THE KONTERRA GROUP

Evaluation of UNICEF Emergency Psychosocial Support Programme in Iraq (2018–2020)

Commissioned by:

The UNICEF Iraq Country Office

Final Report, July 2021

International Team:
Terrence Jantzi (Team Leader), Hisham Khogali, Marie-Adele Salem

National Consultants:
Eman Nash, Nashmil Rasul, Zina Karsoh

Acknowledgements

The evaluation team would like to extend its appreciation to all UNICEF personnel and staff from the Ministry of Labour and Social Welfare and other organizations who contributed to the development of this report. Any evaluation exercise is the product of the labour of many different individuals and groups across multiple levels. In the case of this evaluation, the high degree of collaboration and voluntary action has been particularly evident. A great many persons contributed to the review and development of the evaluation tools, carried out background research, and diligently supported the vast degree of logistical effort required to mobilize field missions to the targeted camp sites throughout the country. While a full list of all persons who have helped would be too extensive to list here, the evaluation team would like to thank all the participating children, youth, caregivers, and adults in the visited camps who took time to come and discuss the structured psycho-social support activities and their consequences. The evaluation would also like to recognize the following persons for their support: Myriam Van Parijs and Karam Hindi as UNICEF Iraq evaluation managers for their extensive support and feedback. Teresa Hanley for her role in leading the Inception Phase process and the production of the Inception Report. In addition, Ahmed Tahir and Abduljabar Arab, UNICEF Governorate Child Protection Officers, were crucial for organizing the logistics for the camp visits and remote FGDs. Ali Shingaly, Hilda El Esh, Ibrahim Eid, Diler Younous, Ammmar Hassan and Aras Nasir as implementing partner focal points were crucial for facilitating access to the targeted camps. Too many additional UNICEF staff and local implementing partner representatives to list were also involved in the organization of the evaluation, interviews, and responded promptly to last-minute adjustments, and the evaluation team would like to thank each one of them.

Disclaimer

This evaluation was conducted by the KonTerra Group. The team members were Terrence Jantzi, Hisham Khogali and Marie Adele Salem with support from Eman Nash, Nashmil Rasul and Zina Karsoh. The evaluation was managed and supported by Myriam Van Parijs and Karam Hindi of UNICEF Iraq. A UNICEF Evaluation Reference Group provided feedback on the draft reports of the final evaluation as well as the inception reports.

The opinions expressed in this report are those of the authors and do not necessarily reflect those of UNICEF. Responsibility for the opinions expressed in this report rests solely with the authors.

TABLE OF CONTENTS

List of Tables

List of Figures

Acronyms

3RP	Regional Refugee and Resilience Plan
ABC	Activity Based Costing
CCC	Core Commitments for Children
CFS	Child-Friendly Space
CO	Country Office
CP	Child Protection
CPAOR	Child Protection Area of Responsibility
CPSC	Child Protection Sub-Cluster
DOLSA	Department for Labour and Social Affairs
EM	Evaluation Manager
ESC	Evaluation Steering Committee
ET	Evaluation Team
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HDI	Human Development Index
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
IASC	Inter-agency Standing Committee
IDP	Internally Displaced Person
IMO	Information Management Officer
IR	Inception Report
IP	Implementing Partner
ISIL	Islamic State of Iraq and the Levant
KII	Key Informant Interview
KRI	Kurdish Region of Iraq
KRG	Kurdistan Regional Government
MICS	Multiple Indicator Cluster Survey
MHPSS	Mental Health and Psychosocial Support
MOE	Ministry of Education
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
PHC	Primary Health Care
PSS	Psychosocial Support
SADD	Sex and Age Disaggregated Data
SCFI	Save the Children Fund International
SMQ	Standard Monitoring Questions
SPSS	Structured Psychosocial Support
TL	Team Leader
TOC	Theory of Change
TOT	Training of Trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

Introduction and Background

This report documents the evaluation of the UNICEF supported Emergency *Structured* Psychosocial Support Programme (SPSS) in Iraq. The evaluation was commissioned by the UNICEF Iraq Country Office (CO) covering the period January 2018 to December 2020. The evaluation captures lessons from the programme for use in future planning in Iraq and elsewhere by UNICEF and partners in relevant contexts. The primary users of this evaluation are the UNICEF Iraq Country Office and its partners in decision-making including donors and the Government of Iraq, especially the Ministry of Labour and Social Affairs (MOLSA) and the Ministry of Education (MOE).

During the last decade, Iraq has hosted both internally displaced persons (IDPs) and refugees. Of the 6 million people displaced during the 2014–2017 conflict against Islamic State of Iraq and the Levant (ISIL), humanitarian partners in 2020 estimated that 4.1 million people continue to require some form of humanitarian assistance. Further, an estimated 514,000 returnees live in areas of high severity of needs, indicating a lack of livelihoods, basic services, social cohesion, and security.[1] In addition, since 2012, Iraq has supported the hosting of Syrian refugees, with 242,163 people still registered with UNHCR as of the end of 2020. The unlikely return of most Syrian refugees in the medium term has meant the humanitarian community has recently focused on longer-term, solutions-oriented approaches including building self-reliance and integrating them into public services and national systems. Iraq refugees and vulnerable populations have been additionally affected by the COVID-19 pandemic. The combined effect of violence and prolonged exposure to multiple displacements continue to impact children and families physically, psychologically, and in terms of their social well-being.

The UNICEF Country Programme of Cooperation 2020–2024 is designed to support the Government at national and sub-national levels to accelerate the realization of rights for all children in Iraq. Mental health and psychosocial support (MHPSS) are fundamental parts of UNICEF's Core Commitments for Children (CCC) in Humanitarian Action. UNICEF leads the Nutrition working group within the Health Cluster, WASH and Education Clusters as well as the Child Protection Sub-Cluster of the Protection Cluster. The Structured PSS programme (SPSS)[2] is part of the support under the Child Protection (CP) Sector.

In 2017, the CP sub-cluster along with national and international partners, formalized a SPSS programme to provide a more systematic approach to addressing three components of psycho-social well-being: Personal well-being, inter-personal well-being, and skills. The SPSS is based on a series of modules developed by Save the Children Fund International (SCFI) and War Child targeting different age groups and implemented by local facilitators over 2-4 months. The services are intended to strengthen resilience and coping mechanisms of children who have suffered from violence and psychological harm. UNICEF delivers SPSS activities with several partners including international and national NGOs and government counterparts such as Department of Labour and Social Affairs (DoLSA). UNICEF funds between 60 and 85 per cent of all implementing partners (IP) carrying out PSS activities in Iraq within the Humanitarian Response Plan (HRP). UNICEF also supports system strengthening, and capacity building interventions related to SPSS.

Evaluation Features

[1] OCHA, 2020, Humanitarian Needs Overview 2020

[2] Within UNICEF, PSS activities are often labelled as MHPSS (Mental Health and Psycho-social activities). This evaluation is commissioned to review the effectiveness of a structured approach to PSS activities. For the purposes of this exercise, the overall MHPSS activities will be referred to either as the Structured PSS (SPSS) the informal PSS activities or the parents' courses which are all included under MHPSS.

The purpose of the evaluation is to provide an independent assessment of the contribution of SPSS to children's well-being in Iraq between 2018–2020 and its positioning in relation to the linkages between the humanitarian, development, and recovery contexts. The evaluation exercise has two overall objectives and the Terms of Reference for the evaluation describes 11 evaluation questions intended to contribute to these overarching objectives:

- Objective 1: To what extent has the SPSS programme promoted the well-being of conflict-affected children?
- Objective 2: How well is this programme positioned for the linkage between the humanitarian context and the recovery and development context?

The evaluation used a mixed- method approach: i) Review of documents and pre-existing qualitative information, ii) pre-existing quantitative information related to the PSS activities and output indicators, iii) primary qualitative data from key informant interviews and focus group discussions; and iv) primary quantitative data from an online perceptions survey administered to implementing partner personnel involved in PSS and Training of Trainers (TOT) trainings.

COVID-19 travel restrictions affected the evaluation methodology with the international team members conducting remote interviews, and in-country data collection carried out by national team members. In total, 446 persons were interviewed. An online survey for PSS Facilitators was also conducted, with a 69 percent response rate (91 responses).

Evaluation Findings

Relevance

The design of the SPSS is well conceptualized and coherently integrated into the overall CP TOC and its nine-dimensions. The evaluation assessed with the SPSS materials, modules, and activities were appropriate to the needs of the affected children and parents. Of particular interest was the degree to which the materials and activities were tailored by partners to the specific context and the degree to which socio-cultural barriers have affected consistent implementation by SPSS partners. The evaluation found that although all partners are using approved modules for SPSS, usage varies widely and there is no consistent tracking by UNICEF of the variations in module usage or how they have been adapted. This is partly due to a lack of a common understanding over the relative weighting of SPSS as an entry to the CP systems versus as a mechanism for building resilience. There is also limited evidence of in-depth needs assessments with specific cohorts being carried before implementation to help identify the specific needs of each population. This combined with the modules being developed for a different context, reduced the relevance of the materials. Partners also undertook relevant pro-active innovations to ensure that SPSS could still be provided during the COVID-19 pandemic, providing appropriate options for home-based sessions. The combination of the provision of PSS as a service without a specialized needs assessment and with few adaptations – leads to a gap in addressing mental health needs for more traumatized communities.

