDPs and infrastructure support as relevant to their needs. Respondents mention that WHO is generally responsive to ad hoc MoH requests on technical topics; typically the Country Office acts as the intermediary, and the Regional Office is responsive. Examples mentioned include support for the RMNCAH strategy and for the HIV control strategy development. Ministry officials convey that WHO is most relevant where specific evidence-based strategies and follow-up support are involved, for example the Joint External Evaluation, which regularly follows up on the IHR commitments.

Looking ahead, the federal MoH considers WHO technical and strategic support to be most relevant. The specific areas of health system support most frequently mentioned are: 1) UHC, including strengthening primary health care, family medicine, health financing and health insurance; 2) digitization of the Health Management Information System , including extending the use of DHIS-2 across all health programmes: and 3) work with other ministries on health-related issues, multisectoral response and One Health. The emphasis of the WHO support should be on ideas and innovation not material support, nor on repeating the same interventions. That said, the evaluation also found that the KRI MoH expressed a need not just for health system support but also for the continuation of WHOs current financial, operational and infrastructure support, while its financial situation is precarious. A UN partner confirmed that it is relatively comfortable for UN agencies to be guided by donor priorities and funding rather than national health needs, thus jeopardizing relevance, scaling potential and sustainability. They argue for WHO and others to come out of that comfort zone and address national priorities, such as national planning and health financing.

[35] IRQ_GPW13_CountrySituation_Interventions

[36] EQ 1.3 "To what extent are WHO interventions aligned to country and sub-national partners' and institutions' policies and priorities?"

Photo credit: WHO; WHO Iraq team visit to Babylon governorate, Iraq – May 2022

The MoH is currently planning its long-term health strategy, which is an opportunity for WHO to increase the relevance of its support. The MoH is about to embark on strategic planning for the National Health Development Plan 2024–2033 and at the same time for a shorter term health strategy (2022–2025) at the request of the prime minister. Planning department staff mention that an official request has gone out to the Regional Office for technical assistance with strategic planning, including experts for a situation analysis. The situation analysis is typically a collaborative effort and may entail partnerships with international organizations and experts. Respondents in WHO and MoH agree that the upcoming strategic planning exercises should identify health sector gaps and needs and the support priorities for WHO and the UN system through the UN Sustainable Development Cooperation Framework. Senior UN respondents mention as a lesson learned that, during the humanitarian crisis, UN agencies distanced themselves from the federal government as they prioritized donor-funded projects in KRI. WHO Country Office experience confirms that the federal MoH saw WHO at some stage mainly as an emergency provider.

WHO Country Office Iraq has started planning for the 2024–25 biennial workplan and budget. The process started in 2022, and workplans for all selected priority outcomes and outputs have been submitted to the regional office, recognizing that priorities may need to be revised as per the context. A regional office survey on the consultative process reportedly gave good marks on Iraq for consulting with the MoH, less for consultation with others, such as the UN and academia.

Finding 7. WHO interventions in Iraq largely respond to the health needs of the people in Iraq.[37]

WHO supported health service target populations with little access to health services. The health services in IDP and refugee camps, and for IDPs outside camps, are relevant as they target people with limited access to existing health services.

WHO undertook needs assessments specific to health emergency contexts to identify the needs on the ground, but these tended to be ad hoc and were not systematically carried out. WHO interventions primarily reflect needs expressed in government requests, as reported by WHO Country Office staff, national/local authorities and by the cluster satisfaction surveys (CCPM Report Iraq, WHO, unpublished observations, 2021). On the contrary, other local authorities and implementing partners report that WHO interventions are generally based on needs assessments. Indeed, WHO has produced several documents that identify gaps in the health emergency response. These include: 1) health facilities in humanitarian settings (Health Resources and Services Availability Monitoring System);[38] 2) national health emergency preparedness (Joint External Evaluation (6) and Universal Health and Preparedness Review (32)); 3) Humanitarian-Development-Peace assessment for health (Humanitarian-Development-Peace Nexus For Health: Iraq Profile, WHO EMRO, unpublished observations, 2021) ; and 4) an assessment of rape and intimate partner violence services, plus a health cluster survey on the domestic violence response during the COVID-19 emergency (Country report for end of Biennium 2020/2021, WHO Iraq, unpublished observations, 2022).

Photo credit: WHO

Accountability mechanisms during the health emergency response further ensured that needs on the ground were addressed. Health partners had channels in place to receive feedback from beneficiaries, such as complaints boxes and focus group discussion to a limited extent. "Third party monitoring" of US government funded programmes in 2022 and 2023 monitored accountability measures towards affected populations and were positive about this (Third Party Monitoring TPM site visit report, Iraq monitoring project, WHO, unpublished observations, 2023). The cluster satisfaction surveys also indicated that accountability to affected populations was 'good'.

Overall, direct and indirect beneficiaries are satisfied with the services they received. Direct beneficiaries (health workers at the Heevi health centre) highlighted satisfaction with the support, noting that WHO staff were responsive to their needs and consulted them about the services and critical needs of the health centres. IDP women in Sharia camp report general satisfaction with health services received, especially antenatal counselling, medication, and health awareness sessions, as supported by WHO. Yet they also mention that minor problems are not reported due to the fear of community reaction, for example requests for additional types of medication and dentist services. Country Office staff mention that needs-based planning in humanitarian settings is challenged by donor priorities, as they override the expressed needs of the population, being restricted in terms of location, beneficiary population and programme area.

WHO also responded to emerging specific health needs for vulnerable populations, such as women and disabled people. WHO has produced several key documents that identify gaps in the health emergency response. The evaluation found no evidence that programme participants, particularly children, were actively consulted in the planning of services. WHO undertook an assessment of the management of rape and intimate partner violence services and the health cluster survey on domestic violence response during the COVID-19 emergency. The assessments provided a better understanding on the health facilities' preparedness to receive survivors; availability and adequateness of domestic violence services; available patient care standards and referral system; and the policies and protocols used in managing domestic violence survivors (Country report for end of Biennium 2020/2021, WHO, 2022). WHO in coordination with the MoH prepared a domestic violence strategy for the MoH in Iraq 2022–2023, including addressing the needs of women in camps and demand for domestic violence services during COVID-19. WHO also supported physical rehabilitation services, including assistive

[37] EQ 1.1 "To what extent have WHO's objectives (including any adjustment of objectives), and interventions responded to Iraq's needs and rights, including those of the most marginalized populations?"

[38] Health Resources and Services Availability Monitoring System is a WHO system that collates information on essential health resources and services is readily available for decision makers.

devices for disabled people, many being disabled because of civil unrest. Site visits undertaken for the evaluation confirmed that gender and disability considerations are included in the construction of clinics and care provided to patients, for example ramps for wheelchair access and separate rooms for female and male patients. In 2019–2020, due to an increase in suicide rates, the partner established mental health centres in Erbil and other governorates of KRI through WHO support. However, there are also reports from implementing partners that integrating additional services based on emerging needs is difficult, so while drafting a proposal the partners include a broad range of services so as to pre-empt emerging needs.

Finding 8. WHO has been relatively slow to respond to evolving needs during the transition from emergency to development.

As of 2019, the beginning of the period evaluated, 90% of Country Office funding and more than 50% of staff were dedicated to health emergency work. The reasons included a sustained humanitarian situation in camps, availability of funding for reconstruction and rehabilitation, and the COVID-19 pandemic response. This also made the Country Office dependent on such funding, as the base budget for normative health system support had remained stable.

Table 9 Iraq Programme Budget Financing (US$)

Category	2018–2019	2020–2021	2022–2023
Total	**121 508**	**63 584**	**50 361**
Base programme	8017	10 509	8600
Emergencies	113 491	52 876	41 635
Special Programme	NA	231	126

At the arrival of the new WHO Representative in 2021, WHO support to Iraq consisted mainly of health emergency work. A strategic planning exercise resulted in a strategy of 'building resilience in the health sector', which meant using rehabilitation and reconstruction funding to strengthen secondary and tertiary health services, benefitting host populations and current and future IDPs and refugees. Examples of such projects include infrastructure support for upgrading an emergency care department, a neonatal care unit in a maternity hospital and a paediatric care unit. As demonstration projects, they were meant to be taken to scale by others; however, that has not yet happened. Regional Office staff express doubt about the comparative advantage of WHO to support (much needed) reconstruction of health facilities. Importantly the ex-WHO Representative considers that there is a false dichotomy between health emergency and health system support: WHO should support the "Iraq national health development plan" but it would maintain a focus on IDPs as vulnerable populations and support health systems and services towards being more resilient for future emergencies.

There was little synergy between the health emergency work from the Erbil office and the health system work from the Baghdad office.[39] Health emergency response work tends to be hands-on, donor-driven and with short time horizons – compared to upstream support, which requires different skills, including patience. WHO staff recruited for the health emergency work had different professional skills and experiences than those working on health systems, plus the teams worked in different offices.

From 2022, WHO documents express a need to transition from emergency work towards health system support. The 2021 annual report mentions a strategic prioritization for 2022 "as the lack of funding is forcing us to scale down some of our operations" and states that "WHO's focus [..] will be on strengthening the health system's resilience and preparedness to meet the global WHO goal of giving everyone, everywhere, an equal chance to live a healthy life" (24). One factor that triggered the transition was the UN Resident Coordinator declaring an end to the official humanitarian response, resulting in de-activation of the clusters, including the WHO-led health cluster. Another factor was the WHO Regional Office initiating a humanitarian-development-peace nexus framework for joint planning and implementation between

[39] This also relates to the evaluation question on coherence but is discussed here.

humanitarian, development and peacebuilding actors. The Iraq humanitarian-development-peace nexus for Health Profile (Humanitarian-Development-Peace Nexus For Health: Iraq Profile, WHO EMRO, unpublished observations, 2021) made the following recommendations: 1) strengthening existing health coordination mechanisms; 2) conducting a health system assessment; 3) defining health sector development objectives and outcomes; 4) shifting towards multiyear strategic planning; 5) bolstering monitoring and evaluation mechanisms; 6) creating resource and financing records; and 7) mainstreaming conflict analysis and peacebuilding prioritization.

This transition is occurring more slowly than planned, and opinions among staff continue to differ about it. Since the WHO Representative left, and with the position remaining vacant, there seems to have been a slowdown in rebalancing towards upstream work. Most Country Office staff articulate a need for a long-term vision for WHO, prioritizing 'upstream' technical, strategic and policy support wherever possible and resorting to health service delivery support only in the last instance. Technical officers in Baghdad and WHO staff based at ministries are more motivated to build national capacity and see WHO as the "provider of last resort". Other officers report that coherence within the Country Office is still a challenge. The evaluation also notes that within WHO, the Emergency Programme employs independent systems for funding, technical assistance and reporting, and that this contributes to the lack of synergy between the two components.

Upstream (health system) support remains deprioritized in the (implicit) WHO strategy for Iraq and among the staff working on health emergencies. Despite a strategy decision to transition, several WHO staff express reluctance to move towards strategic support with longer horizons and less visible results. As some expressed it, WHO "goes first for low hanging fruit, then for health systems improvement". Important contextual factors are the US Government's offer of funding for reconstruction work until the end of 2024 and a reluctance of the MoH KRI to take responsibility for PHC in IDP and refugee camps, which is delaying the planned handover.

Opportunities for synergies between health emergency support and health system support have been missed. There is limited coherence between the Country Office's health emergency and health systems work. For example, WHO infrastructure support for secondary and tertiary care services has failed to link to strengthening PHC services. The

maternity hospital supported with a neonatal intensive care unit is overburdened largely because community-based maternal health services are limited. This root problem remains unaddressed by the Erbil office, while the Baghdad office is working with UNFPA on a review of the national midwifery strategy. Similarly, the emergency department in Erbil East Hospital has 70% non-emergency clients because of barriers to PHC (financial, opening hours and perceived quality). WHO has supported the hospital with one-off infrastructure (extra wards and equipment) and a triage system, but it has not addressed access to PHC centres. Finally, some staff see co-location of the WHO and MoH warehouse as an obvious opportunity for WHO to support the KRI government with supply chain system challenges, as part of WHO's normative and technical assistance mandate. The WHO warehouse, procurement and supply chain activities are housed in the MoH, and procurement staff mention this as a missed opportunity for capacity/technology transfer since the MoH procurement system is weak and inefficient.

Photo credit: WHO; WHO scales up implementation of infection prevention and control measures in Iraq - January 2023

3.4 Sustainability

This chapter explores to what extent WHO has contributed towards building national capacity and ownership for addressing Iraq's humanitarian and development health needs and priorities, especially as Iraq transitions to development status.[40]

Finding 9. Health services in IDP camps and infrastructure support for referral services are unlikely to be sustained post-WHO support

Donor funding for humanitarian and health emergency support is drying up, and the Government of Iraq **is unable to take on the funding of WHO-supported health services.** The humanitarian response was declared over by the UN in 2022, and donor funding for health emergency and reconstruction is due to expire in 2024. Yet there are still IDP and refugee camps, and access to health services for IDP returnees is compromised. In recognition of this, the UN country team developed a transition plan, including handover of PHC services to the Government of Iraq.

[40] See Evaluation Matrix, Annex 2 Question 5. Specific questions are 5.1) to what extent have WHO interventions supported national ownership and capacity on the relevant health policies and strategies?
5.2) to what extent have WHO interventions supported national ownership for a resilient, shock-responsive health system, and national capacity in view of ongoing and future health needs (including emergencies)?

The MoH KRI has not been able to take this up completely for several reasons, including resource constraints and the political consequences of recognizing IDPs and refugees as right holders. KIs confirm that the MoH KRI is unable and unlikely to take on responsibility for camp-based health services. Regional office staff recognize the risks involved in health emergency services, as funding tends to dry up while emergencies tend to be protracted. They mention that other agencies have better systems for surge capacity and closure after the acute phase. A related lesson is that when one of WHO's implementing partners took over the hospital in Ninawa after Médecins sans Frontières (MSF) had left, service continuity was ensured, but sustainability (and reputational) risk was transferred to WHO.

The absence of a tailored WHO exit strategy is a challenge for the sustainability of health emergency work. There was and still is no explicit sustainability and exit strategy for WHO's health emergency interventions. The humanitarian transition overview (15) reflects partners' commitment to supporting the humanitarian to development transition in the country, but it does not contain a plan of action for responsible government actors (33). WHO continues to advocate for the MoH to produce a costed investment strategy and for the approval of the budget required for local government to assume responsibility for health service delivery to IDP in the longer-term. Through the health cluster, WHO provided a mapping of public health facilities within walking distance from camps to the MoH, to help planning, but to little avail.[41] That said, WHO contracted implementing partners, including national NGOs, to deliver health services, and supported them with proposal writing training, to attract private funding for their health centres post-WHO support, even though linking them to the MoH was weaker (CCPM Report Iraq, WHO, unpublished observations, 2021). As an additional sustainability strategy, WHO supported mobile instead of fixed clinics for camps, so that they could be moved elsewhere after camp closure.

Funding for the running costs of WHO-supported infrastructure is uncertain. A post-emergency strategy to maintain health services there is also lacking. WHO has not budgeted for the running costs of newly upgraded hospital units, laboratory equipment, ambulances, etc.,[42] the assumption being that these will be borne by the government health system. This gap also reflects donor policies, which prioritize one-off post-conflict rebuilding investments. Yet the evaluation found evidence during site visits that earlier WHO-supported infrastructure, i.e. the national emergency care training unit, is poorly maintained due to lack of funds: built only in 2010, it is currently in disrepair due to lack of maintenance funding.