Efficiency

UNICEF is one of several donors and agencies which fund implementing partners to carry out PSS activities in Iraq. UNICEF's supports between 70-80 per cent of all children reached through PSS activities. The CP Sub-Cluster (CPSC) dashboard from 2018-2019 shows an increase in UNICEF's share of support to partners implementing SPSS, and the share of children and youth receiving SPSS meets or exceeds the HRP targets. However, the reporting of SPSS is limited by the focus on numbers of children and youth reached, while the *quality* of the interventions is not included.

Further, tracking SPSS costs is impeded by the current financial and programme reporting systems with partners because UNICEF funding is not specific to SPSS. Financial reports from partners are therefore not easily consolidated for tracking overall cost monitoring of individual activities. Despite these

challenges in monitoring cost efficiency of SPSS, funding for CP increased substantially from 2018 to 2019, which *may* be indicative of increased confidence from donors in SPSS compared to PSS.

Effectiveness and Gender

While the coverage of SPSS has reached or exceeded the targets set in the Humanitarian Response Plan (HRP), it is insufficient to cover all those in need. The HRP cites large numbers of children and youth still in need of PSS so there is need for more PSS services than are currently being supplied.

SPSS is considered by UNICEF and partners to be more effective than unstructured PSS activities for psycho-social well-being. However, SPSS is intended for people experiencing *mild* levels of stress, not for addressing higher levels of trauma in the MHPSS pyramid. This limits its usefulness when entire communities are collectively traumatized to level 4 or beyond as is the case in some camps in Iraq.

Stakeholders universally believe the SPSS is having positive results and contributing to improved psycho-social well-being of children citing a range of factors leading to several positive outcomes including: i) the opportunity for longer term engagement with targeted children and youth through the SPSS modules, ii) the availability of a systematic guided framework for capacity building of children and youth through the application of the modules, iii) better recruitment and retention of children and youth in the SPSS activities (and therefore keeping them away from protection risks in the camps) and iv) a complementary effect of the structured activities serving to provide a substitute for school activities for those children who have been out of school for several years under the ISIL.

However, the monitoring system provides limited *evidence* of SPSS effectiveness. There are no outcome level indicators used for tracking SPSS effectiveness and reporting is largely limited to 'efficiency' criteria reporting the numbers of children and youth reached. Some work has been done to measure well-being changes including pre-post self-report questionnaire developed by two partners. However, there are limitations to its use.

The evaluation found that SPSS contributions for referrals are more effective than informal PSS but tracking this is also limited. Referrals are tracked by UNICEF, but these are not linked to whether the referral came from an SPSS activity or other sources. Over the implementation period, there was an increase in referrals and an increase in the number of partners reporting referrals. However, even with increased effectiveness of the referral process, there are still concerns that the overall child protection system is not able to adequately treat the referrals - especially for trauma and mental health concerns.

One of the most accepted and effective resources to support SPSS delivery, was the adolescent girls' toolkit developed by UNICEF and UNFPA. Even though it was not one of the five SPSS modules originally approved, partners cited it as the best resource for increasing awareness of girls' issues. Gender issues have been considered in programme implementation to some extent both in the participation of the SPSS and in the content of the SPSS modules. However, there is a pattern of boys being disproportionately represented in the SPSS activities, with girls often remaining at home due to sociocultural reasons. There is little evidence that the field level PSS facilitators have been trained on gender awareness.

Nexus Considerations

Capacity building for SPSS has been initiated within the humanitarian system through UNICEF's support, but the level of capacity is not yet sustainable. Evaluation stakeholders felt that national policy and institutional components for building capacity on SPSS are in place, but field level capacity strengthening efforts need more work. Rapid turnover of field level personnel and the under-funding to DoLSA has minimized the degree to which capacity efforts have led to long term sustained changes in capacity.

Field level application of SPSS is also constrained by limited in module adaptation and individual capacity building for SPSS facilitators. Currently, the system relies on the delivery through non-specialized field facilitators, but with an absence of high-level PSS technical expertise in the system to make the necessary adaptations to the technical materials. There is also no documented *strategy* for PSS facilitator capacity building that outlines how much training should be done, by whom, for how many hours, or what the criteria for success may be. In the absence of a capacity development system for SPSS, there has been a reliance on large scale ad hoc trainings, but PSS field facilitators have not benefitted from the cascade effect of these trainings.

The gaps in the current system mean that it cannot easily be transferred to a development context although UNICEF is already exploring ways to do so. Gaps in the humanitarian service exist but are manageable compared to the gaps in the development context. The humanitarian system uses different operations, and conditions, and potentially, different state actors. While most interviewed stakeholders could articulate a roadmap for achieving a transition to the development context – primarily through the Education, Health or CP sectors –the system is not yet developed enough to transition. Significant institutional, technical, and organizational barriers exist including module adaptation, integration of SPSS into existing standard operating procedures (SOPs) and mobilizing the political will for transition of SPSS to the development context.

UNICEF's primary government partner for SPSS has been DoLSA but UNICEF/government partnerships will need to be expanded for SPSS in the development context. To integrate SPSS into ministries beyond DoLSA, such as Education and Health, outside of the humanitarian context would require assessing the policy environment, resourcing, technical training of staff, and the integration of SPSS into the SOPs of the education and health ministries. Ongoing technical training of staff on SPSS would also need to be integrated into the existing technical training curriculum for the primary providers – either through the university curriculum, teacher training colleges, or primary health care vocational training curriculum.

The development context is also missing community-based coordination mechanisms for CP and SPSS. In comparison to the camp context, where UNICEF supports a wide range of NGOs to provide local services including SPSS, there are no equivalent community level mechanisms for child protection. A potential roadmap for establishing these community-based mechanisms in the development context includes the participation of NGOs and civil society organizations to serve as service providers and case management resources. However, Iraq law currently prohibits Government funding to these NGO service providers, so other sources of funding will need to be secured. There are already other actors engaging in MHPSS strategy development for the development context including the MHPSS task force currently co-chaired by the World Health Organization (WHO) and MoH. It will be important for UNICEF to engage with the taskforce to pursue transition of SPSS into a development context.

Conclusions

SPSS presents an important opportunity in both humanitarian and development contexts. The evaluation has identified positive gains in the application of SPSS in the humanitarian system, but there are gaps in project management, and capacity strengthening which would be needed to be addressed to further maximize the potential for psycho-social well-being. The system is therefore not yet ready to transition to a development context. UNICEF is well positioned to lead on improving SPSS programming in the humanitarian context and on working in partnership with other key actors to integrate SPSS into the development context in Iraq.

Conclusion 1: UNICEF plays an important leadership role in SPSS support and management that could be further expanded. However, the system is not yet ready for UNICEF exiting the SPSS space – in either the humanitarian or development contexts. SPSS is an integral part of the UNICEF 2018-2021 Global Strategic Plan and SPSS indicators are reported on by all Country Offices. Within Iraq, the SPSS is a foundational component of CP programming by the CPSC and partners, and it is integrated into the larger CP TOC. UNICEF is the primary funder of SPSS activities in Iraq, so there is potential for

UNICEF to play a larger role in leadership on SPSS. There are several factors that could increase UNICEF's influence in SPSS including filling the sub-cluster coordination role, providing technical expertise on PSS, and facilitating the establishment of evidence and knowledge management systems for SPSS institutionalization among SPSS actors.

Conclusion 2: There are several dimensions of inherent tension within the application of SPSS programming in Iraq which UNICEF and other CP actors are constantly balancing however there is not a shared consensus on the appropriate weightings. The dimensions in question are: i) emphasizing the child protection (referrals) value of SPSS against the child well-being values (social emotional improvement); ii) trying to reach as many children and youth as possible versus going in-depth with a smaller cohort for better results; and iii) enforcing a standardized process versus allowing for partner flexibility to adapt to their particular projects. Finally, there are several interpretations among and between CP actors, PSS facilitators and beneficiaries regarding the role of SPSS or what potential SPSS outcomes may be. This is due to the lack of a specific articulated framework for an SPSS TOC. Partners therefore rely on the CP TOC which lacks an articulated causal pathway. This means that partners use different SPSS indicators than those found in the CP TOC. The lack of a common consensus among stakeholders on the relative weightings inhibits the consistency of application, reducing overall effectiveness.

Conclusion 3: SPSS serves as important entry point for CP interventions, but the CP system does not have the capacity to meet all the identified demand. There is consensus among stakeholders that the SPSS activities provide an opportunity for the identification of referrals and case management in the CP system because of the longer term, more structured interactions with SPSS facilitators. Within the humanitarian context, there is a coordinating committee of service providers and a service mapping to provide identified routes for case management referral. However, stakeholders voiced concern about the capacity of the case management system to handle the demand identified through SPSS activities and the perceived absence of an equivalent local coordination mechanism for the development context.

Conclusion 4: SPSS in Iraq is more effective than informal PSS, but not yet sustainable or sufficiently institutionalized. The structured SPSS is perceived by stakeholders to be more effective for achieving improved social and emotional well-being than PSS, even if monitoring evidence is limited. Triangulation of the few available outcome assessments show shifts in psycho-social well-being dimensions. However, institutionalizing SPSS still needs more work, as the system is still heavily reliant on external donor funding and there are still relatively low levels of institutional technical capacity to sustain SPSS programming. The COVID-19 pandemic delayed the implementation of many of the sustainability measures required for maintaining SPSS, both within the humanitarian response system and in the transition to the development context.

Conclusion 5: The dual rationale for SPSS – for wellbeing and for CP referrals - are both important but not enough emphasis was placed on maximizing the contributions of SPSS to wellbeing. Even though some stakeholders emphasize the importance of SPSS for building resilience, the way that the SPSS programming is managed has unintentionally inclined the programme away from maximizing psycho-social wellbeing. This implicit bias is illustrated in the way that activities are tracked, programme reports generated, project documents elaborated, and indicators developed. Further, the variation in the application of SPSS by partners, the absence of a system for continuous process of orientation, training, mentoring, coaching, and review of SPSS, and the incomplete adaptation of the modules also limit the programme contributions for psycho-social well-being. Maximizing SPSS contributions to resilience requires increased organizational investments in staffing (PSS and Information Management Officers), systems building, and clarifying desired outcomes and causal pathways for SPSS. It also requires resourcing for expanded monitoring, to be able to effectively track immediate effectiveness and long-term impact changes in cohorts.

Conclusion 6: The absence of a *system* for ongoing and continuous socialization[3] impedes the building of SPSS expertise among partners and PSS facilitators required for sustaining SPSS implementation. There is currently limited allocation of resources for management and administration of SPSS, including the absence of PSS technical specialists, the absence of a continuous training system, and a limited monitoring and information management system. The establishment of a continuous *system* for socialization is needed to ensure sufficient SPSS expertise is available at all times. Additional expertise is required immediately to enable adjustments and adaptations to the SPSS modules to ensure they are appropriate to the Iraq context.

Conclusion 7: The emphasis of the information management system towards counting beneficiaries rather than measuring effectiveness, means there is limited *evidence* for the effectiveness of SPSS towards achievement of outcomes or for measuring the *quality* of implementation. Although stakeholders perceive SPSS to be effective, there is limited *evidence* within the existing systems to track the quality of implementation, the immediate effectiveness, or long-term impact on children and youth of SPSS. There are no standard outcome level indicators or tools to systematically track changes in resilience or well-being and there are no standard output level indicators for tracking the quality of implementation of SPSS across the partners in a standardized manner. UNICEF Iraq can play several roles in strengthening the evidence base for SPSS including systematizing and strengthening an information management platform that can be used by all implementing partners for better tracking effectiveness. UNICEF can also play a role in supporting external research on SPSS effectiveness for wellbeing. The high degree of field variation in the application of SPSS can provide an important opportunity for UNICEF to sponsor more fine-grained differentiated assessments of the effectiveness of different models of support.

Conclusion 8: While the potential of SPSS exists for transition to the development context, there are significant institutional barriers preventing an effective transition. The existing humanitarian SPSS capacity is also not easily transferable – requiring the establishment of new partnerships, mechanisms, and even new project cycle management processes. The systems and structures for SPSS in the humanitarian system such as the cluster, sub-clusters and working groups, are not yet in place for SPSS within the development context. The most feasible roadmap for such a transition is through the Education and Health Sectors, but little progress has been made yet in terms of creating the necessary cross-ministerial agreements and SOPs for applying SPSS outside of the humanitarian camp context. UNICEF can play an important role by developing collaborations with relevant ministries including the ministries of Health, Education and MoLSA.

Recommendations

The evaluation recommendations address the three major gaps highlighted in the findings: smoothing out field level variations in SPSS application, building an evidence base for effectiveness, and system building for transition to a development context. The first five recommendations should be considered for both humanitarian and development contexts. The last two recommendations are specific for transitioning to a development context.

Recommendation 1: UNICEF should provide expertise for Conceptual Coherence and Theory of Change. UNICEF Iraq Office should provide enhanced technical, coordination, and information management expertise to support SPSS programming in Iraq including strengthening a shared understanding of a common ToC and causal pathways for SPSS, including outcome indicators.

Recommendation 2: UNICEF should support SPSS module adaptation and needs assessments. UNICEF Iraq Office should continue to support adaptation and contextualization of the SPSS modules for the context, based on needs assessments and the experience of SPSS implementation since 2018.

[3] For the purposes of this report, the term socialization refers to the entire range of orientation, training, coaching, mentoring, and certification activities involved in building the capacity of field level personnel to carry out SPSS activities with children.

Recommendation 3: UNICEF should support the establishment of a continuous system for capacity development for both the humanitarian and development contexts. The UNICEF Iraq Office should develop a framework that outlines the strategy, conditions, and procedures for a system of ongoing and continuous orientation, training, and certification for SPSS. The framework should be adjusted to respond separately to the resources and partnerships in the different contexts – either through the relevant national ministries or in the humanitarian context with the CPSC partners.

Recommendation 4: UNICEF should support the development of a comprehensive system for measuring the effectiveness of SPSS. The UNICEF Iraq Office should strengthen the development of an evidence base to show the effectiveness of SPSS activities. This should be done by supporting research and longer-term assessments into outcome level changes with a particular emphasis on articulating the long-term impact on resilience beyond the project cycle.

Recommendation 5: UNICEF should strengthen both partner reporting and information management. The UNICEF Iraq Office should strengthen UNICEF's monitoring and evaluation (M&E) system and the data collection and reporting by partners. This will provide an enhanced and consolidated information management on SPSS outputs and outcomes that could be used to monitor progress of results achieved.

Recommendation 6: UNICEF should develop a framework for transition. The UNICEF Iraq Office should develop a framework that outlines the strategy, conditions, and procedures for uptake and adaptations to scale of SPSS in the development context. The framework should outline the linkages among national and Governorate level actors and identify the factors that may prevent successful transition.

Recommendation 7: UNICEF should develop community-based coordination mechanisms. The UNICEF Iraq Office should collaborate with WHO and MoH to build on and strengthen existing community-based coordination mechanisms by service providers and institutions for child protection. In the development context these mechanisms can be used to strengthen delivery of psycho-social health services in the community and serve as a bridge between the primary service providers and tertiary centralized institutions.

1. Introduction

1. This report documents the evaluation of the UNICEF Emergency Structured Psychosocial Support Programme (PSS) in Iraq. The evaluation was commissioned by the UNICEF Iraq Country Office (CO) covering the period January 2018 to December 2020. The evaluation is to capture lessons from the programme for use in future planning in Iraq and perhaps also be of relevance elsewhere outside of Iraq by UNICEF and partners in humanitarian or development contexts.

2. The purpose of this Evaluation Report (ER) is to describe the programme achievements and results to date, and to present conclusions and recommendations against the primary areas for exploration described in the Terms of Reference (ToR) in Annex 1.

2. Background

2.1 Country Context

3. The population of Iraq is 38.7 million and predominantly urban (70 per cent), with 15 per cent of the population under 5 years of age, 50 per cent under 18 years and 70 per cent under 24 years. With a growth rate of 2.55 per cent, the population is projected to double by 2050.[4]

4. Prior to 2014 following the impact of the Iraq political situation, the impact of sanctions, three major conflicts and the impact of the Syrian refugee influx, Iraq was achieving notable gains. An upper middle-income country which had made important progress towards the achievement of Millennium Development Goals, Iraq was the world's third largest oil exporter.[5] The country had reduced extreme poverty and child malnutrition. Infant and child mortality had also decreased significantly. Net enrolment in primary education had increased and girls' participation in school was improving. Women's participation in parliament was above the 25 per cent constitutional quota.[6]

5. However, devastating conflicts across large swathes of Iraq forced around six million Iraqi citizens to flee their homes and created a complex humanitarian situation with significant impacts on children and families. Combat operations against Islamic State of Iraq and the Levant (ISIL) ended in 2017 but people continued to experience their reverberations even during the period under evaluation with high levels of vulnerability and displacement.

6. The conflict with ISIL also resulted in a fall in oil revenue, which halted progress in Iraq. The Human Development Index (HDI) value of Iraq for 2018 was 0.689, which put the country in the medium human development category and ranked it at 120 out of 189 countries and territories. In 2019, its HDI had deteriorated to 0.674 and positioned it at 123 out of 189 countries and territories. The 2019 Iraq HDI was above the average for countries in the medium human development group and below the average for countries in Arab states. [7] The 2018 female HDI value for Iraq was 0.566 in contrast with 0.731 for males.[8] Children were among those most severely affected by the conflicts.