The WHO warehouse is co-located in the MoH warehouse, as a cost-cutting strategy, but opportunities for sustained national capacity are missed. The WHO-managed warehouse for medicines and other goods for the WHO health emergency interventions used to be rented in the market, but free space is now available in the MoH warehouse complex. Reduced running contributes to sustainability as humanitarian funding decreases. Despite co-location, there have been no efforts to hand over WHO-operated supply and logistics to the MoH or to build MoH capacity.

Finding 10. WHO upstream policy, strategic and technical support tend to be more sustainable

Development programmes remain underfunded. The classification of Iraq as an upper-middle income country and shifting donor priorities decrease donors' interest in supporting Iraq's health sector in non-emergency Health Systems Development.[43] For WHO to contribute meaningfully to the country's development process and ultimately for the realization of a strengthened health system in Iraq, sustained contributions from donors are of great importance (CCPM Report Iraq, WHO, unpublished observations, 2021).

[41] Health Cluster, 2023, 'Health Cluster activities during 2022'.

[42] Sulaymaniyah: Mobile Medical Clinics, Reconstructive Surgery & Burn Hospital; equipment to Shar hospital & central laboratory; Medicines, Medical supplies & Ambulances; intensive care unit beds COVID-19 hospital
Duhok: Semi Intensive Care Unit in Heevi Paediatric Hospital; Paediatric units Akre Paediatric & Maternity Hospital; Oncology Care Centre.
Erbil: expansion Rojhalat Emergency hospital; paediatric intensive care unit, Maternity hospital; mobile clinics

[43] Output Scorecard Tool. Assessment for EM_IRQ WHO Representative's Office, Iraq-Output: Countries enabled to address social determinants of health across the life course (3.1.1) 2022-2023 – Mid-Term Review 2022.

WHO's approach to supporting the health sector is more sustainable than others as it embeds in health systems instead of delivering pilot projects. According to WHO and other UN staff, this is because WHO supports capacity-building, technical guidelines and strategies, rather than pilot projects, which rely on others to be sustained or scaled. Examples of systems with a high likelihood of sustainability are the national MNCH strategy and the DHIS-2. WHO capacity-building is generally in the form of curriculum development and training of master trainers, thus facilitating scaling up, sustainability and efficiency. This is especially important in cases with a turnover of trained health staff that prevents transfers of skills and capacities.[44] Challenges to sustainability remain: respondents mention that the quick turnover of government staff prevents transfer of skills and capacities and that it will take a while before national mechanisms for transparency and accountability stabilize and have a significant impact on health outcomes.

Finding 11. Iraq is an upper middle-income country, so the financial sustainability of WHO-supported health services and systems is largely determined by domestic policies.

As of 2020, Iraq spent 5% of its gross domestic product on health (or 4.7% of total government expenditure (34), which is lower than average in the region. Of the total health expenditure in 2020, 55% was spent on public health services and 45% in the private health sector, as out-of-pocket expense (on average US$ 91 per person/ year) (35). Iraq's Gross Domestic Product (GDP) increased from US$ 181 billion in 2020 to US$ 264 billion in 2022 (36), but health expenditure has not increased proportionately. In 2021, the Government of Iraq issued a Health Insurance Act to establish a voluntary health insurance system covering catastrophic health expenditures. Informants mention that health services at PHC centres currently require a small fixed payment, but that secondary and tertiary care are free of charge in public hospitals. MoH officials identify health financing as one of the major upstream health system areas where WHO could provide more strategic and policy support than it currently does.

3.5 Coherence

This chapter assesses the extent to which WHO interventions are coherent and demonstrate synergies and consistence with one another, across WHO offices and with interventions carried out by other partners and institutions in Iraq, and what adaptations and refinements are needed to improve WHO positioning.[45]

Finding 12. Coherence between WHO headquarters, Regional Office and Country Office support for Iraq is mixed.[46]

There is no CCS that explains how country priorities align with WHO global and regional strategies. However, because the EMRO vision is based on the three GPW13 pillars (UHC, health emergency preparedness and response, and health promotion), all Country Office interventions fit within the GPW13 and regional strategies. Country Office biennial workplans are based on a selection of GPW13 outputs but do not explain the rationale for this selection.

Country Office technical staff successfully draw on Regional Office and headquarters expertise for their work. The evaluation was not able to distil from biennial workplans if WHO interventions are initiated by the WHO headquarters, Regional Office or Country Office. From interviews with Country Office and Ministry staff, there appears to be strong coherence between Country Office and Regional Office support to Iraq. Country Office and Regional Office staff work well together. The Country Office and technical staff serve as a liaison between MoH counterparts and EMRO; sometimes EMRO takes the initiative with offers of technical assistance or requests for specific information, in other cases Country

[44] Country Office presentation.
[45] See Annex 2, evaluation matrix for evaluation question 2.
[46] Evaluation question 2.1, 'To what extent are WHO interventions aligned internally between WCO, EMRO and headquarters, as well as to WHO GPW13 and its result areas?'

Office staff mobilize expertise from EMRO at the request of MoH. EMRO capacity-building benefits both MoH and Country Office staff, and strategies include online or face-to-face meetings and workshops; sharing technical materials and best practices; technical advice and financial support for assessments and policy surveys, strategy development and guideline review.[47] Examples of good coherence between WHO headquarters, Regional Office and Country Office mentioned by Country Office staff are the support for disease surveillance, DHIS-2 and the development of the national RMNCAH strategy, and Regional Office expertise in AMR, digitization and community engagement.

There are also instances where the Regional Office priorities do not align with WHO Country Office priorities and are seen to distract from more relevant support areas. Country offices have become more autonomous since the 2016 reforms within WHO. Some in the Country Office sense that since 2018 the Regional Office has pushed for more control over country offices. At times, Regional Office priorities do not align with what is agreed between MoH and the Country Office. An example is the Regional Office request to assess the prevalence of drowning in Iraq, as part of a regional study, and earlier EMRO-initiated support for youth palliative cancer care units. Other examples are EMRO-specific key performance indicators (KPI) for country offices (see also chapter 3.6 below), which add to the reporting burden, and the Regional Office calling staff to participate in a training (on result-based management, as mentioned above). The latter is not a priority for the Country Office, as expressed by senior management.

The coordination across the different health cluster departments/units in WHO (Country Office, Regional Office and headquarters) seems to have been a challenge. Poor coordination/communication and a lack of clarity on roles across the different levels (particularly at Regional Office and headquarters level), lead to duplication in some activities. The high turnover of the health cluster/partnership position at Regional Office level may also have challenged communication with headquarters. For example, the position of cluster focal point/partnerships at Regional Office level was reported to have changed four times throughout the evaluation period. A Country Office respondent also mentioned that a workshop was organized by WHO Regional Office, which was similar to a previous one carried out by headquarters, and that headquarters was not informed of the event. Moreover, in 2019, the health cluster annual report[48] highlights that prevailing low government capacity to take over service provision was a key challenge. While the Regional Office provided ad hoc capacity-building to WHO Country Office, there was no clear and strategic effort from Regional Office and/or headquarters to anticipate and help mitigate the risk of a failed transition in this process.[49]

Finding 13. Coherence between WHO and other (UN) health partners is good

Coherence within the UN system is ensured through the UN Sustainable Development Cooperation Frameworks (UNSDCF) and the Common Country Analyses underpinning them. The current UNSDCF (2020–2024) is being revised, as is the Common Country Analysis. The Resident Coordinator strongly emphasized that the UN comparative advantage lies in policy support, system strengthening and digitization, whereas small demonstration projects or infrastructure do not significantly add value. The strategic priorities of the current UNSDSF (16) are: 1) achieving social cohesion, protection and inclusion; 2) growing the economy for all; 3) promoting effective, inclusive and efficient institutions and services; 4) promoting natural resource and disaster risk management, and climate change resilience; and 5) achieving dignified, safe and voluntary durable solutions to displacement in Iraq. WHO interventions since 2019, in both health systems and health emergencies, have supported all priorities, but most directly #3.

The new UNSDCF prioritizes the impact of climate change and a policy support role for the UN. According to senior leadership in the UN Country Team (UNCT), the new UNSDCF will reflect a transition from health emergency support to upstream health system support. The overarching concern of the next UNSDCF will be 'climate change and water safety', both with strong implications for the health sector and for WHO support. This transition away from humanitarian aid will also reduce funding for several UN agencies, including WHO, and a shift in human resource needs and location. This

[47] Country Office presentation.
[48] Health Cluster Annual Report, 2019.
[49] Health Cluster, 2020, 'Health Cluster Iraq 2019 Annual Report'.

concern was mirrored during KIIs with Country Office staff who call for a new WHO CCS to reflect the UNSDCF, especially the health chapter.

In the area of health systems support, WHO coordinates well with UN partners. The most quoted example is the collaborative development of national strategies. For the national RMNCAH strategy, WHO provided technical and strategic leadership, and UNICEF and UNFPA contributed technically and where needed financially. The result is a national strategy with broad ownership, not least by the MoH. Respondents also commended the coordination for the national nutrition strategy, the national strategy for domestic violence. Another example is WHO collaborative leadership on digitization and DHIS-2, with UNICEF involvement in EPI and nutrition components, funding and hardware. WHO also engaged UNFPA to collaborate on the DHIS-2 (for the procurement component) instead of an earlier parallel digitization initiative for procuring family planning products only.

In the area of health emergency support, the WHO leadership of the health cluster is seen as appropriate and effective by health sector partners. UN partners, international NGOs and implementing partners interviewed, including UNFPA and the United Nations High Commissioner for Refugees, appreciate WHO leadership and liaison with the MoH, as well as coordination and technical leadership. Examples of strong collaboration with the United Nations High Commissioner for Refugees are drafting the Regional Refugee and Resilience Plan (3RP), WHO supply of medicines to United Nations High Commissioner for Refugees-run refugee camps, and joint work on the health service transition plan. Humanitarian donors interviewed also appreciate WHO's leadership of the health cluster, especially sharing information and liaising with the Ministry and other health partners. One donor reportedly even channelled their financial support for the national response through WHO as a trusted intermediary.

However, with the current dismantling of the health cluster, coordination has been affected. Presently operating under the leadership of the Ministry and Departments of Health, the technical working groups were described during interviews with health partners as less effective than their health cluster predecessors, with less commitment and engagement from organizations, probably as a result of the transition and departure of various international humanitarian NGOs. The effects of dismantling the health cluster on the coordination of health partners was also reported during interviews with health partners. UN partners interviewed suggest that WHO could act as the health coordinator even as Iraq and the development sector transition out of humanitarian support and that it could continue liaising with the MoH on behalf of other health partners, so as to hold the MoH accountable and help ensure that health services continue.

Photo credit: WHO: WHO-supported Kabarto healthcare centre in Duhok governorate in Iraq – October 2022

Finding 14: The comparative advantage of WHO in Iraq includes good relations with national health counterparts, a broad health mandate and WHO's global presence.

The comparative advantage of WHO in supporting the health sector support is well established. UN counterparts see WHO as the lead in health, especially at health system level, and they recognize the value of this status over the service delivery that they sometimes refer to. This role of WHO is reflected in interviews with many MoH officials, who value to access to international expertise and best practice. That said, the evaluation also found that WHO is not seen by every MoH department as the only or main technical advisor on health systems: the directorate of planning recently requested support on UHC not only from the Regional Office but also from the World Bank.

The mandate of WHO in emergencies is debated at the highest levels. The evaluation found that the ambivalence within the Country Office about WHO's comparative advantage in operational support in health emergencies is reflected by respondents from Regional Office and headquarters. Although personal perspectives clearly vary, the evaluation found that health emergency preparedness and response is and will remain one of the three pillars of WHO's GPW13 (and the draft GPW14) and as such will remain the mandate of WHO, including Country Offices (see also the finding related to relevance and transition).

3.6 WHO achievements in Iraq since 2019

This chapter addresses some operational issues related to WHO delivering interventions and results in an efficient and timely way; allocating human and financial resources efficiently; and measuring results adequately.[50]

Finding 15. Timeliness of Country Office processes are compromised by due diligence systems in WHO Regional Office and headquarters

To ensure efficient contracting and reporting, the Country Office established a 'grant management unit'. The unit is managed by international staff based in the Erbil office due to the extensive grant management and subcontracting load happening in the emergency work. In 2021, as part of the transition, the unit moved to the WHO Baghdad office and was renamed 'Planning and Programme Management Unit'. Responsibilities widened to cover strategic planning, reporting, human resources and financial management for the entire Country Office.

WHO corporate FENSA (37) rules cause delays in contracting implementing partners, especially local NGOs. FENSA rules on working with non-state actors aim to manage reputational risk but are cumbersome and cause delay in clearance processes at headquarters. WHO headquarters staff mentioned that the processes are easier for international NGOs but that local NGOs need to be checked; this affected the Country Office's main implementing partners: Iraqi NGOs Heevi and Dary.

EMRO due diligence systems add to delays in contracting and proved problematic for health emergencies. KIIs reported procurement delays of up to seven months and situations where implementing partners had to provide services for months without funding for staff salaries. This applied to both new contracts and contract extensions. Some WHO staff report that the bottleneck is not so much the contracting or due diligence system but rather the human factor of people applying the system, as the relevant committee meets only so often. However, it was also explained that when the terms of reference change in a contract extension, additional review is needed.

EMRO quality assurance systems cause delays and reporting to donors. The Iraq Country Office report for 2022 calls for better coordination with the Regional Office and headquarters to ensure that donor reports are submitted in a timely fashion and for the Country Office to remain informed on the process (23). Some WHO staff question the added value of Regional Office and headquarters review and clearance of progress reports to donors as they typically do not alter the content. Donor representatives confirm that Country Office reporting was not smooth and suggest informal communication on pending implementation delays, in advanced of the more formal report. Donors' main concern, however, is not about formal progress reports but about ongoing informal updates, such as on disease surveillance, as they rely on WHO for intelligence on broader health contexts.

The WHO Health Emergency unit is considered more responsive than the rest of WHO, both at headquarters and Regional Office. The WHO Emergency programme reportedly signs off on contracts more quickly. During the emergency phase,[51] systems were more efficient, but the usual procedures now apply again.[52] Regional Office staff agree that for emergency situations, WHO can recruit staff faster but only for short-term contracts. They are working on a roster with prequalified staff for surge capacity, as the EMRO region experiences many emergencies that require region-specific expertise.

[50] See Annex 1, Evaluation Matrix, Question 4. "To what extent did WHO interventions deliver, or are likely to deliver results in an efficient and timely way?"

[51] This mainly refers to the period between 2014 and 2017 when there was an Islamic State of Iraq and Syria insurgency.

[52] Country Office team presentation.

WHO quality assurance of technical documents, such as national strategy documents, cause more delays than in partner UN agencies. For example, the national maternal and child health strategy, which was developed under WHO leadership carries the UNICEF and UNFPA logo but not the WHO logo, because formal endorsement was pending.[53] Regional Office staff explained that in contrast to other UN agencies, WHO's normative role requires several checks at many levels.

Finding 16. Results-based management is limited, reflecting Organization-wide challenges.[54]

A recent independent evaluation of the WHO results-based management (RBM) system concluded that there are several organizational factors that make it challenging for country offices to prioritize, determine result frameworks, monitor progress beyond outputs and learn lessons (38). Recommendations include 1) creating conditions to deliver results at country office level; 2) strengthening and simplifying monitoring systems; and 3) revolutionizing organizational learning. This evaluation found similar issues in Iraq.