2.1.1 The Humanitarian Context

7. During the last decade, Iraq has hosted to high numbers of both internally displaced persons (IDPs) and refugees. Out of the 6 million people displaced during the 2014–2017 conflict against ISIL, humanitarian partners estimate that 4.1 million people continue to require some form of humanitarian assistance. Of the people in acute need, approximately 1.5 million people remained internally displaced, 70 per cent of whom have been displaced for more than three years. The

[4] UNICEF, 2019, Country Programme Document
[5] UNDP, 2019, Independent Country Programme Evaluation
[6] Iraq, UNDAF 2015–2018
[7] http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/IRQ.pdf.
[8] http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/IRQ.pdf

process of return to areas of origin is fraught with difficulties. An estimated 514,000 returnees live in areas of high severity of needs, indicating a lack of livelihoods, basic services, social cohesion, and security.[9]

8. As of December 2020, camps hosting 251,000 of internally displaced persons (IDPs) of Iraq were closed as mandated by the Government of Iraq (GOI). At the time of the beginning of the evaluation, the Government announced an intention for all camps to close by June 2021 although this has not yet been finalized. For those affected by camp closures in 2020, departing IDPs indicated to protection partners that they cannot return to areas of origin and do not have other options for safe, voluntary, and dignified resettlement. There have been ongoing concerns from humanitarian actors regarding the welfare and risks faced by many households departing camps, including those who face acute vulnerability in return areas.[10]

9. In addition to the conflict-related humanitarian situation, Iraq has been affected by the COVID-19 pandemic. Beyond the immediate health impact, the outbreak of COVID-19 in Iraq and the associated preventative measures have increased humanitarian needs of the conflict-affected population, primarily driven by the loss of livelihood and associated reduced household financial security as well as a deteriorating protection environment. The containment measures imposed by the Government of Iraq have resulted in the disruption of trade, transport and banking and financial services, as well as sharply increasing unemployment.[11]

10. Since 2012 Iraq has also been host to Syrian refugees. As of 31 December 2020, a total of 242,163 UNHCR-registered refugees from Syria are currently in Iraq.[12] The vast majority reside in the Kurdish Region of Iraq (KRI). Fifty per cent of Syrian refugees reside in the Governorate of Erbil with most living outside camps, in urban environments.[13] Fluctuations in the conflict in Syria mean that there continues to be movements of Syrians across the border to Iraq. For example, the conflict in North-East Syria in 2019/20 resulted in an estimated influx of 15,000 refugees.[14]

11. The longevity of the conflict in Syria and the unlikely return of most Syrian refugees in the medium term has meant that the focus of the humanitarian community through the 2020–2021 Regional Refugee and Resilience Plan (3RP) was on transition from humanitarian assistance to a longer-term, solutions-oriented approach. This includes supporting refugees to move from reliance on humanitarian assistance to self-reliance and integrating them into public services and national systems.[15]

12. The lack of access to sustainable employment and livelihood opportunities is the main vulnerability reported by Syrian refugees in the 2018 and 2019 Multi-Sector Needs Assessments.[16] The lack of sustainable livelihoods has led to protection issues such as school dropouts, child labour and child marriage as households look for ways to earn income and save money.[17]

13. The 2020 Humanitarian Response Plan (HRP) intended to address four strategic objectives: critical problems related to physical and mental well-being and critical problems related to living standards and protection. The humanitarian community in Iraq identified key activities to be maintained or implemented. These were grouped as:

[9] OCHA, 2020, Humanitarian Needs Overview 2020
[10] OCHA, 2020, Humanitarian Snapshot
[11] OCHA, 2020, COVID-19 Addendum to the Humanitarian Response Plan
[12] 3RP 2021-2022
[13] https://data2.unhcr.org/en/documents/details/84200
[14] UNHCR, 2020, Regional Refugee Resilience Programme, Iraq
[15] ibid
[16] REACH, 2019, Multi-Sector Needs Assessment
[17] UNHCR, 2020, Regional Refugee Resilience Programme, Iraq

- Immediate health-related responses, including measures to prevent the spread of disease (hygiene promotion, water and sanitation, disease-outbreak preparedness and response, quarantine and isolation measures, communication with communities/ awareness-raising etc.)
- Interventions that enable an adjusted response to new and changing needs due to the different operational environment during COVID-19 (remote protection monitoring and case management, psychosocial support, legal assistance, alternative education, alternative care for unaccompanied children and capacity-building for humanitarian actors to operate during COVID-19)
- Provision of food assistance, multipurpose cash, and livelihood support for the most vulnerable within the HRP target population (expansion of cash-based food assistance, cash-for-work for rehabilitation of key service infrastructure, agricultural/livestock inputs/services, and multipurpose cash). [18]

2.2 Mental Health and Psychosocial Support Needs in UNICEF

2.2.1 Mental Health and Psychosocial Support in UNICEF

14. Mental health and psychosocial support (MHPSS) are fundamental parts of UNICEF's Core Commitments for Children (CCC) in Humanitarian Action, released in 1998 and revised in 2010.[19] It is also a critical component of the United Nations Global Strategy for Women's, Children's, and Adolescents' Health for 2016–2030.[20] The CCC is driven by a need to fulfil children's rights in humanitarian contexts.

15. MHPSS interventions "help promote resilience by aiming to strengthen protective factors in children's lives so that they are able to develop attachments and rebuild hope and agency."[21] Though it is known that children's development benefits from positive attachment to caregivers, new findings show that the social environment of children and families – such as cultural adherence, social cohesion, material resources and identity – are also important. [22]

16. Resilience is the ability to overcome adversity and positively adapt after challenging or difficult experiences. Children's resilience relates not only to their innate strengths and coping capacities, but also to the pattern of risk and protective factors in their social and cultural environments.[23] Well-being, on the other hand, describes the positive state of being when a person thrives. In mental health and psychosocial work, well-being is commonly understood in terms of three domains:[24]

    - Personal well-being – positive thoughts and emotions such as hopefulness, calm, self-esteem, and self-confidence
    - Interpersonal well-being – nurturing relationships, a sense of belonging, the ability to be close to others.
    - Skills and knowledge – capacities to learn, make positive decisions, respond effectively to life challenges, and express oneself.

17. Based on the inter-agency standing committee (IASC) MHPSS guidelines,[25] organizing safe spaces where children can play and adults can meet and discuss ways to increase protection, including

[18] OCHA, 2020, COVID-19 Addendum to the Humanitarian Response Plan
[19] UNICEF, 2020, Core Commitments for Children in Humanitarian Action.
[20] Every Woman, Every Child. The Global Strategy for Women's, Children's, and Adolescent's Health (2016-30): Survive, Thrive, Transform
[21] Symposium 'Growing up in conflict: The impact on children's mental health and psychosocial well-being', convened by UNICEF together with the Government of the Netherlands and humanitarian and academic partners in May 2015 in The Hague.
[22] Community-based psychosocial support in humanitarian settings: three-tiered support for children and families.
[23] Dr. Michael Ungar, in Hague Symposium Report, 2015
[24] UNICEF, Inter-agency Guide to the Evaluation of Psychosocial Programming in Emergencies, United Nations Children's Fund, New York, 2011.
[25] Reference

child protection, and well-being is recommended to respond to protection threats in an appropriate community-guided action. Evaluations of models based on child-friendly spaces (CFS)[26] have shown certain limitations in engaging families and communities, as well as in transitioning early emergency response to recovery and regular programming. These highlight the need to improve both the scale and quality of MHPSS. SPSS for children and their families, aimed at strengthening resilience and protection and promoting well-being fall under the third layer of the IASC MHPSS intervention pyramid, the focused non-specialized support provided through group or individual interventions by trained and supervised workers.

2.2.2 Child Protection and Mental Health and Psychosocial Support Needs in Iraq 2018-2020.

18. Within the Iraq context, MHPSS and CP support are important components of the humanitarian response. Children who were used by ISIL or lived under its control have a high likelihood of having witnessed, survived, and been forced to participate in extreme forms of violence, exploitation, and abuse, including sexual violence and rape. The crisis has not only affected children but their caregivers and communities as well.

19. Even in the absence of conflict, violence is a significant hallmark of the lives of women and children in Iraq. Children routinely experience physical and sexual violence and psychological aggression at home, school and in their community, often in the hands of people they trust and with whom they interact daily. According to a UNICEF assessment in Iraq in 2018, almost 81 per cent of children aged 1 to 14 years experienced some form of violent discipline method during the last one month before the survey.[27] It did not include surveys of families within IDP camps, with a likelihood that these numbers could be higher. In addition, 18.4 per cent of caregivers believe that physical punishment is needed to bring up or educate a child properly.[28]

20. The combined effect of violence and prolonged exposure to multiple displacements continue to impact children and families physically, psychologically, and in terms of their social well-being. In 2019, as many as 1 million people in Iraq were estimated to need MHPSS[29] and CP partners reported more than 15 districts across Iraq with 30 to 50 per cent of children showing signs of psychosocial distress.[30] In parallel, health actors identified a need to increase MHPSS, physical and mental rehabilitation and prevention and response programming.[31]

2.3 UNICEF's response in Iraq, 2018–2020

21. The UNICEF Country Programme of Cooperation 2020–2024 is designed to support the Government at national and sub-national levels to accelerate the realization of rights for all children in Iraq. The programme aims to address gaps and challenges in the enabling environment, including social norms, access to and quality of basic services as well as levels of demand for services.

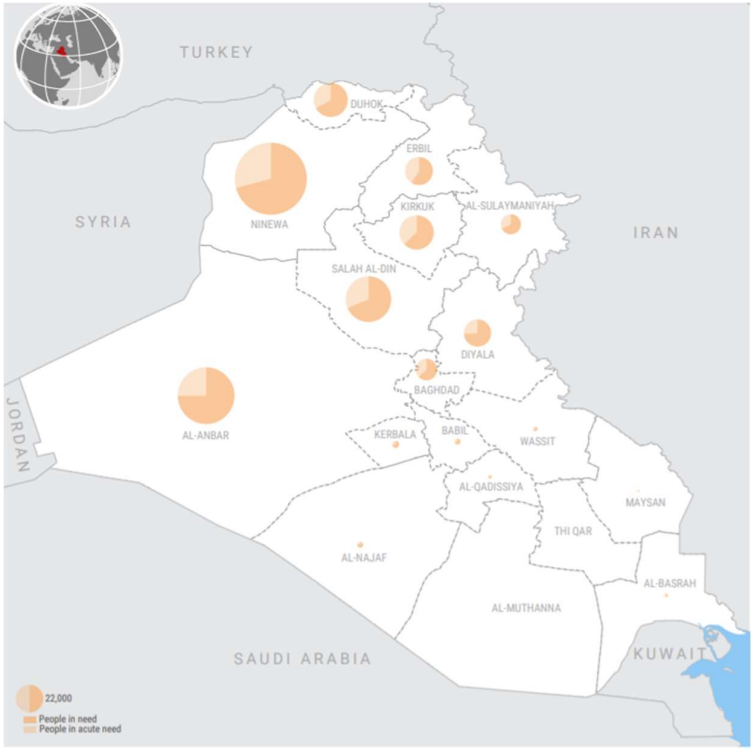
22. The programme includes the need for a multisectoral risk-informed approach to address the long-term impact of conflict and exposure to violence on the mental health and psychosocial well-being of children, adolescents, their caregivers, and communities.

23. Some aspects of the UNICEF Iraq programme, including its work on system-strengthening, are designed to have national coverage. The rest of the UNICEF programme prioritizes ten governorates[32] of the total 18 as per the HRP, although programming support will also cover additional governorates on a project specific basis to a lesser degree for all governorates within the HRP. The ten prioritized governorates are prioritized due to the numbers of the most deprived and

[26] Inter-agency guide to evaluations of psychosocial programming in humanitarian crisis
[27] UNICEF (2018) Multiple Indicator Cluster Survey (MICS) Iraq
[28] UNICEF, 2020, Terms of Reference UNICEF Emergency Psychosocial Support Programme in Iraq
[29] UNICEF, 2020, Terms of Reference UNICEF Emergency Psychosocial Support Programme in Iraq
[30] UNICEF, 2020, Terms of Reference UNICEF Emergency Psychosocial Support Programme in Iraq
[31] Humanitarian Needs Overview, Health, 2019
[32] Ninewa, Al-Anbar, Sulaymaniyah, Kirkuk, Salah Al-Din, Dahuk, Baghdad, Diyala, Al Basrah, and Al Qassidaya.

hard-to-reach children and women, including those with disabilities, internally displaced persons, and refugees. Figure 1 reflects the coverage of the HRP for 2020 reflecting the relative geographic focus of UNICEF for the period under evaluation.

Figure 1: HRP Coverage anticipated for 2020.[33]



24. UNICEF's sectoral focus as part of the plan includes Health and Nutrition, Water, Sanitation and Hygiene (WASH), Education, Child Protection and Social Inclusion.[34] UNICEF is leading the WASH, and Education Clusters and the Child Protection Sub-Cluster. In addition UNICEF Co-leads the Nutrition working group under the Health Cluster.

25. The Structured PSS programme (SPSS)[35] is part of the support provided to these governorates under the CP Sector. The CP Sector represents about 10 per cent of all UNICEF programming in Iraq based on resource allocations in the 2019 and 2020 Country Programme Documents (CPD). The 2019 CPD has increased about three times in amounts from the 2016 CPD in terms of resourcing, and the relative percentage allocated to CP has held stable also reflecting a nearly threefold increase. Table 1 describes the anticipated sector resourcing for UNICEF according to the Country Programme Documents for 2016 and 2019.

Table 1: Resourcing anticipated per Sector in CPDs for 2016 and 2019

Sector	2016 CPD Resourcing (in thousands of USD)	2019 CPD Resourcing (in thousands of USD)
Health and Nutrition	21,800	42,000
WASH	21,700	101,125
Education	27,000	49,157
Child Protection	12,900	36,761

[33] Source: Humanitarian Response Plan for Iraq. Issued January 2020.
[34] UNICEF, 2019, Country Programme Document
[35] Within UNICEF, PSS activities are often labelled as MHPSS (Mental Health and Psycho-social activities). This evaluation is commissioned to review the effectiveness of a structured approach to PSS activities. For the purposes of this exercise, the overall MHPSS activities will be referred to either as the Structured PSS (SPSS) the informal PSS activities or the parents' courses which are all included under MHPSS.

Adolescent Development	5,400	NA
Social Policy	3,600	38,911
Emergency Capacity and Coordination	400	NA
Programme Effectiveness	19,200	62,648
Total	**112,000**	**333,602**

26. SPSS is one of seven categories of beneficiary-oriented activities within the Child Protection Area of Responsibility (CPAOR) programming, but it occupies a significant position in terms of number of partners engaged and number of beneficiaries reached. Based on the criteria of number of implementing partners (IP) or the number of beneficiaries reached through an activity, PSS support represents a major activity under Child Protection programming with PSS activities comprising between 40-50 per cent of all beneficiaries reached through UNICEF support in any one year.

27. PSS activities represent the second most beneficiaries among all CPAOR activities, behind general awareness raising campaigns. UNICEF also supports CPAOR programming through the 3RP although the HRP beneficiary support represents about 90 per cent of all UNICEF programming support in Iraq. In total, UNICEF has reached almost 1.2 million CPAOR beneficiaries between 2018-2020, including 546,000 receiving PSS (Table 2). Table 2 shows the number of beneficiaries reached by activity according to the Child Protection Cluster Dashboard for 2018-2020 for the HRP programming.

Table 2: Number of Beneficiaries Reached per CP Activity: 2018-2020

Child Protection Sector Activities[36]	**2018 Beneficiaries Reached**	**2019 Beneficiaries Reached**	**2020 Beneficiaries Reached**
Awareness Raising on CP issues	149,383	210,904	230,477
PSS	190,207	181,283	174,517[37]
Parents Programming	12,447	24,642	23,124
Legal/Documentation services	3,801	14,745[38]	11 952
Case Management	7,328	18,985	18,194
Referrals	4,752	7,656	4,265
Family Tracing	665	175	NR
CP Capacity Development - Various	15,060	13,508[39]	7,381
Total[40]	**384,178**	**473,518**	**342,025[41]**
	1,199,721		

2.4 Subject of the Evaluation: UNICEF Emergency Psychosocial Support Programme in Iraq

28. The overall objective of UNICEF's PSS is to enhance the resilience and capacity of children and address stressors related to violence, displacement and loss and family separation.

29. To achieve this objective, UNICEF is supporting a PSS response targeting children and their families through a variety of MHPSS partners (Government and international and national non-

[36] Some activities described in the CP Dashboard are clustered into a single category for this ranking purpose.

[37] As noted in the programme description section, COVID-19 restrictions forced implementing partners to adjust how they reached beneficiaries in 2020. PSS beneficiaries reported here are a combination of those who were able to meet with face to face (before the restrictions began) and then subsequent participation through online activities as implementing partners adapted their ways of working – combined with implementing partner door-to-door campaigns and additional small group meetings still carried out within camps as well as the distribution of PSS family kits.

[38] These values are the summation of three activities related to legal services cited in the CP dashboard and do not adjust for double-counting

[39] These values are summations of three separate capacity building activities most relevant to PSS (the dashboard is for all CP activities). Double-counting is not controlled for.

[40] Individuals reached may have received more than one type of service from UNICEF CP Sector programming support – this value may therefore include double-counting of some families or individuals.

[41] This does not include COVID-19 related activities but only the original HRP plans.

governmental organisations (NGO)) who provide a layered response based on the IASC guidelines.[42] The response includes building capacities of the communities and frontline workers, provision of age- and gender-appropriate PSS services as part of child protection, GBV and education intervention and ensuring effective coordination in the sector.

30. In 2017, the CP sub-cluster along with national and international partners, formalized a SPSS programme to provide a more systematic approach to addressing the three components of psycho-social well-being described in section 2.2. Beginning in 2018, this involved an extensive review of existing SPSS curricula developed by partners in Iraq or elsewhere that provided a standardized curriculum intended to enhance the resilience and psychosocial well-being of IDP and returnee children and families. The proposed modules put forth to the CP sub-cluster were reviewed and assessed against possible relevance to importation to the Iraq context.

31. From this process, three evidence-based, age- and gender-appropriate individualized and group structured PSS curricula were selected for use in Iraq with youth and children.[43] The main modules were presented by Save the Children Fund International (SCFI) and WarChild. After selection, a training of trainers of around 85 staff from UNICEF, Protection Cluster partners, and implementing partners took place. Additional partner-specific modules were also approved by the CP sub-cluster on a case-by-case basis and eventually reached around 131 staff from UNICEF and Protection Cluster partners.

32. Services are offered to children and their families through a network of child- and adolescent-friendly spaces, outreach services with activities ranging from simple recreational activities to the full 16 session cohort approach covering three months. The services are aimed specifically at strengthening resilience and coping mechanisms, to the provision of specialized PSS and case management support for children who have suffered from violence and psychological harm, including unaccompanied and separated children. UNICEF also supports some system strengthening and capacity building interventions for field level activities including of social workers, community based nonspecialized child protection workers and specialized child protection workers. UNICEF also provides overall system strengthening interventions including the review and development of legal and policy frameworks and strengthening information management. These set of activities present an opportunity to contribute to both humanitarian and longer-term developmental aims (nexus-relevant).