In the absence of a Country Office broad results framework, Country Office staff work in silos, and link to WHO higher level results remain unclear. WHO Iraq has not articulated long-term or short-term objectives in a CCS, identified earlier as a challenge to assessing effectiveness. The Country Office has developed biennial workplans, but these do not contain a result framework either. Individual projects (for example donor-funded rehabilitation projects or a disease-specific initiative) may articulate objectives, targets and timelines, which results in WHO staff focusing on their own outputs and results and not on the larger Country Office strategy to support the health sector in Iraq. Indeed, some senior ministry officials comment on the lack of transparency of WHO reports on overall results in Iraq. This affects confidence to the extent that some MoH officials questioned the WHO mandate and benefits.

The GPW13 results framework applies to Country Office planning. Iraq **Country Office** selects outcomes and outputs from the GPW13 'menu' for each biennium (see Table 10, below). Most outcomes and outputs in operational planning documents relate to the three GPW13 pillars, especially outcome 1 (access to health services) and outcome 2 (emergency preparedness and response). WHO global programmes such as polio, tobacco, pandemic influenza are reflected in biennial workplans as separate outcomes, outputs and budgets, not as part of the three GPW pillars. They also have separate monitoring and reporting systems, as indicated below.

Table 10 GPW13 outcomes and number of outputs selected per biennial workplan[a]

	GPW Outcome	Outputs selected per outcome		
		2018–2019	2020–2021	2022–2023
1	Health services	13	11	12
2	Emergency preparedness	0	9	7
3	Social determinants	6	4	6
4	HMIS & data	0	3	2
6	WHO management	11	8	9
10	Polio eradication	1	2	1
12	Outbreak/emergency (GPW12)[b]	11	-	-

[53] Country Office presentation.

[54] See Annex 1, evaluation matrix, evaluation question 4.3: 'To what extent are the internal controls and RBM systems adequate to ensure efficient operational and timely allocation of resources and adequate measurement of results including in changing circumstances?'

[a] Summarised from Operational Planning worksheets 2018–2019, 2020–2021 and 2022–2023.

[b] Outputs under Outcome 12 were moved per GPW13 under Outcome 2 (GPW pillar 2) & Outcome 13 (WHO Health Emergencies Programme).

	GPW Outcome	Outputs selected per outcome		
		2018–2019	2020–2021	2022–2023
13	Outbreak/emergency (GPW13)	-	3	3
14	Pandemic Influenza & Humanitarian Response Plan	0	4	2
50	Tobacco control	0	0	1
	Total outputs selected	**42**	**44**	**43**

In practice, planning is incremental (continuing ongoing work) and ad hoc (based on support requests or funding opportunities). Biennial workplans lack a narrative. They consist of one spreadsheet with *top tasks* for the GPW13 *outputs* that the Country Office has prioritized for the biennium,[57] plus another spreadsheet with budget for the relevant GPW13 *outcomes*, but with no activities clearly linked to them.[58] Biennial plans are developed by individual Country Office staff prioritizing interventions in their technical area, in consultation with government counterparts and health partners. The WHO Regional Office (Project Management and Evaluation unit) approves priority interventions and a budget for activities to be funded by the WHO core budget. The workplan also includes aspirational interventions for which the Country Office needs to mobilize resources, typically the larger part of the budget (up to 80%). During implementation, WHO may respond to ad hoc requests for support from the MoH within the budget limitations and to ad hoc requests from WHO Regional Office or headquarters, for example to support the MoH in providing data for global reports or to participate in regional initiatives. In the case of Iraq, most activities (and budget) reflect donor-funded projects, for example infrastructure support or health services. WHO Iraq has started developing the 2024–2025 programme budget, with priority interventions for relevant GPW13 outputs. An EMRO survey on consultative process gave good marks on Iraq for consulting with MoH, but not with others, such as the UN or academia. The WHO Health Emergencies Programme and corporate programmes (e.g. the Polio Eradication Programme) have separate RBM frameworks altogether. Activities supported through these programmes are not included in the biennial workplans. The *WHO management system* brings core, WHE and other interventions together in terms of budget and expenditure.

Progress reporting is not a management tool for the Country Office, which perceives it as a requirement from Regional Office and headquarters. The recent RBM evaluation found that corporate level monitoring is undermined by the need for individual project and programme monitoring and that country level reporting may be overly positive, as it is self-reported and not based on a results framework. In Iraq, progress reporting to the Regional Office consists of various components.

1. *Results reports*:[59] These annual reports (midterm and end of biennium) consist of 1) "Output score cards" (32 in the case of Iraq) scoring on 5 dimensions; 2) a narrative component on successes, lessons and recommendations; and 3) an overall narrative result report. After problems with the score card method, the 2022 report was only a narrative progress on priority outputs. These reports are based on a self-assessment by the Country Office, reviewed by the Regional Office and shared with WHO headquarters and the World Health Assembly.

2. *Financial progress report*: This report is the most comprehensive, as it includes all Country Office expenditures, including GPW13-related interventions and special programmes, but not donor-funded projects. Expenditures are reported per GPW13 outcome, outputs and top task/activity.

3. *Regional Output-level KPI report*: In the absence of corporate output KPIs for GPW13, EMRO (Project Management and Evaluation unit) developed their own KPIs (for 2020–2021 and 2022–2023), which will be replaced by corporate KPIs after 2023 (see Annex 6). This report has no narrative component. It is perceived as duplicative by the Country Office staff. Iraq reports on 62 output KPIs (several KPIs per output), which are self-scored using traffic light colours. EMRO Project Management and Evaluation staff recognize that self-scoring

[57] Operational Planning for 2018–19, 2020–2021 and 2022–2023.
[58] 'Planned Cost vs Allocated PB' for 2018–19, 2020–2021 and 2022–2023.
[59] 2020 midterm Assessment Report; 2021 End of Biennium Assessment report; and 2022 mid-term report.

needs to adjust for context and be triangulated by government staff. These regional output reports do not feed directly into corporate level outcome reporting, as this is the responsibility of another unit (Division of Data, Analytics and Delivery for Impact), which uses modelling for country contributions to GPW13 pillars.

4. *Country impact case studies*: The Country Office provides case studies at outcome level for possible inclusion in the corporate WHO result report. The Country Cooperation Team at the Regional Office (not the Project Management and Evaluation unit) requests and collates these cases.

5. *Progress reports for WHO special programmes*: The Iraq Country Office reports separately on interventions funded through the WHO Health Emergency programme (for inclusion in the global WHE report) and on the polio programme (for the Polio global report).

6. *Donor narrative and financial reports*: The Country Office reports directly to relevant donors on projects.

The most significant Country Office reports are for external audiences, including donors. The Iraq Country Office has produced annual narrative reports since 2021, highlighting achievements, donor funding received and priorities for the following year. Besides, the programme planning unit prepares narrative and financial report to donors on specific activities (which involved the majority of the Country Office activities during the period 2019–2023)

The GPW13 result framework and progress reporting are not helpful for Country Office staff to monitor their achievements. Of all Country Office technical staff, only one referred to the GPW13 result framework to describe progress made in their work. Many staff recognize that GPW outputs are not useful to capture Country Office achievements (technical and strategic support) because they refer to country achievements (services and systems). The Country Office leadership interviewed recognizes that there are no systems for RBM and that – in the absence of joint and overarching results – technical people are working in silos. However, they stated that COVID and the health emergency situation were more important priorities to deal with than 'bean counting'.

Finding 17. A challenge for the Country Office is to maintain funding for its health emergency human resource capacity and operations.[60]

Engagement in health emergency work has enabled the Country Office to mobilize significant resources, but since 2019 this funding has been reduced, and it will dry up completely in 2024. Resources mobilized for emergency work were substantial, including as a proportion of the total country expenditure: 92%, 83% and 80% over the three biennia between 2019 and 2023. (see Table 11, below). Even within the WHO base programming, namely the three GPW13 pillars, the budget spent on pillar 2 (emergency preparedness and response) was consistently high compared to other pillars: 34%, 60% and 27% in the three biennia. In the biennium 2022–23, an equal proportion of the budget was spent on pillar 1 (access to health services). The budget summary below further shows that resource mobilization for health emergency support also dropped significantly. From US$ 115 million in 2018–2019 to US$ 41 million from in the current biennium. This reflects shifting donor priorities, with the humanitarian situation declared over.

Table 11 . Budget per GPW outcome area (mobilized and spent)[a]- 2018-2023

	GPW12 Outputs (2018–2019)	Budgeted	Mobilized	Spent
Base		'000 US$	'000 US$	'000 US$
1	Communicable diseases	620.3	620.3	620.3

[60] See Annex 1: Evaluation Question 4. 1 (To what extent do WHO interventions reflect efficient economic and operational use of resources?) and 4.2 (Do new and emerging health needs in Iraq require adjustment or re-prioritization of interventions, in terms of cost-effective use of resources?) are addressed in Chapter 3.3, Finding 8.

[a] Details of biennial budgets per output area can be found in Annexes 7 and 8.

	GPW12 Outputs (2018–2019)	Budgeted	Mobilized	Spent
2	NCDs	618.6	618.6	618.6
3	Public health laboratories	749.4	749.4	749.4
4	Health systems	901.2	901.2	901.2
6	Corporate functions	3438.8	3438.8	3438.8
12	WHO Health Emergencies Programme	3362.5	3362.5	3362.5
Total base		**9690.8**	**9690.8**	**9690.8**
Emergencies				
10	Polio eradication and transition plans	17 859.1	17 859.1	17 859.1
13	Outbreak, crisis response and scalable operations (OCR)	97 538.1	97 538.1	97 538.1
Total emergencies		**115 397.2**	**115 397.2**	**115 397.2**
Total		**125 087.9**	**125 087.9**	**125 087.9**

	GPW13 Outputs (2020–2021)	Budgeted	Mobilized	Spent
Base		'000 US$	'000 US$	'000 US$
1	One Billion more people benefiting from UHC	2437.2	1491.1	1418.6
2	One Billion More People Better Protected from Health Emergencies	7534.6	6628.9	5962.4
3	One Billion More People Enjoying Better Health and Well-Being	218.4	195.0	194.0
4	More effective and efficient WHO	3962.0	2360.3	2317.2
Total Base		**14 152.0**	**10 675.4**	**9892.3**
Emergencies				
10	Polio eradication and transition plans	2642.0	1002.5	1002.5
13	Outbreak, crisis response and scalable operations (OCR)	58 420.2	50 875.7	50 869.8
Total Emergencies		**61 062.2**	**51 878.3**	**51 872.3**
Special Programme				
14	Special Programmes	206.5	199.5	193.9
Special Programme Total		**206.5**	**199.5**	**193.9**
Total		**75 420.7**	**62 753.2**	**61 958.5**

	GPW13 Outputs (2022–2023)	Budgeted	Mobilized	Spent [b]
Base		'000 US$	'000 US$	'000 US$
1	One Billion more people benefiting from UHC	5763.1	3169.6	2667.2
2	One Billion more people Better Protected from Health Emergencies	5623.3	3378.1	2607.8
3	One Billion more people Enjoying Better Health and Well-Being	291.5	255.3	242.3
4	More effective and efficient WHO	8712.1	3276.5	3989.4
Total base		**20 390.0**	**10 079.4**	**9506.7**
Emergencies				
13	Outbreak, crisis response and scalable operations (OCR)	42 094.0	41 044.8	38 390.2
Total emergencies		**42 094.0**	**41 044.8**	**38 390.2**
Non-PB				
50	Partner mechanisms	5.0	4.4	4.4
Total non-PB		**5.0**	**4.4**	**4.4**
Special Programme				
14	Special Programmes	126.0	126.0	93.9
Total special programmes		126.0	126.0	93.9
Total		**62 615.0**	**51 254.6**	**47 995.2**

Resource mobilization for WHO base work (on the three GPW13 pillars) remained stable during the humanitarian phase. Although the anticipated budget for base work more than doubled from the first to the last biennium (from US$ 9.6 million to US$ 20.4 million), funds mobilized remained stable at roughly US$ 10 million per biennium (see Table 11, above).

The reduction of Country Office resources for health emergency programming has implications for human resources management. The evaluation found a Country Office that is facing the reality of downsizing its human resources. There is also clear impact on Country Office staff, notably as staff recruited for health emergency work are typically on short term contracts so as to allow flexibility. WHO senior staff mention that in most countries, country offices are generally

[b] As of October 2023.

underfunded and that the “assessed contribution” budget pays for only four staff. This is significant, as the Country Office employed around one hundred staff at some stages in the evaluation period. In 2021, when the Country Office started the transition away from health emergency in earnest, operational teams and normative teams were developed, that is teams to strengthen health systems and operational teams to implement the vision of health systems. Although the evaluation team did not have access to the current Country Office organigram, it was clear that staff numbers have decreased. Regional Office staff mention that lessons learned from the transition in the polio eradication work are that transition must happen in a phased manner and that WHO needs to work with short-term contracts. The Iraq polio programme team has downsized from 25 to 3 staff since 2019.

Advice on human resources for the Country Office is pending a functional review. Shortly before this evaluation, the Country Office underwent a functional review to make recommendations for adjusting the staffing structure in the transition. This evaluation did not have access to the functional review, nor to the current Country Office organigram. Country Office leadership mentioned that the review overestimated the financial resources available. In anticipation of the report, the Country Office leadership stated that it is important to maintain the current human resource capacity, and Regional Office colleagues argued that dedicated staff remain available for their field, for example a health information officer to follow up on the agenda to improve the health information system.

The sustainability of Country Office operations is at risk due to resources being reduced and it is mitigated by cost-cutting strategies. Examples of cost-saving strategies included co-housing the WHO warehouse in the MoH warehouse, thus saving rent. Another example was not replacing international staff positions and handing over any remaining work responsibilities to existing staff. The evaluation found that some technical officers now have responsibility for multiple portfolios. The allocation of technical areas across technical officers seems to be informal and based on availability and interest.

Some of the most effective WHO interventions were not expensive. An important finding of the evaluation is that WHO normative support and technical assistance can be cost-effective. For example, one technical officer facilitated the development of the national MNCAH strategy, with no other costs than her salary. As she is based at the MoH, it was easy to enable collaboration with the MoH and UN partners, who were willing to finance meetings and workshops.

The WHO Country Office lacks a resource mobilization strategy. According to Country Office staff, at the time of the health emergency, a resource mobilization strategy was not necessary. WHO knew most humanitarian donors and actively engaged with them. At present, however, health emergency donors are phasing out, and the Country Office faces challenges in reaching a new set of donors for non-emergency, health systems support. Therefore, some respondents now call for a resource mobilization strategy. Meanwhile, the main strategy employed is to develop project proposals for recovery and emergency preparedness support as long as there is funding, thus allowing the Country Office to charge overheads to maintain corporate functions. Regional Office colleagues recommended that the Country Office be more strategic and less reactive and match human resources according to a new strategy. They also highlight that financial resources for a resource mobilization officer are available, as Iraq is an emergency country.

Photo credit: WHO; entomology and surveillance workshop, Iraq – October 2022

4. Conclusions

This chapter draws an overarching conclusion on the full set of evaluation criteria and questions. More importantly, the evaluation identified three strategic issues for the WHO country office: developing a balanced CCS; measuring progress; and transitioning responsibly out of ongoing health emergency work. Conclusions and recommendations for these issues are presented below.