33. UNICEF has been providing PSS support even before the period under review (2018-2020). UNICEF CO documents reported that since the onset of the crisis in 2012, the UNICEF PSS response has reached close to 300,000 children and around 40,000 members of their families. In 2019, the UNICEF child protection programme reached 20,106 children with specialized protection services; 176,674 children with age- and gender-appropriate SPSS; 21,688 women with individual and group psychosocial support services; and 23,566 parents and caregivers with the parenting education programme.[44] Budgeting for SPSS is merged with overall CP budgeting which ranges from 4 million USD to 12 million USD across the two CPD. SPSS activities are implemented on a rolling basis by partners throughout a calendar year that are aggregated under a single annual partner agreement document which is renewed with UNICEF upon completion of the prior year activities. The partner activities and the overall programme document with UNICEF are linked to the HRP or 3RP plans and are coordinated with the CP Sub-Cluster and PSS Task Force.

34. **Module Summary**: The modules used for SPSS are part of two curriculum produced by WarChild and Save the Children Fund International (SCFI). The three WarChild modules comprise a curriculum for children and youth across an age cycle from 6-20 years. The two SCF modules comprise a similar

[42] UNICEF Country Programme Document, 2019.

[43] There is an additional structured PSS for parenting, but it falls outside the scope of this evaluation for direct analysis but will be considered in terms of its connectivity to the child-focused structured PSS.

[44] UNICEF, 2020, Terms of Reference UNICEF Emergency Psychosocial Support Programme in Iraq

age-cycle curriculum from 10-20 years. Stakeholders in the CP Sub-Cluster tended to refer to each curriculum as a "module" although there are actually several modules within the overall curriculum. For the purposes of this report, the ET is using the term 'modules' to refer to the collective set of curricula produced by WarChild and by SCF. Table 3 provides a brief summary of each module within the curriculum.

Table 3: Summary of key activities per SPSS module

Curriculum	Module	Summary
WarChild	**Little Fellow**	Designed to support children 6-9 years old in conflict affected contexts. Emphasizes teaching coping skills to adapt to circumstances, internalizing positive values, and building constructive relationships. Incorporates conflict resolution tools to strengthen self-confidence. Designed to be 11 sessions. Each session 1.5 hours. Applied weekly over a period of 6-11 weeks. 12 participants for one facilitator or 20 participants for two facilitators.
WarChild	**I DEAL**	Intended to children 10-14 years of age for gaining life skills to cope with life after conflict. Focuses on supporting children to develop problem solving skills and ability to see various options and solutions to problems. Also includes exercises for anger control, empathy and tolerance, and self-esteem. Divided into four sections: a) identify and assessment; b) relations; c) dealing with emotions; and d the future. Designed to be 16 sessions across four modules. Each session has a duration of 1.5 hours. Sessions to be carried out weekly or bi-weekly over a period of 2-4 months. 12 participants maximum for one facilitator or 25 maximum for two facilitators.
WarChild	**Win-Win DEAL**	Designed for youth 15-20 years old. Intended to help youth understand and address interpersonal and intergroup conflict. Provides exercises to support conflict analysis and collaborative solutions, dealing with strong emotions constructively, develop effective and non-violent communication skills and develop strategies to be agents of change. Divided into five sub-modules: i) team building; ii) understanding conflict; iii) conflict resolution; iv) taking action; and v) beyond win-win deal. Designed to be 16 sessions. Each session 1.5 hours. Applied weekly over a period of 2-4 months. 12 participants for one facilitator or 20 participants for two facilitators.
SCF	**Child resilience**	Designed for children 10-14 years old. Intended to promote positive coping and resilience. Participatory methodology seeks to support youth to resume normal activities after a crisis, improve personal and social skills, increase self-esteem and life choices and to act as role models for other children and youth. The youth component has eight workshop themes with each theme comprising 2-5 thematic workshops and also includes two introductory workshops and two closing workshops. The module also includes seven meetings with parents and caregivers. Designed to be flexible in terms of number of sessions. Each session is intended to be 2 hours in length. Applied weekly over a period of 3-4 months. Optimal size recommended is 10-20 youth working with two PSS facilitators.
SCF	**Youth Resilience**	Designed for youth ages 14-20 and parents and caregivers. Intended to promote positive coping and resilience. Participatory methodology seeks to support youth to resume normal activities after a crisis, improve personal and

		social skills, increase self-esteem and life choices and to act as role models for other children and youth. The youth component has eight workshop themes with each theme comprising 2-5 thematic workshops and also includes two introductory workshops and two closing workshops. The module also includes seven meetings with parents and caregivers. Designed to be flexible in terms of number of sessions. Each session is intended to be 2 hours in length. Applied weekly over a period of 3-4 months. Optimal size recommended is 10-20 youth working with two PSS facilitators.

35. This aspect of the MHPSS intervention is particularly focused on serving internally displaced children and refugee children as outlined in the HRP though inception interviews indicated that other conflict-affected children had also been included in activities, e.g., returnees and others in school- and community-based activities.

36. The activities within the approved programme encourage children to express their feelings and needs and help re-engage in trusting relationships, reduce social isolation, resolve conflicts peacefully and build skills and knowledge on how to protect themselves against risk. They are largely based on group activities.[45] These modules and their application serve as the focus of the evaluation exercise.[46]

2.4.1 SPSS Theory of Change.

37. There is no separate UNICEF theory of change (ToC) for SPSS, but SPSS is integrated as a cross-cutting activity contributing to the overall Child Protection ToC (Figure 2). One of the three underpinning principles of the Community Based MHPSS Operational Guidelines highlights the critical role of MHPSS in creating and supporting conditions for children's optimal development and wellbeing in emergencies.

[45] UNICEF IDP response planning sheet 2020

[46] Specific linkages from SPSS to SDGs would be ambitious because the SPSS programming is one element within a larger sectorial framework which in turn sits within a larger strategic plan for the humanitarian response. However, the SPSS itself would be expected to eventually contribute to SDG 3 (Good Health and Wellbeing) if wellbeing is defined to include psycho-social wellbeing.

Figure 2: The CP Theory of Change and SPSS

OUTPUTS AND UNICEF INTERVENTIONS (9 CIRCLES OF SUPPORT)		
Child and adolescent	**Family/Caregiver**	**Community**
1. SAFE, NURTURING ENVIRONMENTS Safe spaces, safe and supportive play, recreation and learning environments, support to vulnerable families and violence reduction	**4. SUPPORTING CAREGIVER WELLBEING** Focused care for distressed caregivers, specialized MHPSS care for parents with MNS disorders, support in coping	**7. WELLBEING AND PROTECTION AWARENESS-RAISING,** CP messaging and stigma reduction campaigns
2. POSITIVE RELATIONSHIPS Peer-to-peer groups for adolescents, cultural and expressive activities for children, mother-baby groups	**5. POSITIVE PARENTING** Awareness-raising of distress reactions among children of different ages and developmental stages, promotion of positive parenting knowledge and skills, support for parents/caregivers in caring for children with MNS disorders	**8. ACTIVATED NATURAL COMMUNITY SUPPORTS** Engagement, mobilization and support to community organizations (communication for development activities), support to community leaders in promoting child and family wellbeing
3. STIMULATION, LEARNING, SKILLS DEVELOPMENT: Little fellows' program, ECD activities, life and vocational skills training for adolescents, adolescent girls and adolescent mothers	**6. FAMILY AND COMMUNITY SUPPORT NETWORKS** Caregiver/women's/men's support groups, facilitaion for inclusion and participation of vulnerable families in communal activities	**9. STRENGTHENED CARE SYSTEMS** Training of professional and lay staff in CP, coordinated MHPSS care for children and families, adolescent life skills and development of functional referral systems for at-risk and families

Source: UNICEF SPSS Evaluation Terms of Reference. Annex 1.

38. The Community Based MPHSS ToC explains how the MHPSS intervention operating at three layers or tiers: child, family/caregiver, and community, can help to reduce suffering and improve people's mental health and psychosocial wellbeing. The MHPSS program ultimately aim to (1) reduce and prevent harm, (2) strengthen resilience to recover from adversity, and (3) improve the care conditions that enable children and families to survive and thrive. This approach strengthens the innate capacities of children, caregivers, and communities to support their wellbeing and protection.

39. The MHPSS intervention is further elaborated into nine circles of integrated support across the layers of the IASC pyramid. These circles address the needs of children and families for wellbeing and safety in their context – from the delivery of basic services in culturally appropriate ways, to strengthening family and community social networks, to focused or specialized care when needed.

40. The SPSS activities implemented by UNICEF partners in IRAQ between 2018 and 2020 are integrated in two out of the 9 circles of support, namely the second and third circles "Positive Relationships" and "Stimulation, Learning, Skills Development" (Figure 2).

41. The UNICEF approach in Iraq sees SPSS as part of connected component to other aspects of MHPSS detailed earlier and which relate to components 1 and 4-8 of the ToC. It also links to UNICEF's work to strengthen national and local systems for MHPSS through e.g., training, and other capacity development interventions for NGOs and government departments (component 9 of the ToC). The evaluation explores component 9 and linkages with other areas of MHPSS. This has important implications for SPSS programming choices further detailed in the findings section.