4.1 Conclusions regarding the evaluation criteria

Conclusion 1. WHO has delivered many relevant and substantive interventions in Iraq, with little evidence on effectiveness and mixed evidence on sustainability. (Findings 1–9,11–13)

In the absence of a CCS, comprehensive needs assessment and results framework, it is hard to confirm the relevance and effectiveness of WHO interventions (see Table 12, below). WHO health emergency work responds to the health needs of some of the most vulnerable populations, but it is unlikely to be sustained. WHO support for health systems strengthening is more sustainable. Coherence within the UN system is good, and WHO is appreciated for its specific normative expertise, but coherence within the three levels of the Organization is mixed, partly resulting in delays and complex monitoring and evaluation systems. The biggest threat to WHO support in Iraq is the adjustment to remain relevant and effective as the health sector needs change from health emergency to health systems support.

The evaluation concludes that in the period under review, WHO has supported Iraq mainly with health emergency responses and universal health coverage, and to a lesser extent with health systems strengthening. Unmet needs for health system support exist in the areas of (further) digitization; UHC (especially PHC and health financing); addressing the health impacts of climate change; and systems for health emergency prevention and response.

Table 12 Scoring of evaluation questions based on evaluation findings

Evaluation Criteria	Evaluation question[a]	Score	Findings[b]
Effectiveness	Output level progress		1,3,4
	Outcome level progress		2,3,4,6
	Reaching those left behind		4,5,7
	Added value EMRO/WHO headquarters		1,2,3,4,8,12
Relevance	Responsive to needs of people		1,4,5,7
	Responsive to needs of MoH		1,3,5,6
	Aligned with relevant policies		12,13
	Transition out of emergency		1,5,8
Sustainability	MoH capacity and policies		1,3,6,10,11
	Financial sustainability WHO interventions		1,9,11
	Country emergency preparedness		1,3,6,11
Coherence	Within WHO		5,12
	Within UN system		5,13
	Work as per comparative advantage		1,5,14
Efficiency	Timelines of implementation		15

[a] See the evaluation matrix in Annex 2.
[b] See Chapter 3 for the findings.

Evaluation Criteria	Evaluation question[a]	Score	Findings[b]
	Cost effectiveness or resource allocation		17
	Human resource management		17
	Result based management		2,5,16

4.2 Developing a vision: balancing health system and health emergency support

Conclusion 2. Although WHO fundamentally attends to the health needs of the people in Iraq, it has not developed a situational analysis of their priority health needs. While WHO mostly addresses the needs of the government, it has not agreed on health system priorities with the MoH. (Findings 1–7)

Conclusion 3. Despite many substantive achievements, it is hard to determine effectiveness or impact, as WHO results are poorly defined, and there is no theory of change that clearly outlines a set of coherent interventions leading to specific outcomes and contributing to WHO corporate goals. (Findings 1–6,16)

Conclusion 4. There is little synergy between the operational work from Erbil office and the health system work from Baghdad office. Health services in camps and infrastructure support for referral services are unlikely to be sustained post WHO support, whereas WHO upstream policy, strategic and technical support tends to be more sustainable. (Findings 1,3,5,6,8–11)

Conclusion 5. In an emergency-prone setting like Iraq, "transitioning out of emergency work" may imply a false dichotomy, as health systems strengthening includes strengthening systems for health emergency preparedness and response. (fFindings 1,3,5,6,8)

WHO support to Iraq has been largely determined by health emergencies but has lost focus. For understandable reasons, including a rapidly changing context and external incentives to fully engage in operational support for health emergencies responses, the Country Office has prioritized health emergency work. Since the last 5-year CCS expired, there has been little opportunity for WHO to reflect on long-term needs and strategies or engage in strategic planning. Therefore, WHO support to Iraq has lost focus.

WHO *operational support* has been useful but cannot be evaluated and has become less relevant and less sustainable. It is evident that WHO support for PHC targeting people living in camps and WHO support for the national response to COVID-19 have been major achievements. At the same time, these WHO interventions took place in relative isolation of the core work of WHO in Iraq, that is from a separate office and supported by and accountable to separate funding streams. Over the years, intervention design became incremental (more of the same) or opportunistic (driven by donor priorities or funding opportunities). As a result, for a significant part of the health emergency work of WHO, there are questions about relevance (secondary and tertiary care services), sustainability (one-off infrastructure support) or effectiveness (no stated objectives).

WHO *health system support* has become deprioritized, and important opportunities have been missed. As of 2019, WHO health system support amounted to just 10% of its total expenditure in Iraq. Due to efforts to rebalance the focus of WHO support in favour of upstream health system support, major achievements have been made in areas like DHIS-2 and national strategy development (MNCAH). However, important opportunities for stronger upstream support have been missed, including the request to support the next 10-year health strategy and emerging national health priorities such as

health financing/health insurance, climate change, and NCDs. The health emergency support office of WHO has missed evident opportunities for synergy with health systems, for instance to strengthen PHC and procurement and supply chain systems.

There are several opportunities for WHO to increase the relevance of its work in Iraq. First and foremost, as the country is about to develop its 10-year health sector priorities, WHO can support a national health situation assessment and use this as a baseline for its own long-term support strategy. Secondly, the Iraqi Government has requested WHO support for the development of the 10-year national health strategy. This is an opportunity for WHO to align its next CCS with national needs.

A new CCS will be an opportunity for synergies between health emergency and health systems support. The WHO GWP14 will retain support for member states in health emergency preparedness and response systems as one of the three pillars. This means that WHO can support Iraq –technically, strategically and through policy – in preparing for and responding to health emergencies. By integrating health system and health emergency support, WHO could usefully reduce the tendency to work in silos (assuming that the same happens at headquarters level between WHE and the rest of the Organization).

Recommendations for developing a strategic vision:

1. WHO Country Office should develop a CCS aligned with the national health strategy and the UNSDCF. (high urgency)

2. WHO Country Office should undertake a national health sector support needs assessment aligned with and informing the national strategic planning process. (high urgency)

3. WHO Country Office should incorporate all support (operational as well as normative) for health emergency preparedness and response under one strategic objective (e.g. GPW4 pillar 2). (medium urgency)

4. WHO Regional Office should support strategic planning, including situation analysis and CCS development. (high urgency)

4.3 Monitoring progress towards results

Conclusion 6. The findings and conclusions of the recent WHO Corporate RBM evaluation apply to Iraq, whereby there is no enabling environment for meaningfully monitoring and reporting progress in a way that supports the Country Office in demonstrating progress towards results. (Findings 2,5,16)

Conclusion 7. Country Office progress reporting is labour-intensive and time-consuming, consists of many products for various audiences and yet fails at aggregate level to communicate progress towards milestones. (Findings 2,5,16)

Conclusion 3 is also relevant for a discussion on monitoring progress, namely that despite many substantive achievements, it is hard to determine effectiveness or impact, as WHO results are poorly defined, and there is no theory of change.

This evaluation confirms and supports the findings and conclusions of the recent WHO Corporate RBM evaluation. Importantly, the inability to establish the effectiveness of WHO support to Iraq is due to the failure of corporate systems at headquarters and Regional Office to support the country offices. Therefore, this evaluation confirms the recommendations

1) to the WHO Secretariat to create the conditions for delivering results at Country Office level; 2) to the Secretariat and Regional Office to strengthen and simplify monitoring systems; and 3) for the Secretariat and Regional Office to revolutionize organizational learning by addressing a widespread fear of failure and creating space in country offices for reflective analysis of results (38).

A WHO CCS needs to articulate the relative contribution to health outcomes in the country of WHO versus the Iraqi Government. WHO country offices typically struggle to articulate the specific contribution of WHO to health outcomes, which hinders a meaningful contribution analysis. A theory of change would explain how WHO operational, technical, strategic and policy support would support the national systems and services.

To assess effectiveness, a CCS needs to articulate specific results. Such results would draw on the corporate result framework (GPW13 or 14), but the **Country Office** could add country-specific indicators and means of verification. In Iraq the vast majority of WHO interventions take place outside the core result framework and are therefore not included in the system to monitor progress or effectiveness. Ideally, all WHO activities should be included in the result framework and subsequent country workplans, irrespective of funding source or corporate home (such as a special programme).

Annual reports should be based on the (corporate) result framework and specify outputs as well as outcomes, allowing special reports for special audiences. As introduced in Iraq since 2021, an annual progress report is a useful product to present to internal and external audiences progress towards intended results, lessons learned, resource mobilization and expenditure. Ideally, the progress report reflects the result framework and presents achievements in relation to agreed milestones. The current corporate monitoring systems are not conducive to such reporting, as this evaluation confirmed. The absence of supportive corporate systems prevents the Country Office from developing a result framework, set milestones and targets, and report on these, as a tool for learning and accountability.

Recommendations for improving monitoring results:

5. WHO Country Office should develop a CCS that contains a theory of change and result framework with specific indicators and targets. (high urgency)
6. In line with the recommendations of the WHO Corporate RBM evaluation, especially recommendations 5, 7 and 8, WHO Secretariat and EMRO should work to create an enabling environment for measurement and learning, by simplifying the monitoring and reporting system and encouraging a culture of learning and evaluation in country offices.
7. In the meantime, the WHO Country Office should report annually based on the CCS result framework *in one single* report and develop additional documents for any additional audiences (such as donors or media) as needed. (medium urgency)

4.4 Responsible disengagement from health emergency work in Iraq

Conclusion 7. As the humanitarian crisis is winding down and national priorities and needs change, the ongoing transition of support towards health systems and disengagement from health emergency work needs to find a balance between doing it quickly but also responsibly towards those still affected. (findings 1,5,8)

Conclusion 5 (above) is also relevant for responsible disengagement, namely 'In an emergency-prone setting like Iraq, "transition out of emergency work" may imply a false dichotomy, as health systems strengthening includes strengthening systems for health emergency preparedness and response'.

The transition process has been a challenging experience for humanitarian actors in Iraq, as the country has experienced a complex protracted crisis. Aspects such as the COVID-19 pandemic, the continued insecurity in the country, sectarian and ethnic tension, the politicization of aid, and differences in the level of readiness among governorates have made it challenging to transition in Iraq; in addition, the dichotomy in governance in Iraq means that humanitarian actors have to deal with the MoHs in Baghdad (Federal Iraq) and Erbil (KRI).[65]

Timing was key to both the transition from humanitarian to development and cluster de-activation processes. According to the Inter Agency Standing Committee guidelines, cluster transition and de-activation needs to be planned once a cluster has been activated. Moreover, periodic reviews and communication between the Resident Coordinator/Humanitarian Coordinator and Humanitarian Country Team and clusters is needed to ensure that transition arrangements are placed and efforts to build counterparts' capacities are made. Furthermore, prior to decisions on de-activation, it is important for the Resident Coordinator/Humanitarian Coordinator and Humanitarian Country Team to consider residual humanitarian needs as well as the national and local context, particularly in the case of Iraq, where governance structures are more complex and fragile. Moreover, a phased approach to the de-activation of the health clusters is likely to have enabled a smoother transition/de-activation process. Furthermore, the de-activation of clusters based on their 'readiness' is also likely to have facilitated a more organic de-activation process, rather than de-activation having to take place simultaneously within a given timeline.[66]

It is likely that a longer transition period would have been appropriate for the volatile context of Iraq, where urgent humanitarian needs and human rights violations remain; the possibility of disasters to re-emerge is likely, and the capacities and willingness of national counterparts to lead sectoral coordination is low.[67] Iraq continues to be at great risk of becoming a humanitarian crisis context and is increasingly struggling with a shortage of water and frequent droughts, affecting people's livelihood and health (13, 14).

Responsible disengagement comes with these aspects in mind. Moreover, continued support to national and local counterparts is imperative even after phasing out and completion of the transition to aid them in their early recovery process and coordination.[68]

In situations like Iraq, where conflict is protracted and complex, it may make more sense to look at humanitarian, development and peace efforts to be made in parallel (that is, to take a Nexus approach (39) rather than through a transition (40). Moreover, the disconnect between humanitarian and development efforts in protracted crisis situations is likely to be a challenge to a smooth exit strategy and transition. Looking at the case of Iraq, the transition and consequent cluster de-activation process has been a challenge for responsible disengagement among the humanitarian actors.

Recommendations for responsible disengagement:

8. The WHO Country Office should advocate with counterparts to strengthen public health care services and expand these to reach and address the needs of marginalized people, including IDPs, refugees and other persons of concern, particularly those in hard-to-reach areas like camps. (high urgency)
9. The WHO Country Office should establish monitoring mechanisms to ensure that national counterparts fulfil the responsibilities that have transitioned to them in a suitable and non-discriminatory manner. (high urgency)
10. The WHO Country Office should advocate with other UN Agencies for continued funding to support the residual health needs of the most vulnerable and for pooled funding towards humanitarian-development interventions. (high urgency)

[65] GCCG to the EDG: Learning from the cluster transition in Iraq. INTERNAL.

[66] GCCG to the EDG: Learning from the cluster transition in Iraq. INTERNAL.

[67] GCCG to the EDG: Learning from the cluster transition in Iraq. INTERNAL.

[68] GCCG to the EDG: Learning from the cluster transition in Iraq. INTERNAL.

Photo credit: WHO; COVID-19 Mass Vaccination Campaign site in Iraq – November 2021

5. Recommendations

Developing a vision, balancing health system and health emergency support (conclusions 2–5)

1. The WHO Country Office should develop a CCS aligned with the national health strategy and the UNSDCF. (high urgency)
2. The WHO Country Office should undertake a national health sector support needs assessment aligned with and informing the national strategic planning process. (high urgency)
3. The WHO Country Office should incorporate all support (operational as well as normative) for health emergency preparedness and response under one strategic objective (such as GPW4 pillar 2). (medium urgency)
4. The WHO Regional Office should support strategic planning, including situation analysis and CCS development. (high urgency)

Monitoring progress towards results (conclusions 6,7 and 3)

5. The WHO Country Office should develop a CCS that contains a theory of change and result framework with specific indicators and targets. (high urgency)
6. The WHO Secretariat and Regional Office should act on the recommendations of the RBM evaluation, especially recommendations 5, 7 and 8 (to create enabling systems, simplify monitoring systems and encourage learning for country offices). (medium urgency)
7. In the meantime, the WHO Country Office should report annually based on the CCS result framework *in one single* report and develop additional documents for any additional audiences (such as donors or the media) as needed. (medium urgency)

Responsible disengagement from health emergency work in Iraq (conclusions 7 and 5)

8. The WHO Country Office should advocate with counterparts to strengthen public health care services and expand these to reach and address the needs of marginalized people, including IDPs, refugees and other persons of concern, particularly those in hard-to-reach areas like camps. (high urgency)
9. The WHO Country Office should establish monitoring mechanisms to ensuring that national counterparts fulfil the responsibilities that have transitioned to them in a suitable and non-discriminatory manner. (high urgency)
10. The WHO Country Office should advocate with other UN Agencies for continued funding to support the residual health needs of the most vulnerable and for pooled funding towards humanitarian-development interventions. (high urgency)

6. Lessons learned

This chapter contains the key lessons identified from respondents and documents. The lessons also draw on the co-creation workshop with evaluation reference group members on the key evaluation findings. Lessons selected have wider application than the Iraq context.

Lessons on working with the MoH

- Positioning WHO staff *within* the MoH is important. During the COVID-19 pandemic, WHO established a second liaison office in the KRI MoH with a dedicated liaison officer, which significantly improved the effectiveness, relevance and efficiency of WHO support in KRI.

- Building health systems in a country with "two parallel administrations" (and two MoH) is a challenge if the ministries do not cooperate well. WHO established a second office in the semi-autonomous KRI (one already existed in the federal ministry).