42. There are two limitations for drawing on the MHPSS Theory of Change to inform the SPSS analysis. First, the SPSS component does not have its own articulated outcome and goal objectives and associated indicators but relies on its integration into the MHPSS overall TOC. The MHPSS TOC describes three outcome dimensions towards which these nine outputs are to contribute: i) reducing and preventing harm, ii) strengthening resilience, and iii) improving the care conditions that enable children to thrive. Based on the narrative in the Terms of Reference for the Evaluation,

the SPSS is expected to contribute to the first two outcomes: Reducing and preventing harm (through SPSS providing an entry point for children into the child protection system) and Strengthening Resilience (through participation in the SPSS activities and modules).

43. The MHPSS TOC posits SPSS as a cross-cutting contributor. However, there is no clearly articulated causal link from the SPSS activities to the individual outputs, nor from the outputs to the associated outcomes. Because SPSS is merged as a cross-cutting component without its own ToC or clearly articulated causal pathways, there are a variety of implicit interpretations by SPSS stakeholders regarding the causal relationships between SPSS activities, outputs, and outcomes. These different understandings have impeded the development of a common and shared understanding for programme choices and project management. This is explored in more detail in the Findings section.

44. Additional potential barriers that this ToC describes for MHPSS overall are the challenges of coordinating MHPSS systems at a national level, the limited cultural acceptance of MHPSS activities, the stigma/discrimination of children/caregivers with MNS disorders/disabilities, the limited financial investment in MHPSS activities, the lack of national technical expertise, and the ongoing conflict dynamics limiting MHPSS operations. In 2020 the programme experienced a further unforeseen challenge: COVID-19. The adaptations and limitations in SPSS programming during the pandemic are further profiled in the findings section.

45. **Partners and Humanitarian Response.** There are two primary instruments guiding humanitarian response programming in Iraq: The HRP and the 3RP. These are reported separately on the Child Protection Dashboard for Iraq, but the modules, activities and partners related to SPSS are similar. The HRP contains a far greater number of beneficiaries compared to the 3RP and thus the HRP comprises the primary dashboard for tracking UNICEF efficiency questions.[47] More details on the degree of support and numbers reached are included in the Findings section on efficiency and effectiveness.

46. According to the CP dashboard,[48] UNICEF engages with a diverse group of child protection partners to deliver SPSS activities. IP agreements detail planned activities for structured PSS as per the agreed guidelines. Implementing partners included international (e.g., SCFI, Terre des Hommes) and national NGOs (e.g., Al Soroor, Association for Women and Child) as well as government counterparts such as Department of Labour and Social Affairs (DoLSA). Funding for SPSS comes through UNICEF with the NGO and Government counterparts providing the implementation of the activities. UNICEF provides support to the majority of the overall implementing partners engaged in SPSS each year. The percentage of SPSS partners supported by UNICEF has increased over the period under review. The overall range of partners stays relatively consistent, but there are variations in who are the largest partners in any given year. The number of partners UNICEF worked with on SPSS within the HRP are detailed in Table 4. Annex 3 provides a more detailed description of SPSS stakeholders and their associated roles in SPSS activities and management.

Table 4: SPSS Implementing Partners and UNICEF[49]

UNICEF Partners PSS in HRP	2018	2019	2020[50]	
			PSS	PSS Kits
Number of all PSS Partners	50	53	36	21
Number of Partners Supported by UNICEF	30	34	44	28
Per cent of Total	60%	64%	82%	75%

[47] In 2018-2020, the 3RP beneficiaries in SPSS were only about 1/10th the number of those in the HRP SPSS activities.

[48] Source: Child Protection Sub-Cluster Dashboard – HRP status. Not all UNICEF personnel were aware of the partners listed in the dashboard during anecdotal conversations, but the dashboard serves as the default point of information throughout.

[49] Source: Child Protection Sub-Cluster Dashboard – HRP status

[50] Due to the pandemic, PSS was rolled out in two forms: SPSS activities or the distribution of SPSS basic family kits.

Largest Partners (by Beneficiary)	DOLSA Sulaymaniyah BRHA BROB Tdh-Lausanne	Tdh-Italy GW DOLSA Sulaymaniyah BROB	Tdh-Italy DOLSA Dohuk SOSD SCI	Tdh-Italy SOSD UADF WRO
Average Number of Beneficiaries - Largest Partners	25,400	20,750	10,500[51]	15,000

47. **COVID-19 adaptions to the programme:** COVID-19 resulted in changes to how the PSS interventions were delivered, e.g., group activities, the basis of SPSS were suspended, emergency PSS interventions were designed including home PSS kits, home visits were undertaken, and guidance notes were issued to manage social distancing as some group activities began again.

3 Evaluation Features

3.1 Purpose, Scope, and Objectives

48. In line with the evaluation ToR, the purpose of the evaluation is to provide an independent assessment of the contribution of SPSS to children's well-being in the Iraq context of 2018–2020 and its positioning in relation to the linkages between the humanitarian, development, and recovery contexts.

49. The evaluation aims to:

- Assess the relevance, efficiency, effectiveness, and humanitarian-development nexus aspects of UNICEF efforts to address the MHPSS needs of vulnerable children in Erbil, Ninewa, Dohuk, Sulaymaniyah and Salah El Din Governorates of Iraq using SPSS.
- Assess the quality of SPSS services provided by all partners at the different levels of the Inter-Agency Standing Committee (IASC) and MHPSS pyramid
- Assess if and when UNICEF might be able to exit the PSS space in Iraq without endangering the quality or quantity of PSS services available to vulnerable populations.
- Determine the extent to which UNICEF and partner SPSS programming is providing an entry point to overall child protection interventions.
- Document main lessons learnt and propose recommendations to deliver PSS services in a more effective and efficient way.

50. The scope of the evaluation is consistent with the original ToR with small adjustments as detailed in the IR. The adjustments consider the evolution of emergency PSS during the COVID-19-affected context of 2020 and lessons that can be derived from that experience (an aspect not identified in the original ToR) as well as practicality, security, and other considerations.

51. The focus of the evaluation for the COVID-19 PSS response reviewed the flexibility of the structured PSS approach for such a context (the utilization of remote PSS interventions and the distribution of the family PSS kits) and implementing partner perceptions on possible adaptations that could be used in PSS programming going forward.

[51] As noted in the programme description section, COVID-19 restrictions forced implementing partners to adjust how they reached beneficiaries in 2020. PSS beneficiaries reported here are a combination of those who were able to meet with face to face (before the restrictions began) and then subsequent participation through online activities as implementing partners adapted their ways of working – combined with implementing partner door-to-door campaigns and additional small group meetings still carried out within camps.

52. Overall, the evaluation has focused on the SPSS as developed and implemented by UNICEF and its partners from 2018–2020 in Iraq. Given the connections between SPSS and other aspects of child protection and emergency PSS it considered these linkages and complementarity as well.

53. **Beneficiary Group –** The evaluation explored the contribution of structured PSS to the well-being of children from among IDPs, refugees, returnees and host communities living in both camp and non-camp settings but with a particular emphasis on the application within the camp context of the HRP. Although the focus was on the camp-based interventions, interviews with partners and others, and document review, considered experiences and insights from other non-camp settings. These are integrated into the consideration of nexus opportunities.

54. **Geographic Scope –** The findings of the evaluation aim to be relevant to UNICEF in all geographic locations it works in Iraq. Data collection focused on the five governorates of Erbil, Ninewa, Dohuk, Sulaymaniyah with additional interviews with stakeholders (but not camps) in Salah Al-Din.

55. **Time Period –** The evaluation covered the time period from 2018 up to the end of 2020. Some analyses of secondary data will focus on 2019 as it is the only full year of the implementation of the structured PSS approach before COVID-19 restrictions.

56. **Expected Users of the Evaluation –** The primary expected users for this evaluation are the UNICEF Iraq Country Office and its partners in decision-making (especially those involved in adjustments to the SPSS implementation and/or design), and to support discussions with donors, the Government of Iraq, especially the Ministry of Labour and Social Affairs (MOLSA) and the Ministry of Education (MOE), to ensure that the SPSS programming can be sustained and transitioned into the development context. The evaluation will also serve to inform MOLSA, UNICEF, and the Child Protection Sub-Cluster on the lessons learned and to present recommendations based on the essential findings.

3.2 Evaluation Framework

57. The ToR provides 11 evaluation questions which are intended to contribute to responding to the two overall objectives of the evaluation:

    - Objective 1: To what extent has the SPSS programme promoted the well-being of conflict-affected children?
    - Objective 2: How well is this programme positioned for the linkage between the humanitarian context and the recovery and development context?

58. The evaluation criteria are structured along the OECD-DAC criteria although adjusted somewhat for the specific evaluation. For example, the ToR is not requiring all OECD-DAC criteria to be covered and the Nexus and Gender categories are not OECD-DAC criteria, but are requested by UNICEF in the TOR. The following table 5 summarizes the key evaluation questions (EQ) as described in the ToR against the evaluation criteria.[52]

[52] The full evaluation matrix linking these questions to data sources is described in Annex 2.