Lessons on balancing health systems support with disease-specific programming support

- WHO supports vertical programmes as well as cross-cutting health systems strengthening. The Country Office learned that if WHO support for vertical programmes ignores cross-cutting health system challenges (such as health information systems), support may become fragmented. WHO support for vertical programmes is more effective, relevant and sustainable if relevant health systems are addressed.

Lessons on health emergency response versus health systems support

- During a health emergency with acute needs, it may be challenging to engage in a dialogue on health system strengthening, which has longer time horizons and more distant outcomes. However, a lesson learned by the WHO Country Office was that there are significant synergies and a false dichotomy between health emergency and health system support. Health emergency preparedness is part of health systems strengthening. In fact, a health emergency, like the COVID-19 pandemic or the humanitarian situation in Iraq, can support a policy dialogue on health emergency and response. For example, the WHO Country Office learned that the WHO warehousing, procurement and supply chain activities funded through the health emergency programme provide an opportunity for strengthening MoH procurement systems, especially as they are co-located within the government warehouse.

- UN partners learned that a health emergency, and humanitarian funding, may create perverse incentives in terms of prioritization of operational support over normative support. WHO and other health partners may be guided by donor priorities and funding for immediate and highly visible humanitarian support, often with restrictions in terms of target population or location, rather than broader national health needs. This jeopardizes relevance and the scaling potential sustainability of support. UN agencies 'distanced' themselves from the Federal Government as they prioritized donor-funded projects in the KRI. Country Office experience confirms that MoH saw WHO at some stage mainly as an emergency provider. UN partners urge WHO to focus on the normative role of the UN system.

- Health systems support is more sustainable than health emergency support, as it builds national capacities.

Lessons on health emergency work

Responsible disengagement from health emergencies

- Health emergencies tend to be protracted, and premature funding cuts to WHO health service support are a risk, as health services cannot stop. Other agencies have better systems for surge capacity, big operational presence and departure after the acute phase.

- A WHO implementing partner took over the MSF hospital when they no longer had funding. MSF tried to hand over to the Department of Health, but the quality of services were likely to drop. WHO financial and administrative support enabled continued hospital services, but this presents a sustainability and reputational risk to WHO's exit strategy.

Financial Sustainability

- Sustainability of infrastructure interventions needs a budget line for maintenance.

Programmatic sustainability of normative support

- Quick turnover of government staff prevented the transfer of skills and capacities.

- Iraq as an upper middle country has contributed financially to UN support, for example to UNCTA for digitization of the customs department.

- Some of the most effective WHO interventions were not expensive. For example, one technical officer facilitated the development of the national maternal and child health strategy, with no other costs than her salary. She is based at the MoH, which enables collaboration and works with UN partners that contributed (financially) to meetings and workshops.

Coherence within UN

- Coordination in the UN system is imperative, and competition does not help anybody.

- WHO could act as the health coordinator even as Iraq and the development sector transition out of humanitarian support; it could continue liaising with the MoH on behalf of other health partners.

Implementation, timeliness

- To copy donors in on reports which are sent to the WHO Regional Office and headquarters for processing – so donors do not experience late reporting.

Implementation, financial reporting

- A limitation of the current management system is that one cannot have financial information per major intervention area, only at top task level or at output level.

Human Resource Management

- Transition must happen in a phased manner (unlike in Nigeria, where the tap was turned off), and WHO needs to work with short-term contracts. The Iraq polio programme team has downsized from 25 to 3 staff since 2019.

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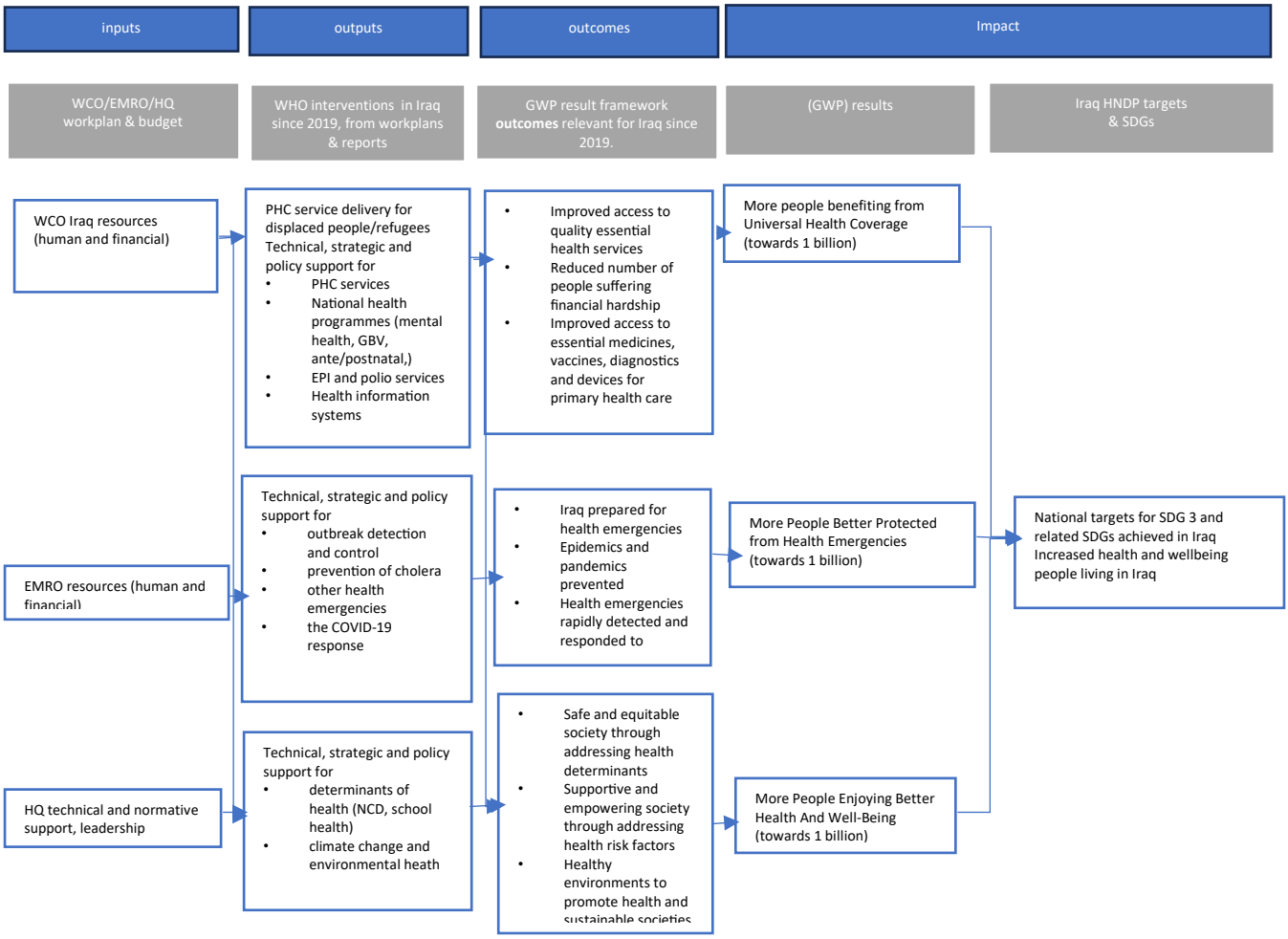
8. Annexes

1. Proposed theory of change for WHO support to Iraq
2. Evaluation matrix
3. Data collection tools
4. Bibliography
5. Progress per EMRO key performance indicators for GPW13 outputs
6. Budget per GPW outcome area for each biennium
7. Allocated programme budget per biennium
8. Outputs of co-creation workshop

Annex 1. Proposed Theory of Change for WHO support to Iraq



assumptions

WHO resources are relevant to country needs	WCO activities coordinated with EMRO & HQ, with MOH and other national counterparts, national partners, international partners including UNCT, and responsive to emerging needs and opportunities.	Iraq national authorities provide health services using the support of WHO	Iraq national health goals aligned with SDGs

Annex 2. Evaluation matrix

Evaluation sub-questions	Indicator/measure	Main source of information
EQ1 - To what extent are WCO's interventions relevant to the context and the evolving needs and health rights of the Iraqi population, including IDPs, as well as country and regional partners and institutions' needs, policies, and priorities, and continue to do so if circumstances change? **(relevance)**		
1.1 To what extent have WHO's objectives (including any adjustment of objectives) and interventions responded to *Iraq's needs* and rights, including those of the most marginalized populations?	1. WCO country strategy and interventions strategies: 1) contain evidence on relevant health diagnostics, including of those most left behind (incl. IDP, women, minorities); and 2) align with health priorities of the national health development plan and national SDG targets. 2. Evidence that the WHO strategy, priorities and interventions are reviewed and revised based on emerging evidence of health needs.	**Document review** - WCO strategies - any adaptations made to global or regional strategies - national strategies - health research **KII** - WCO staff - MoH, health authorities - health researchers - health workers - NGOs
1.2 To what extent have WHO's objectives (including any adjustment of objectives) and interventions responded to the *country's and partners' policies and support priorities*?	1. WCO country strategy and interventions align with 1) the priorities of the national health development plan and national SDG targets; and 2) the priorities of MoH and other relevant ministries and partners. 2. Evidence that the WHO strategy, priorities and interventions are reviewed and revised based on evolving support needs and priorities of national counterparts.	**Document review** - WCO strategies - national strategies - research **KII** - WCO staff - MoH - national partners - development partners
1.3 To what extent are WHO interventions aligned to country and subnational partners' and institutions' policies and priorities?	1. WCO country strategy and interventions demonstrate: 1) how they align with national policies and efforts; and 2) the comparative advantage of WHO vis-à-vis other stakeholders. 2. Evidence that interventions are regularly reviewed and revised based on contextual changes and analysis, in coordination with national counterparts	**Document review** - WCO strategies - national strategies - partner strategies **KII** - WCO staff - MoH, - regional health authorities - service providers
EQ2 - To what extent are WHO interventions coherent and demonstrate synergies and consistence with one another as well as with interventions carried out by other partners and institutions in Iraq? **(coherence)**		
2.1 To what extent are WHO interventions aligned internally between WCO, EMRO and headquarters, as well as with WHO GPW13 and its result areas?	1. WCO country strategy and interventions: 1) align with the WHO GWP13; 2) align with EMRO priorities; 3) align with WHO disease specific priorities and guidance; and 4) demonstrate how interventions	**Document review** - WCO strategies, biennial workplans and budget - EMRO strategies - WHO technical strategies **KII**

Evaluation sub-questions	Indicator/measure	Main source of information
	support and enhance each other towards the WCO strategic objective (e.g. in a theory of change). 2. Evidence that strategic choices and interventions are regularly reviewed and revised based on emerging priorities and evidence, in coordination with EMRO and headquarters.	- WCO staff - WHO technical staff - EMRO (CSU and others)
2.2 To what extent are WHO interventions aligned with country and regional partners' (e.g. UNSDCF) and institutions' policies and priorities and other sector-specific policies (e.g. SDGs)?	1. WHO country strategy and interventions: 1) demonstrate the comparative advantage of WHO; and 2) align with the UNSDCF priorities and modus operandi. 2. Level of clarity among UN partners about the role of WHO in Iraq. 3. Evidence that strategic choices and interventions are regularly reviewed and revised based on emerging priorities and evidence, in coordination with UN partners.	**Document review** - WCO strategies - UNDSCF - UN partner strategies - research **KII** - WCO staff - UNCT (UNRC, UNICEF, UNFPA, the World Bank, etc.) - health cluster members
2.3 What has been WHO's comparative advantage in Iraq, especially in relation to others?	1. WCO country strategy and interventions demonstrate the comparative advantage of WHO. 2. Level of clarity among counterparts about the role of WHO in Iraq.	**Document review** - WCO strategies - research **KII** - WCO staff - MoH, implementers, donors
2.4 What adaptations and refinements are needed to improve its positioning?	1. Evidence of current and expected health sector needs in Iraq 2. Evidence of current and projected external support for the health sector in Iraq 3. Evidence of current and expected UN system priorities for Iraq 3. WHO/EMRO global and regional strategic priorities relevant for Iraq	**Document review** - national strategies - UNSDCF - WHO GWP/technical strategies - health research **KII** - MoH, national counterparts - WHO/EMRO leadership - UNRC, UNCT, UN agencies - development partners - health researchers
EQ3. To what extent were WHO results (including contributions at outcome and system level) achieved or are they likely to be achieved, and what factors influenced (or not) their achievement? **(effectiveness)**		
3.1 To what extent were programme outputs (including any adjustment) delivered, and to what extent did WCO outputs contribute to progress *toward the stated WCO outcomes*?	1. Level of achievement for each priority in biennial WCO workplans 2. Level of achievement for overall outcomes in WCO strategic documents 3. Identification of key results and best practices	**Document review** - WCO progress & annual reports - WCO financial/progress reporting on WHO dashboard (online) **KII** - WCO staff - WHO/EMRO staff - development partners/donors
3.2 To what extent did WCO outputs contribute to the reduction of inequalities and exclusion,	1. Level of achievement on equity outcomes in WCO strategy or biennial workplans	**Document review** - WCO progress & annual reports

Evaluation sub-questions	Indicator/measure	Main source of information
related to socio-economic and environmental determinants of health?	2. Identification of key results for marginalized population and best practices in addressing social determinants of health 4. Identification of key results and best practices	- WCO financial/progress reporting on WHO dashboard (online) **KII** - WCO staff - WHO/EMRO staff - MoH and national counterparts - development partners/donors - researchers - NGOs
3.3 To what extent has WHO demonstrated a reasonable contribution at the outcome or health system level? To what extent has WHO supported Iraq's national longer-term goals	1. Level of achievement of national health and health systems outcomes 2. Indication of role played by WHO in the development of the national health agenda 3. Indication of role played by WHO in development of main national partners in the health sector 4. Identification of key results and best practices	**Document review** - national health statistics, progress reports and score cards - WCO progress & annual reports **KII** - WCO staff - MoH and national counterparts - development partners - health researchers - NGOs - development partners/donors
3.4 What has been the added value of regional and headquarters contributions to the achievement of results in Iraq?	1. Indication of headquarters/EMRO contribution to design and implementation of relevant WCO activities in Iraq 2. Indication of participation of the country partners in regional or global initiatives/capacity development opportunities directly linked to WCO priorities 3. Indication of key national capacities developed, or changed practices following WHO support and capacity development activities 4. Identification of added value from the above 5. Identified key results and best practices	**Document review** - Headquarters/EMRO progress reports - WCO progress & annual reports **KII** - WCO staff - WHO/EMRO staff - MoH and national counterparts - development partners/donors
3.5 What factors influenced their achievement or non-achievement?	1. Identification of internal and external barriers and facilitators for achieving WCO activities, outputs, and results 2. Identification of lessons learned and best practices of WCO contributions	**Document review** - WCO progress & annual reports **KII** - WCO staff - WHO/EMRO staff
EQ4. To what extent did WHO interventions deliver, or are they likely to deliver results in an efficient and timely way? **(efficiency)**		
4. 1 To what extent do WHO interventions reflect efficient economic and operational use of resources?	1. Identification of relative costs of each WCO intervention, vis-à-vis total programme expenditure and perceptions on effectiveness (see EQ3.1)	**Document review** - WCO progress & annual reports - WCO financial reporting **KII** - WCO staff - WHO/EMRO staff

Evaluation sub-questions	Indicator/measure	Main source of information
4.2 Do new and emerging health needs in Iraq require adjustment or re-prioritization of interventions, in terms of cost-effective use of resources? (See also 1.2)	1. Identification of national health priorities, including external support needs 2. Evidence of WHO comparative advantage to support the national health sector 3. Evidence of relative value for money of current and potential support strategies	**Document review** - National health policies - UNDSCF - WCO-Government of Iraq prioritization reports **KII** - WCO staff - WHO/EMRO staff - MoH and national counterparts - development partners/donors
4.3 To what extent are the internal controls and RBM systems adequate to ensure efficient operational and timely allocation of resources and adequate measurement of results, including in changing circumstances?	1. Evidence of effective internal control systems for planning and resource allocation 2. Evidence of effective internal systems to report progress & expenditure, to measure results and for organizational learning	**Document review** - WCO progress & annual reports - WCO financial/progress reporting **KII** - WCO staff - WHO/EMRO staff - WCO donors
EQ5. To what extent has WHO contributed towards building national capacity and ownership for addressing Iraq's humanitarian and development health needs and priorities, especially as Iraq transitions to development status? **(sustainability)**		
5.1 To what extent have WHO interventions supported national ownership and capacity on the relevant health policies and strategies?	1. Evidence of national partners mobilizing additional resources to enhance and sustain outputs and outcomes of WCO supported interventions 2. Indication of continued activities by national partners following end of WHO support 3. Other evidence that WCO intervention benefits will be sustained over time.	**Document review** - WCO progress & annual reports - National health strategies **KII** - WCO staff - MoH and national counterparts - development partners/donors - researchers - NGOs
5.2 To what extent have WHO interventions supported national ownership for health system strengthening, a resilient, shock-responsive health system and national capacity in view of ongoing and future health needs (including emergencies)?	1. Evidence of national partners mobilizing additional resources to enhance and sustain outputs and outcomes of WCO support for health systems strengthening 2. Evidence of national and regional partners capacity to address health emergencies 3. Indication of continued activities by national partners following end of WHO support 5. Other evidence that WCO support for health system strengthening will be sustained over time	**Document review** - WCO progress & annual reports - National health strategies **KII** - WCO staff - MoH and national counterparts - development partners/donors - researchers - NGOs

Annex 3. Data collection tools

Key informant interview topic guide

Questions
EQ1 – Relevance of the WHO work in Iraq in the period since 2019 In your view, to what extent does the WHO work in Iraq respond to the needs of the country?
1.1 What about the needs and priorities of Iraqi people including marginalized populations?
1.2 What about the needs and priorities of the Iraqi Government, e.g. *policies and support needs*?
1.3 What about the needs and priorities of the local governments and counterparts?
1.4 Has the WHO responded to changing needs, for example COVID, and balancing humanitarian and longer-term development needs? How?
EQ2 – Coherence, internal and external alignment of WHO's work in Iraq In your view, to what extent are WHO interventions aligned with interventions carried out by other partners in Iraq, since 2019?
2.1 What about alignment of activities of the WHO Country Office, Regional Office and headquarters? (and alignment with GWP13 outcomes)
2.2 What about alignment with UN partners and humanitarian partners? (and the UNSDCF)
2.3 What is the comparative advantage of WHO in Iraq, in relation to others?
2.4 What adaptations and refinements are needed to improve WHO's positioning?
EQ3. WHO results in Iraq since 2019 In your view, what is the main contribution of WHO in Iraq (vis-à-vis WHO's objectives) since 2019
3.1 What has WHO achieved in terms of 1) humanitarian work in Iraq and 2) supporting the health sector in Iraq
3.2 Did WHO interventions reduce health and social inequalities?
3.3 Did WHO interventions support Iraq's health system and longer-term goals?
3.4 What was the added value of regional and headquarters support in Iraq?
3.5 Any lesson on barriers and facilitators of WHO's impact in Iraq
EQ4. Efficiency of WHO implementation What is your view of the efficiency and timeliness of WHO's work?
4. 1 What about cost-effective use of human and financial resources?
4.2 Looking to emerging health needs in Iraq, how should WHO allocate staff and budget?
4.3 What about WHO systems to measure results and identify new support priorities?
4.4 What about the timeliness of WHO's support?
EQ5. Sustainability of WHO's work in Iraq In your view, did WHO build lasting national capacity to addressing Iraq's humanitarian and health needs?
5.1 What about national ownership/capacity for health policy development?
5.2 What about national ownership/capacity for health system strengthening (incl. emergency preparedness)?
EQ6. Any other comment on the WHO in Iraq?
6.1 Any lesson for the future in Iraq?

Focus group discussions topic guides

Preliminary Form for all FGDs

Location:	
Date of FGD:	
Age range of Participants:	
Number of women attending:	
Number of men attending:	
Name of interviewer:	
Start time of interview:	
End time of interview:	

Introduction and consent

My name is…….. I am a consultant working for WHO on an evaluation of its work in Iraq. The objective of the evaluation is to understand how WHO and its partners have supported your and other IDP/HCs' health needs (they might not know what IDP means). WE want to provide advice to WHO and partners on how to improve their work. The period we are especially focused on is 2019 to 2023. The FGD will take about 1 to 1.5 hours.

This discussion is anonymous, and we will not identify you by name or attribute any remarks or quotes directly to you. You have the right to stop participating from this FGD at any time. Also if any issues we talk about today make you feel upset or sad, let me know and I can direct you to the right person/Focal Point of the organisation

Do you agree to proceed with the FGD?

Any person refusing to agree must not participate in FGD

Do you agree for the FGD to be audio recorded?

Audio recording carried out only if all participants accept the FGD to be audio recorded.

Interview Guide for FGDs- Sharia Camp

Intro	
1.	Can you please introduce yourselves
Age, area of residence, originally from, marital status, special needs, number of years receiving services from WHO and/or [name of Implementing partner]?	
Relevance	
2.	Think back from 2019 until now - what are the health issues you needed **support** (like for example, treatment, medication, etc.) for from [this centre and others supported by [name of partner]]/ [or **activities** under the partner (like for example COVID-19 awareness, health awareness, etc.)]
3.	How did the support/activity you received /took part in help address your health needs? (what was most useful, less useful, giving examples) and why?
Effectiveness	
4.	How **easy/difficult it was to access** the service(s)/activities? If easy, please explain why giving examples. If difficult, please explain challenges how they were addressed (if at all).
5.	What was the **quality** of the support you received? (*Prompts*: Can you describe for ex, how the consultation took place, the advice they gave you, were you explained things in a simple way, was the

	information clear in terms of what you had to do to prepare (eg for a surgery) or what you had to do after…etc)
6.	What **suggestions would you have to improve** the support (or activities) that you received/ took part in [from the partner] so that it allows you to become independent?
7.	Did the support/activities you received affected your health, or changed the way you think about things or the way you usually behave (if at all)? If so, please explain what and how? (For example, COVID-19 awareness changing hygiene practices/ treatment improving well-being, etc.)
Cross-Cutting issues	
8.	Do you feel like it is easier for some people to receive these health-related services than others? (ex: people with disabilities, women, people from other ethnicities, people without IDs, people in rural/urban areas, people who are displaced, people who are refugees, etc.) Why or why not?
9.	What kind of things helped you receive health care services/activities? (ex: the partner provided transportation, the partner covered costs of medication, the partner
Feedback and Complaints	
10.	Have you ever shared your feedback or made a complaint about the support you received you took part in as part of the project? If yes, how was your feedback/complaint dealt with? If not, why not?
Closing	
11.	Is there anything you would like to say that we haven't talked about today?
Evaluator's reflective notes	

Interview Guide for FGDs with Beneficiaries – Tal Mark

Intro	
1.	Can you please introduce yourselves
Age, area of residence, originally from, marital status, special needs, number of years receiving services from WHO and/or [name of Implementing partner]?	
Relevance	
2.	Think back from 2019 until now - what are the health issues you needed **support** (like for example, treatment, medication, etc.) for from [this centre and others supported by [name of partner]]/ [or **activities** under the partner (like for example COVID-19 awareness, health awareness, etc.)]
3.	How did the support/activity you received /took part in addressing your health needs? (what was most useful, less useful, giving examples) and why?
Effectiveness	
4.	How easy/difficult is it to access services/activities? If it is easy, can you explain with examples? If difficult, please explain the challenges and how (if any) they were addressed.
5.	What kind of support did you receive? (For example: Can you describe how you were consulted, did they explain things in a simple way, was the information clear in terms of what you had to do to prepare (e.g. surgery) or what you had to do next?

6.	What **suggestions would you have to improve** the support (or activities) that you received/ took part in [from the partner] so that it allows you to become independent?
7.	Did the support/activities you received impact your health, change the way you think or the way you normally behave (if at all)? If so, please explain what has changed and how? (Example: (COVID-19) awareness, changing hygiene/treatment practices, etc.)
Cross-Cutting issues	
8.	Do you think that people in your community have an equal opportunity to access support from WHO and/or partners?
9.	What things helped you obtain healthcare services/activities? (i.e: Did the partner provide transportation, cover medication costs)?
Feedback and Complaints	
10.	Have you ever shared your feedback or made a complaint about the support you received you took part in as part of the project? If yes, how was your feedback/complaint dealt with? If not, why not?
11.	Have you ever received feedback/complaints from patients? If so, have you made any changes based on their feedback? If no, why not?
Closing	
12.	Is there anything you would like to say that we haven't talked about today?
Evaluator's reflective notes	

Interview Guide for FGDs – Tal Mark Emergency and Maternity Hall in Tammar – Tal Afar

Intro	
1.	**Can you please introduce yourselves**
Age, area of residence, originally from, marital status, special needs, , number of years receiving services from WHO and/or [name of Implementing partner]?	
Relevance	
2.	Tell me about the types of support you received from the WHO (and/or partners) since 2019? Please give specific examples to showcase support/services while displaced and when you returned to your area of origin)
3.	Could you tell me how the support you received from the WHO and/or partners addressed your major needs? (What did you find most useful? Why? What did you find least useful? Why?
4.	Were you asked about the services that you needed before being provided the support? If yes, please explain how this took place.
Effectiveness	
1.	What has been your experience receiving support from WHO staff/implementing partners? (Discuss the quality and accessibility of support

2.	Did you face any challenges getting support? If so, please explain what the challenges were and how (if any) they were addressed.
3.	What suggestions could improve the support (or assistance) you have received from WHO and/or partners to become independent?
Cross-Cutting issues	
4.	Do you think that people in your community have an equal opportunity to access support from WHO and/or partners?
5.	Do some people have less access to center/clinic services than others? If so, who are they and why? What measures is the center taking to address this - if any?
Feedback and Complaints	
1.	Have you ever shared your feedback or made a complaint about the support you received you took part in as part of the project? If yes, how was your feedback/complaint dealt with? If not, why not?
2.	Have you ever received comments/complaints from patients? If so, were any changes made based on their feedback/comments? If no, why not?
Closing	
3.	Is there anything you would like to say that we haven't talked about today?
Evaluator's reflective notes	

Interview Guide for Clinic staff

Intro	
1.	**Can you please introduce yourselves**
Age, area of residence, originally from, marital status, special needs, , number of years receiving services from WHO and/or [name of Implementing partner]?	
Relevance	
2.	Tell me about the types of support you received from the WHO (and/or partners) since 2019? Please give specific examples to showcase support/services while displaced and when you returned to your area of origin)
3.	Could you tell me how the support you received from the WHO and/or partners addressed your major needs? (What did you find most useful? Why? What did you find least useful? Why?
4.	Were you asked about the services that you needed before being provided the support? If yes, please explain how this took place.

Effectiveness	
1.	What has been your experience receiving support from WHO staff/implementing partners? (Discuss the quality and accessibility of support
2.	Did you face any challenges getting support? If so, please explain what the challenges were and how (if any) they were addressed.
3.	What suggestions could improve the support (or assistance) you have received from WHO and/or partners to become independent?
Cross-Cutting issues	
4.	Do you think that people in your community have an equal opportunity to access support from WHO and/or partners?
5.	Do some people have less access to center/clinic services than others? If so, who are they and why? What measures is the center taking to address this - if any?
Feedback and Complaints	
1.	Have you ever shared your feedback or made a complaint about the support you received you took part in as part of the project? If yes, how was your feedback/complaint dealt with? If not, why not?
2.	Have you ever received comments/complaints from patients? If so, were any changes made based on their feedback/comments? If no, why not?
Closing	
3.	Is there anything you would like to say that we haven't talked about today?
Evaluator's reflective notes	

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Annex 5. Progress per EMRO performance indicators for GPW 13 outputs

Output	KPI	KPI Definition	2019	2020	2021	2022
		% incomplete	61/62	14/62	10/62	5/62
		% satisfactory (green)	1/62	21/62	28/62	30/62
		% unsatisfactory (red)	0/62	8/62	4/62	7/62
		Pillar 1: access to health services				
1.1.3	1.1.A	Status of adoption/update of WHO reproductive and maternal health guidelines				
1.1.3	1.1.B	Status of implementation of key community and facility-based interventions for new-born and child health & development				
1.1.3	1.1.C	Status of achievement of the Eastern Mediterranean Vaccine Action Plan targets				
1.1.2	1.1.D	Status of integration of cardiovascular risk factors assessment and management at PHC level				
1.1.2	1.1.E	Status of adoption of the UNGA political declaration and multi-sectoral accountability framework				
1.1.1	1.1.F	Percentage of Health care facilities that have implemented UHC essential package of services				
1.1.1	1.1.G	Status of implementation of the WHO PHC quality indicators				
3.1.1	1.1.H	Status of the emergency care assessment and related roadmap				
1.1.2	1.1.I	Status of implementation of the mental health gap action programme				
1.1.4	1.1.J	Status of implementation of governance actions to develop/recover the health system				
1.1.5	1.1.K	Status of implementation of the health workforce strategic plan				
1.2.1	1.2.A	Status of development of the health financing strategy				
1.2.2	1.2.B	Status of implementation of national health accounts				
1.3.5	1.3.A	Status of national AMR surveillance reporting in Global Antimicrobial Resistance and use Surveillance System				
1.3.1	1.3.B	Status of National list of Essential Medicines				
1.3.3	1.3.C	Existence of an institutional development plan for drug regulation				
1.3.3	1.3.D	Status of development of national control testing policy for medical products				
1.3.2	1.3.E	Status of medicines pricing policies and monitoring systems.				
1.3.2	1.3.F	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis				
1.3.4	1.3.G	Assessed status of research priority agenda for access to essential medical products				
1.3.1	1.3.H	Status of National list of Priority Medical Devices				

Output	KPI	KPI Definition	2019	2020	2021	2022
		Pillar 2: Emergency preparedness and response				
2.1.1	2.1.A	Status of implementation of simulation exercises using WHO tools and guidelines				
2.2.2	2.1.B	Officially nominated rapid response teams at all levels (national, regional)				
2.3.2	2.1.C	Percentage of medical commodities received from WHO Dubai platform				
2.3.1	2.1.D	Status of adaptation and implementation of the real-time early warning surveillance framework				
2.3.1	2.1.E	Percentage of signals detected by the Regional Office which have been verified within 72 hours				
2.1.1	2.1.F	Status of country State Party Self-Assessment Annual Reporting on IHR implementation.				
2.1.2	2.1.G	Status of using findings from the IHR monitoring framework to develop or update the national action plans				
1.1.3	2.2.D	Status of development of the polio transition plan				
2.2.2	2.2.H	Status of capacity-building on Field Epidemiology to prevent potential disease outbreaks caused by high-threat pathogens				
2.2.2	2.2.I	Percentage of health facilities covered by the national prevention strategic plans for epidemic prone diseases				
2.3.1	2.3.B	Status of event risk assessments (public health situation analysis for events) within recommended timeframe				
2.3.3	2.3.C	Status of implementation of the surveillance system for attacks on health care				
2.3.3	2.3.D	Status of the National response plans to provide health services for migrants, refugees, and displaced populations				
		Pillar 3: social determinants of disease				
3.3.1	3.1.B	Status of implementation of a surveillance mechanisms(surveys) for reporting on drinking water safety				
3.3.1	3.1.C	Status of development and implementation of the national action plan on health resilience to climate change				
3.3.1	3.1.E	Status of implementation of the health impact assessment of air pollution				
3.2.2	3.2.A	Status of implementation of the national multi-sectoral action plan				
3.2.1	3.2.B	Utilization of STEPS survey findings to develop evidence-based policies, and set national targets on NCDs				
3.2.1	3.2.C	Status of enforcement of total bans on advertising promotion and sponsorship of tobacco				
3.2.1	3.2.D	Status of introduction of the regional package of inter-sectoral policies and interventions into their national health systems				
3.3.2	3.3.A	Status of establishment of the needs, priorities and plans of action for HiAP				
3.3.2	3.3.B	Status of incorporation of environmental health into health city programmes				

Output	KPI	KPI Definition	2019	2020	2021	2022
3.3.2	3.3.C	Status of road map on healthy workplace and environmental systems in health care facilities				
3.3.2	3.3.D	Status of the development and integration of a national school health service package into education system				
3.3.2	3.3.E	Status of integration of community engagement principles and activities in the Country Support Plan				
		Corporate performance				
4.1.3	4.1.A	Number of research papers published by institutions based in the Country in peer-reviewed journals anywhere in the world				
4.1.1	4.1.B	Status of actions included in the health information system improvement plan based on the assessment findings				
4.2.1	4.2.A	Status of fulfilment of the key strategic communication resources				
4.2.1	4.2.B	Percentage of leadership and health diplomacy events organized with the support of WHO				
4.2.3	4.2.C	Percentage of allocated budget mobilized (both base and OCR funding)				
4.2.3	4.2.D	Percentage of partnerships established to cover gaps for preparedness and response activities				
4.2.4	4.2.E	Status of submission of the Output Score Card and KPIs reports				
4.2.4	4.2.F	Status of the CCS				
4.3.4	4.2.I	Annual goods procurement plans prepared and submitted timely				
4.2.5	4.2.J	Operational and maintenance service contracts are executed through negotiated Long Term Agreements				
4.2.2	4.3.A	Overall score of the managerial KPIs				
4.3.1	4.3.B	Percentage of the funds utilized out of the total available per Budget Centre				
4.3.2	4.3.C	ePMDS: Prior year performance reviews, current year objectives and mid-year performance review fully executed				
4.3.2	4.3.D	Inter/national staff recruitments are completed within 15 weeks of the initial request				
4.3.3	4.3.E	Guarantee high availability of IT network services				
4.3.4	4.3.F	The annual self-assessment of Security Risk Management and compliance with UNDSS security policies is submitted in timely fashion				

Annex 6. Budget per GPW outcome area for each biennium in US$

	GPW12 Outputs (2018–2019)	Planned	Received	Used
Base				
1	CAT 1 Communicable diseases	620 299	620 299	620 299
2	CAT 2 NCDs	618 601	618 601	618 601
3	CAT 3 Public health laboratories	749 433	749 433	749 433
4	CAT 4 Health systems	901 223	901 223	901 223
6	CAT 6 Corporate functions	3 438 754	3 438 754	3 438 754
12	CAT 12 WHO Health Emergencies Programme	3 362 457	3 362 457	3 362 457
Total	**base**	**9 690 767**	**9 690 767**	**9 690 767**
Emergencies				
10	Polio eradication and transition plans	17 859.073	17 859 073	17 859 073
13	Outbreak, crisis response and scalable operations (OCR)	97 538.097	97 538 097	97 538 097
Total	**emergencies**	**115 397.170**	**115 397 170**	**115 397 170**
Total		**125 087.937**	**125 087 937**	**125 087 937**

	GPW13 Outputs (2020–21)	Planned	Received	Used
Base				
1	One Billion more people benefiting from UHC	2 437 166	1 491 139	1 418 641
2	One Billion More People Better Protected from Health Emergencies	7 534 463	6 628 907	5 962 384
3	One Billion More People Enjoying Better Health and Well-Being	218 372	195 006	194 035
4	More effective and efficient WHO providing better support to countries	3 961 963	2 360 336	2 317 239
Total Base		**14 151 964**	**10 675 388**	**9 892 298**
Emergencies				
10	Polio eradication and transition plans	2 642 000	1 002 526	1 002 526
13	Outbreak, crisis response and scalable operations (OCR)	58 420 166	50 875 743	50 869 776
Total Emergencies		**61 062 166**	**51 878 269**	**51 872 301**
Special Programme				
14	Special Programmes	206 517	199 517	193 857
Special Programme Total		206 517	199 517	193 857
Total		**75 420 647**	**62 753 174**	**61 958 456**

	GPW13 Outputs (2022–23)	Planned	Received	Used[a]
Base				
1	One Billion more people benefiting from UHC	5 763 097	3 169 562	2 667 187
2	One Billion More People Better Protected from Health Emergencies	5 623 327	3 378 053	2 607 764
3	One Billion More People Enjoying Better Health And Well-Being	291 500	255 266	242 319
4	More effective and efficient WHO providing better support to countries	8 712 063	3 276 509	3 989 421

[a] As of October 2023.

	GPW13 Outputs (2022–23)	Planned	Received	Used[a]
Total base		**20 389 987**	**10 079 390**	**9 506 692**
Emergencies				
13	Outbreak, crisis response and scalable operations (OCR)	42 094 014	41 044 812	38 390 222
Total emergencies		**42 094 014**	**41 044 812**	**38 390 222**
Non-PB				
50	Partner mechanisms	5000	4391	4366
Non-PB Total		5000	4391	4366
Special Programme				
14	Special Programmes	126 000	126 000	93 874
Special Programme Total		126 000	126 000	93 874
Total		**62 615 001**	**51 254 593**	**47 995 154**

Details 2018–2019

	GPW12 Outputs	Planned	Received	Used
	BASE			
1	**CAT 1 CMD (communicable diseases)**	**620 299**	**620299**	**620 299**
1.1.1	Increased capacity of countries to deliver key HIV interventions	10 564	10 564	10 564
1.1.2	Increased capacity of countries to deliver key hepatitis interventions	24 407	24 407	24 407
1.2.1	Worldwide adaptation and implementation of the End TB Strategy	145 779	145 779	145 779
1.4.1	Implementation and monitoring of the WHO roadmap for neglected tropical diseases	203 018	203 018	203 018
1.5.1	Implementation and monitoring of the global vaccine action plan, plus service delivery and immunization monitoring	178 376	178 376	178 376
1.6.1	Countries have essential capacity to implement national action plans for antimicrobial resistance	58 155	58 155	58 155
2	**CAT 2 NCD**	**618 601**	**618 601**	**618 601**
2.1.1	Development and implementation of national multisectoral policies and plans for NCDs	479 067	479 067	479 067
2.1.1	Countries' capacity to develop and implement national policies, plans and information systems for mental health	67 575	67 575	67 575
2.3.1	Development and implementation of multisectoral plans and programmes to prevent injuries and Road Safety	12 000	12 000	12 000
2.4.1	Implementation of the WHO global disability action plan 2014–2021	42 134	42 134	42 134
2.6.1	Countries enabled to control the risk and reduce the burden of foodborne diseases	17 825	17 825	17 825
3	**CAT 3 PHL (Public health laboratories)**	**749 433**	**749 433**	**749 433**
3.1.1	Countries enabled to improve maternal health	649 433	649 433	649 433
3.5.1	Country capacity to develop and implement policies for the health impacts of environmental and occupational risks	100 000	100 000	100 000
4	**CAT 4 HSY (health systems)**	**901 223**	**901 223**	**901 223**
4.1.1	Improved country governance capacity comprehensive national health policies ("Health in All Policies" and equity)	541 223	541 223	541 223
4.2.1	Equitable integrated, people-centred service delivery systems in place	160 000	160 000	160 000

	GPW12 Outputs	Planned	Received	Used
4.4.1	Monitoring of country health situation using global standards, including system performance assessment	200 000	200 000	200 000
6	**CAT 6 COR (corporate functions)**	**3 438 754**	**3 438 754**	**3 438 754**
6.1.1	Effective WHO leadership and management and improved capacities of the WHO Secretariat	836 464	836 464	836 464
6.1.3	WHO governance strengthened	500	500	500
6.2.1	Accountability ensured and corporate risk management strengthened	12 000	12 000	12 000
6.2.2	Organizational learning and evaluation	2 000	2 000	2 000
6.3.1	Needs-driven priority-setting and resource allocation	2 000	2 000	2 000
6.3.2	Predictable, adequate, and aligned financing in place	5 700	5 700	5 700
6.4.2	Effective and efficient human resources management	394 801	394 801	394 801
6.4.3	Efficient and effective computing infrastructure	175 000	175 000	175 000
6.4.4	Operational and logistics support for WHO staff and property	2 009 258	2 009 258	2 009 258
6.5.2	Timely and accurate communications, including during disease outbreaks, public health emergencies and humanitarian crises	1 031	1 031	1 031
12	**CAT 12 WHE (WHO emergencies)**	**3 362 457**	**3 362 457**	**3 362 457**
12.3.2	Up-to-date information to inform public health interventions and monitor response	58 861	58 861	58 861
12.4.1	Health operations effectively managed in support of national and local response	641 152	641 152	641 152
12.4.2	Collective response by operational partners effectively coordinated	838 732	838 732	838 732
12.4.3	Effective logistics and operational support rapidly established and maintained	700 826	700 826	700 826
12.4.4	Priority gaps in humanitarian policy and guidance addressed, with specific emphasis on health	693 804	693 804	693 804
12.5.1	WHO Health Emergencies Programme effectively managed and sustainably staffed and financed	429 082	429 082	429 082
	BASE Total	**9 690 767**	**9 690 767**	**9 690 767**
	Emergencies			
10	**CAT 10 POLIO**	**17 859 073**	**17 859 073**	**17 859 073**
10.1.1	Technical assistance for surveillance to maintain polio-free status	17 859 073	17 859 073	17 859 073
13	**CAT 13 OCR (outbreak control and response)**	**97 538 097**	**97 538 097**	**97 538 097**
13.1.1	Health service delivery	85 391 507	85 391 507	85 391 507
13.2.1	Outbreak prevention and control	4 106 197	4 106 197	4 106 197
13.3.1	Surveillance and health information management	3 464 982	3 464 982	3 464 982
13.4.1	Leadership, coordination and operations support	4 575 411	4 575 411	4 575 411
	Emergencies Total	**115 397 170**	**115 397 170**	**115 397 170**
	Grand Total	**125 087 937**	**125 087 937**	**125 087 937**

Details 2020–2021

	GPW13 Outputs	Planned	Received	Used
	BASE			
1	**One Billion more people benefiting from UHC**	**2 437 166**	**1 491 139**	**1 418 641**
1.1.1	Countries enabled to provide PHC strategies and comprehensive essential service packages	397 533	282 197	348 746
1.1.2	Countries enabled to deliver disease-specific service coverage	807 675	731 265	601 560
1.1.3	Countries enabled to address population-specific health needs and barriers to equity across the life course	518 706	314 018	316 038
1.1.4	Countries' health governance capacity strengthened for accountability	82 376	15 422	9 791
1.1.5	Countries enabled to strengthen their health and care workforce	180 376	18 482	12 851
1.2.1	Countries enabled to develop and implement equitable health financing strategies towards UHC	166 500	12 148	12 149
1.2.3	Countries enabled to improve transparent decision-making in priority-setting and resource allocation	5 000	-	-
1.3.1	Provision of standards o health products, essential medicines and diagnostics lists	169 000	78 511	78 411
1.3.2	Improved access to health products through global market shaping and support procurement and supply systems	60 000	14 874	14 874
1.3.3	Country regulatory capacity strengthened for safe health products	20 000	-	-
1.3.5	Countries enabled to address antimicrobial resistance	30 000	24 222	24 222
2	**One Billion More People Better Protected from Health Emergencies**	**7 534 463**	**6 628 907**	**5 962 384**
2.1.1	All-hazards emergency preparedness capacities in countries assessed and reported	1 302 797	1 188 487	1 145 833
2.1.2	Capacities for emergency preparedness strengthened in all countries	130 656	156 060	99 341
2.1.3	Countries operationally ready to assess and manage identified risks and vulnerabilities	513 845	510 895	415 224
2.2.1	Research agendas, predictive models and innovative tools, available for high-threat pathogens	99 492	92 261	92 256
2.2.2	Proven prevention strategies for epidemic-prone diseases implemented at scale	26 102	4 000	3 850
2.2.3	Mitigate the risk of the (re)emergence of high-threat pathogens and improve pandemic preparedness	374 768	249 423	235 382
2.2.4	Polio eradication plans implemented	2 567 092	1 883 687	1 831 828
2.3.1	Potential health emergencies rapidly detected, risks assessed and communicated	852 960	788 229	651 280
2.3.2	Acute health emergencies rapidly responded to, leveraging national capacities	436 533	583 557	335 305
2.3.3	Essential health services and systems maintained in vulnerable settings	1 230 218	1 172 308	1 152 086
3	**One Billion More People Enjoying Better Health and Well-Being**	**218 372**	**195 006**	**194 035**

	GPW13 Outputs	Planned	Received	Used
3.1.1	Countries enabled to address social determinants of health across the life course	-	-	-
3.1.2	Countries enabled to strengthen access to safe foods through a One Health approach	100 473	94 879	94 813
3.2.1	Countries enabled to address risk factors through multisectoral actions	49 570	41 137	41 136
3.2.2	Countries enabled to reinforce partnerships across sectors	59 000	50 667	49 763
3.3.1	Countries enabled to address environmental determinants, incl. climate change	9 329	8 323	8 323
4	**More effective and efficient WHO providing better support to countries**	**3 961 963**	**2 360 336**	**2 317 239**
4.1.1	Countries enabled with health information systems to inform policy and deliver impacts.	970 000	-	-
4.1.2	GPW 13 outcomes, SDG indicators and disaggregated data monitored	195 000	42 092	40 230
4.1.3	Uptake of WHO standards to scale up innovations, including digital technology.	165 000	-	-
4.2.1	Leadership, and external relations enhanced at country level, in the context of United Nations reform	706 501	684 399	687 366
4.2.2	Organizational learning and a culture of evaluation	2 000	-	-
4.2.3	Strategic priorities resourced	2 200	2 112	2 112
4.2.5	Cultural change and organizational performance through WHO-wide transformation agenda	-	-	-
4.3.1	Sound financial practices and oversight, internal control framework	194 448	224 553	223 824
4.3.2	Effective and efficient management and development of human resources	123 018	198 312	144 014
4.3.3	Effective, innovative, and secure digital platforms	319 848	267 241	274 806
4.3.4	Safe and secure environment, with efficient infrastructure maintenance	1 283 948	941 627	944 887
BASE Total		**14 151 964**	**10 675 388**	**9 892 298**
Emergencies				
10	**Polio eradication and transition plans**	**2 642 000**	**1 002 526**	**1 002 526**
10.1.1	Polio plans implemented in partnership with the Global Polio Eradication Initiative	2 642 000	1 002 526	1 002 526
13	**Outbreak, crisis response and scalable operations (OCR)**	**58 420 166**	**50 875 743**	**50 869 776**
13.2.2	NA	744 231	737 722	737 721
13.3.2	NA	22 410 410	17 803 047	17 732 730
13.3.3	NA	35 265 525	32 334 974	32 399 324
Emergencies Total		**61 062 166**	**51 878 269**	**51 872 301**
Special Programme				
14	**Special Programmes**	**206 517**	**199 517**	**193 857**
14.2.1	Humanitarian Response Plan - Strengthened evidence base, prioritization and uptake of WHO-generated norms and standards and improved research capacity and the ability to	48 750	44 750	44 535

	GPW13 Outputs	Planned	Received	Used
	effectively and sustainably scale up innovations, including digital technology, in countries			
14.3.1	National influenza laboratory and surveillance systems contribute to GISRS for timely risk assessment & response measures	102 422	102 422	101 069
14.3.3	Timely access to quality-assured influenza pandemic products is supported	30 345	27 345	23 394
14.3.6	National pandemic influenza preparedness & response plans are updated in the context of all-hazards preparedness and global health security	25 000	25 000	24 858
Special Programme Total		**206 517**	**199 517**	**193 857**
Grand Total		**75 420 647**	**62 753 174**	**61 958 456**

Details 2022–2023

	GPW13 Outputs	Planned	Received	Used[b]
BASE				
1	**One Billion more people benefiting from UHC**	**5 763 097**	**3 169 562**	**2 667 187**
1.1.1	Countries enabled to provide PHC strategies and comprehensive essential service packages	1 147 625	620 407	326 988
1.1.2	Countries enabled to deliver on condition- and disease-specific service coverage	528 452	261 045	246 299
1.1.3	Countries enabled to address population-specific health needs and barriers to equity across the life course	2 086 536	1 953 665	1 870 082
1.1.4	Countries' health governance capacity strengthened for accountability,	468 347	191 484	92 249
1.1.5	Countries enabled to strengthen their health and care workforce	86 137	15 896	20 465
1.2.1	Countries enabled to develop and implement equitable health financing strategies towards UHC	476 000	8 528	780
1.2.2	Countries enabled to analyse information on financial protection and health expenditures	200 000	-	-
1.3.1	Provision of standards on health products, essential medicines and diagnostics lists	150 000	19	19
1.3.2	Improved access to health products through global market shaping and support procurement and supply systems	105 000	-	-
1.3.3	Country regulatory capacity strengthened for safe health products	317 000	820	820
1.3.4	Research agenda defined and coordinated in line with public health priorities	25 000	-	-
1.3.5	Countries enabled to address antimicrobial resistance	173 000	117 698	109 485
2	**One Billion More People Better Protected from Health Emergencies**	**5 623 327**	**3 378 053**	**2 607 764**

[b] As of October 2023.

	GPW13 Outputs	Planned	Received	Used[b]
2.1.1	All-hazards emergency preparedness capacities in countries assessed and reported	1 997 672	1 050 376	747 355
2.1.2	Capacities for emergency preparedness strengthened in all countries	687 501	326 048	283 494
2.1.3	Countries operationally ready to assess and manage identified risks and vulnerabilities	91 595	100 421	64 051
2.2.2	Proven prevention strategies for epidemic-prone diseases implemented at scale	369 000	28 605	29 213
2.2.3	Mitigate the risk of the (re)emergence of high-threat pathogens and improve pandemic preparedness	304 001	295 170	197 671
2.3.1	Potential health emergencies rapidly detected, risks assessed and communicated	1 508 121	1 211 181	921 750
2.3.2	Acute health emergencies rapidly responded to, leveraging national capacities	80 000	70 000	30 818
2.3.3	Essential health services and systems maintained in vulnerable settings	585 437	296 252	333 412
3	**One Billion More People Enjoying Better Health and Well-Being**	**291 500**	**255 266**	**242 319**
3.1.1	Countries enabled to address social determinants of health across the life course	14 631	14 393	14 393
3.1.2	Countries enabled to strengthen access to safe foods through a One Health approach	60 000	60 000	57 535
3.2.1	Countries enabled to address risk factors through multisectoral actions	86 642	73 479	67 151
3.2.2	Countries enabled to reinforce partnerships across sectors	28 000	28 000	31 124
3.3.1	Countries enabled to address environmental determinants, including climate change	102 227	79 394	72 115
4	**More effective and efficient WHO providing better support to countries**	**8 712 063**	**3 276 509**	**3 989 421**
4.1.1	Countries enabled with health information systems to inform policy and deliver impacts	1 897 001	93 126	101 481
4.1.3	Uptake of WHO standards to scale up innovations, including digital technology	395 000	21 548	21 548
4.2.1	Leadership and external relations enhanced at country level in the context of United Nations reform	901 500	876 691	637 419
4.2.2	Organizational learning and a culture of evaluation	5 000	-	-
4.2.3	Strategic priorities resourced	549 877	59 100	182 242
4.2.4	Allocation of resources to achieve country impact and value-for-money	3 500	-	-
4.2.5	Cultural change and organizational performance through WHO-wide transformation agenda	1 000	-	-
4.3.1	Sound financial practices and oversight, internal control framework	1 318 001	380 680	593 632
4.3.2	Effective and efficient management and development of human resources	184 702	49 351	74 314
4.3.3	Effective, innovative and secure digital platforms	396 051	222 050	289 977
4.3.4	Safe and secure environment, with efficient infrastructure maintenance	3 060 431	1 573 963	2 088 809

	GPW13 Outputs	Planned	Received	Used[b]
BASE Total		**20 389 987**	**10 079 390**	**9 506 692**
Emergencies				
13	**Outbreak, crisis response and scalable operations (OCR)**	**42 094 014**	**41 044 812**	**38 390 222**
13.2.2	NA	508 000	477 886	373 259
13.3.2	NA	12 167 680	11 287 538	10 868 776
13.3.3	NA	29 418 334	29 279 388	27 148 187
Emergencies Total		**42 094 014**	**41 044 812**	**38 390 222**
Non-PB				
50	**Partner mechanisms**	**5 000**	**4 391**	**4 366**
50.1.10	Capacities for assessing progress and exchange of information strengthened in all Parties	5 000	4 391	4 366
Non-PB Total		**5 000**	**4 391**	**4 366**
Special Programme				
14	**Special Programmes**	**126 000**	**126 000**	**93 874**
14.3.1	National influenza laboratory and surveillance systems contribute to GISRS for timely risk assessment & response measures	108 000	108 000	93 896
14.3.6	National pandemic influenza plans are updated	18 000	18 000	-22
Special Programme Total		**126 000**	**126.000**	**93 874**
Grand Total		**62 615 001**	**51 254 593**	**47 995 154**

Annex 7. Allocated programme budget per biennium in US$

2018–2019			2020–2021			2022–2023		
Strategic Priority	Global Outcome	Allocated PB	Strategic Priority	Global Outcome	Allocated PB	Strategic Priority	Global Outcome	Allocated PB
01 1COMD	01.001 11HIV	35 000	01 1UHC	01.001 11EHS	2 003 700	01 1UHC	01.001 11EHS	3 595 700
	01.002 12TUB	118 700		01.002 12FIN	211 500		01.002 12FIN	676 000
	01.004 14NTD	203 200		01.003 13EMD	348 000		01.003 13EMD	770 000
	01.005 15VPD	223 000	**01 1UHC Total**		**2 563 200**	**01 1UHC Total**		**5 041 700**
	01.006 16AMR	58 200	02 2WHE	02.001 21PRE	1 953 550	02 2WHE	02.001 21PRE	6 854 000
01 1COMD Total		**638 100**		02.002 22EPP	3 134 650		02.002 22EPP	1 029 000
02 2NCD	02.001 21NCD	484 100		02.003 23EDR	2 443 500		02.003 23EDR	3 403 500
	02.002 22MHS	67 600	**02 2WHE Total**		**7 531 700**	**02 2WHE Total**		**11 286 500**
	02.003 23VIP	12 000	03 3HWB	03.001 31DET	101 600	03 3HWB	03.001 31SEQ	48 700
	02.004 24DIS	42 200		03.002 32RIS	108 600		03.002 32SES	140 700
	02.005 25NUT	4 700		03.003 33HIP	9 700		03.003 33HEP	128 300
	02.006 26FOS	18 000	**03 3HWB Total**		**219 900**	**03 3HWB Total**		**317 700**
02 2NCD Total		**628 600**	04 4EFF	04.001 41DAT	1 330 000	04 4EFF	04.001 41DAT	2 418 000
03 3PHL	03.001 31RMC	711 200		04.002 42LED	812 400		04.002 42LED	912 000
	03.005 35HEN	100 000		04.003 43FRH	1 956 700		04.003 43FRH	1 811 500
03 3PHL Total		**811 200**	**04 4EFF Total**		**4 099 100**	**04 4EFF Total**		**5 141 500**
04 4HSY	04.001 41NHP	645 000	10 10POL	10.001 101POL	2 642 000	10 10POL	10.001 101POL	0
	04.002 42IPH	160 000	**10 10POL Total**		**2 642 000**	**10 10POL Total**		**0**
	04.004 44HSI	200 000	13 13OCR	13.001 131OCR	0	13 13OCR	13.001 131PRE	0
04 4HSY Total		**1 005 000**		13.002 132OCR	882 000		13.002 132EPP	680 000
06 6COR	06.001 61GOV	837 000		13.003 133OCR	62 580 500		13.003 133EDR	67 876 995
	06.002 62TAR	14 000	**13 13OCR Total**		**63 462 500**	**13 13OCR Total**		**68 556 995**

	2018–2019			2020–2021			2022–2023	
Strategic Priority	Global Outcome	Allocated PB	Strategic Priority	Global Outcome	Allocated PB	Strategic Priority	Global Outcome	Allocated PB
	06.003 63SPR	8 000	14 14SPE	14.002 142HRP	45 000	14 14SPE	14.002 142HRP	0
	06.004 64ADM	2 639 900		14.003 143PIP	266 250		14.003 143PIP	126 000
	06.005 65COM	1 100	**14 14SPE Total**		**311 250**	**14 14SPE Total**		**126 000**
06 6COR Total		**3 500 000**	**Grand Total**		**80 829 650**	50 PRTNER	50.001 SECFTC	5 000
10 10POL	10.001 101POL	18 206 300				**50 PRTNER Total**		**5 000**
10 10POL Total		**18 206 300**				**Grand Total**		**90 475 395**
	12.003 123HIM	109 100						
	12.004 124EMO	2 874 600						
	12.005 125ECS	654 300						
12 12WHE Total		**3 .638 000**						
13 13OCR	13.001 131IAS	85 391 600						
	13.002 132PCO	4 106 200						
	13.003 133SSI	3 836 100						
	13.004 134CSO	4 626 100						
13 13OCR Total		**97 960 000**						
Grand Total		**126 387 200**						

Annex 8. Outputs of co-creation workshop

On 22 November, prior to finalization of recommendations, the WCO Representative convened a co-creation (online) workshop to discuss the findings and conclusions of the evaluation and co-create recommendations. The aim of the workshop was to ensure buy-in and commitment to the conclusions, lessons and recommendations of the evaluation. Specific outputs of the workshop were for participants to 1) jointly reflect on key findings of the evaluation; 2) reflect on the main conclusions; and 3) suggest actionable recommendations for the three levels of WHO.

On effectiveness and measuring results and result-based management

Recommendations
Headquarters and EMRO should:

- provide overall leadership and a framework for implementation of RBM in the Organization, including in Iraq, which could be accomplished by revisiting the recent RBM evaluation report and implementing its recommendations;
- engage in extensive monitoring and evaluation processes, including the use of performance indicators, metrics, and peer-reviewed research to assess its programmes;
- work towards establishing clear, measurable and time-bound objectives for its programmes and interventions since clearly defined objectives will provide a solid foundation for assessing the effectiveness of activities and demonstrating tangible outcomes;
- develop country-specific result monitoring framework;
- generate clear goal settings, robust metrics and indicators, and focus on impact, not just output;
- invest in building the capacity of WHO staff and partners in results-based management and evaluation methodologies as equipping personnel with the necessary skills enhances the Organization's ability to define and measure impact.

Comment:

- There are many WHO projects with clear impact outcome, especially in the secondary health facilities. The impact was published a few years later by comparing the results with a database.

On relevance: doing the right thing for the people and Government of Iraq

Recommendations:

- Conduct a comprehensive assessment of the country's health system, considering its upper-middle-income status, disease outbreak vulnerabilities and the volatile environment. This assessment should identify specific challenges and gaps that require targeted interventions. Conduct field assessments in various regions of Iraq. Collect data and analysis through collecting relevant health data from multiple resources, engaging the local health authority and the health providers to gain valuable insights on the health challenges. Use upcoming opportunities (such as the new CCS development and upcoming health policy) to address the needs and government priorities, including health system priorities in line with WHO's mandate, These could be continually reviewed in the biennial planning processes.
- Adopt a long-term perspective. Focus on comprehensive Health System Strengthening. WHO can play a pivotal role in shaping health policies through the dissemination of research and evidence. For health system strengthening, more efforts need to be made to enrol the private sector such as universities other interventions in donation or any contributions. Highlight global strategies from headquarters and the Regional Office as the main approaches to implementing support interventions, especially in common issues like climate change impacts.
- Develop plan to strengthen coordination and cooperation between MoH in Erbil and Baghdad. To avoid the need for WHO to push for subnational systems in KRI like a recognized referral laboratory, separate reporting in KRI, standard supply chain system.

On balancing upstream and health systems support

Lesson

- The modality of 'area coordinators' in Iraq can be considered a synergy between the two areas of support.

Recommendations:

- Collaborate with MoH to develop a health policy that addresses key issues (e.g. AMR). Advocate for sustainable health financing. Include a strategic plan for health emergencies in health system support. Work on the six health-system blocks rather than on vertical programmes. Emphasize the DHIS-2 to cover all vertical health programmes. Optimize these approaches:
  1- prioritize capacity-building
  2- facilitate policy dialogue and advocacy
  3- customize technical assistant
  4- promote multisectoral collaboration
  5- establish long-term partnership
  6- encourage community engagement
  7- leverage technology for innovation
  8- invest in health information systems

On responsible transition and coping with reduced health emergency funding

Recommendations:

- Develop a comprehensive transition plan in collaboration with local authorities. This plan should outline clear steps and responsibilities for the gradual transfer of responsibilities from WHO to local entities. Determine critical WHO functions and services that must be preserved despite budget constraints. Focus on core activities and allocate resources accordingly.
- Create cross-office teams and task forces on specific projects. Teams should include members from both Erbil and Baghdad offices. Implement regular progress review and feedback where both offices can provide feedback on each other's work.

On coherence with other WHO levels, UN system and other health partners

Lesson:

- Coordination between the three levels of WHO (headquarters, Regional Office, Country Office) including regular structured engagement, is essential to support WCO in realizing planned agreed priorities between CO and MoH and to avoid situations of non-coordination, such as de-activation of the health cluster.

Recommendation:

- Strengthen the dialogue among the three WHO levels. Improve their collaboration and coherence through joint planning and work on an agreed work plan. Decentralize decision-making, empower the country office with more decision-making authority to avoid delays in contracting and reporting.

Lesson:

- The strong relationship between the Country Office, UN agencies and national health counterparts was perceived as a comparative advantage of WHO. This relationship helps to promote WHO's health mandate and global presence to offer strategic support the Government of Iraq.

Recommendation for WCO:

Sustain the current relationship with UN agencies and partners and forge opportunities for future engagement. Promote partnerships with local and international stakeholders, highlighting the importance of addressing the prioritized health needs. Collaborate with other agencies and organizations to leverage resources and expe

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