Table 5: Summary of the Evaluation Matrix

Dimensions	Evaluation Sub- Questions
Relevance	
EQ1. To what extent do stakeholders of different ages and genders—particularly children, parents, and communities—feel that the structured PSS programme's objectives and activities are tailored to beneficiaries' MHPSS needs and cultural context across geographic sites of operation?	
EQ2. What are the sociocultural barriers to UNICEF structured PSS approach and how have UNICEF and partners worked to identify and address these barriers?	
EQ3. To what extent are partners using the child protection sub-cluster approved structured PSS programme?	
Efficiency	
EQ4. To what extent does UNICEF and implementing partners with structured PSS programming use their resources in a way that allows for cost monitoring and maximum achievement per dollar of investment (cost of response/beneficiary) as compared to other MHPSS programmes operating in the same geographic areas?	
Effectiveness	
EQ5. How have rights holders' skills and knowledge, emotional well-being and social well-being changed over the course of the programme?	
EQ6. To what extent did high-quality, structured PSS programming, as defined by international guidelines on MHPSS programming, reach vulnerable refugee, IDP and returnee children in the geographic target areas and why (geographic coverage, duration, children reached vs. children in need)?	
EQ7. How, if at all, did the structured PSS programming change the way that rights holders engage with and regard community-based child protection structures, service providers and social norms?	
Nexus	
EQ8. To what extent have PSS decision-making bodies (government, civil society, development agencies) and implementing partners taken actions to ensure that the structured PSS programme will become institutionalized financially, organizationally, and otherwise in the absence of humanitarian assistance?	
EQ9. To what extent has the capacity of national PSS authorities, organizations and service providers been strengthened as a result of UNICEF and partner PSS programming?	
EQ10. To what extent has the coordination of agencies providing psychosocial support interventions for children in Iraq been successful in closing service gaps and creating referral mechanisms that are likely to endure in a development context?	
Gender	
EQ11. How did/do the structured PSS interventions, including design and monitoring procedures, specifically address gender issues?	

3.3 Evaluation Approach and Methodology

59. The evaluation matrix in Annex 2 describes in detail the categories, key questions, judgement criteria and data collection and analysis methods. The evaluation matrix serves as the foundation of an evaluation process and dictates the structure of this report. Cumulatively the evidence available for each question and performance indicator should enable a response to the relevant evaluation questions.

60. The evaluation uses a mixed- method approach**.** It included review of existing quantitative data,[53] document review,[54] remote interviews,[55] site visits,[56] focus group discussions with affected populations[57] and the distribution of an online survey.[58] The methodology aimed to facilitate a learning process and an ethical approach. Key principles include: i) Commitment to an ethical approach, ii) Commitment to producing an evaluation of practical value and to support learning; and iii) Commitment to flexibility to respond to an evolving context in light of security, COVID-19, and other contextual considerations.

61. **COVID-19 and Evaluation Design.** The COVID-19 pandemic had implications for the evaluation methodology. Travel restrictions meant that the original three-person international evaluation team was supported by three national consultants who were able to visit the camps. Access to the camps and key stakeholders was still restricted or shifting during the evaluation. Also, 2019 was the only year when structured PSS activities ran without disruption, which meant that monitoring data was limited.

62. As a result, the evaluation combined both remote and in-person methods of data collection and teamwork. The approach also captured lessons from the three implementation years:

    - 2018 when the structured PSS was defined and training of trainers took place,
    - 2019 when full scale implementation of the SPSS activities was carried out, and
    - 2020 when implementation was adjusted to take account of COVID-19 restrictions as well as being affected by accelerated population movements due to camp closures and other context changes as described earlier.

63. **Ethical Treatment of Minors and Vulnerable Populations**. Due to security conditions and the involvement of children in the data collection exercises, the methodology was subject to an external ethics review in alignment with the UNICEF Procedures for Ethical Research. The Institutional Review Board approval for the methodology was obtained during the inception phase, and the certificate of approval is attached in Annex 9.

64. As per the discussions during the inception phase, the evaluation approach follows UNICEF[59] and UK FCDO[60] ethics guidelines. The approach was also guided by sector standards of good practice such as developed by WHO.[61] Consent was essential in any interviewee and all interviewees were anonymised. Given the nature of the evaluation and of the vulnerabilities of the beneficiary group(s) this was crucial. The evaluation was not exploring children's experiences which led to participants' involvement in the PSS programme but rather focused on their experience of the programme and perspectives of its relevance though some aspects of the FGD tool explore their perceptions of the difference participation in PSS made to them. Participation in the evaluation was voluntary with all participants fully informed of its purpose and how their input will be used.

65. The ET members conducting the field visits were experienced psychologists/PSS specialists to help improve sensitivity to potential trauma surfaced during interviews. Data collection tools for FGDs were specifically designed to avoid causing discomfort or any distress. The ET gathered verbal consent from participants before interviews and discussions begin. At community level written

[53] Annex 6
[54] Annex 6
[55] Annex 5
[56] Table 6
[57] Table 6
[58] Annex 8
[59] UNICEF Procedure for Ethical Standards in Research Evaluation, Data Collection, and Analysis
[60] DFID Ethics and Principles for Research and Evaluation, 2011.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67483/dfid-ethics-prcpls-rsrch-eval.pdf .
[61] WHO Ethical and safety recommendations for researching, documenting, and monitoring sexual violence in emergencies.
http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

consent was secured and for children this included parental consent as well as the children's verbal consent.

66. In terms of data management, the evaluation adhered to the ethical considerations related to safety, confidentiality, and data protection. Although the ET used their own computers, once data is collected, data protection measures were used to ensure respondent confidentiality across all data instruments. Any data shared with the evaluation team were stripped of any personal information.

67. For the qualitative data, all interview notes from the evaluation team including national consultants were kept electronically on password-encrypted computers. Personal names and other potential personal identifiers were removed from the data prior to analysis. Data analysis were carried out only by the evaluation team members to ensure confidentiality. Both quantitative and qualitative information are maintained on evaluation team computers only until the finalization of the report, at which time it will be deleted to protect individuals further from possible identification.

3.4 Data Collection and Analysis Methods

68. The four main types of information collected were: i) Review of documents and pre-existing qualitative information, ii) pre-existing quantitative information related to the PSS activities and output indicators, iii) primary qualitative data from key informant interviews and focus group discussions; and iv) primary quantitative data from an online perceptions survey administered to implementing partner personnel involved in PSS and Training of Trainers (TOT) trainings.

69. Document Review: The Country Office provided extensive secondary documentation that is integrated into the evaluation analysis (Annex 6)..[62] These documents were used throughout the evaluation phase to address the relevant evaluation criteria and served as both a complementary source for triangulation with the data collection phase's primary quantitative and qualitative data, and as an historic overview of changes in SPSS programming. The document review has pertinence for addressing questions related to relevance and efficiency.

70. Pre-Existing Quantitative Data: Within the frame of the evaluation criteria, the pre-existing quantitative data is best suited to address elements pertaining to the efficiency and effectiveness of SPSS programming. Extensive data for activities and outputs were already collected through the maintenance of an information management system. UNICEF and the Child Protection Sub-Cluster maintain a dashboard of all CP programming activities and beneficiaries.[63] This database also served as one of the sources for analysis of efficiency and effectiveness. Finally, a selection of partner reports, monitoring data, and pre-post test results applied were reviewed by the ET to contribute to assessing efficiency and effectiveness of the reporting and information management systems.

71. Primary Qualitative Data – Remote Interviews and camp visits: Primary qualitative data included remote Key Informant Interviews (KIIs) with key SPSS and child protection stakeholders within UNICEF, the CP sub-cluster, implementing partners, and government. These interviews and conversations were used to contribute to the analysis of all the evaluation sub-questions but with a particular pertinence for relevance, effectiveness, gender, and the Nexus. The selection of stakeholders was intended to represent the array of potential stakeholder categories developed in the stakeholder analysis section of the IR (Annex 3) with a prioritization of specific individuals who were particularly information rich with regards to SPSS activities.

72. In addition to the remote KIIs, site visits to seven selected camps were carried out by contracted national consultants. The seven sites were selected in consultation with UNICEF. The site visits included focus group discussions (FGDs) with children, caregivers, community members, and the CP camp coordination committees. The planning and implementation of these FGDs took

[62] Including additional documentation identified during the inception mission and currently requested of UNICEF for the document review phase.

[63] https://public.tableau.com/profile/hussein1725#!/vizhome/IraqCPSCHRPresponse2019/Story1

consideration ethical aspects as detailed in the section on ethical considerations of the IR. They were also carried out to ensure confidentiality and privacy for participants i.e., in spaces where participants cannot be overheard. All data were accessible to the ET only.

73. Primary Quantitative Data – The primary quantitative data obtained through the evaluation focused on the PSS and TOT trainings and the quality of these trainings for preparing participants for implementing SPSS. An English/Arabic fixed response questionnaire was distributed to all participants via an online platform. The categories of questions included perceived quality of the training, subsequent follow-up, ongoing use, and relevance to context. The distribution list was obtained from the UNICEF CO. In total, out of the 131 email addresses, 19 (14.5%) were inactive. Of the remainder, the response rate was good with 81 per cent of contacted persons with active emails responding (91). Descriptive statistics on all outputs are found in Annex 8.

74. **Sample interviewing**. The international team carried out the remote interviews while the national consultants, supported remotely by one of the international team members, carried out the camp visits and FGDs. In total, 446 persons were interviewed (75 remote interviews and 371 through in-person FGDs in the camps). An additional 91 responses were collected through the online survey to PSS facilitators (69% response rate).[64] The following table 6 lists the FGDs carried out in the camps and Annex 5 lists the persons interviewed through remote interviews.

Table 6: Camp FGD Data Collection Summary

Site	Governorate	Number Interviewed
Berseve 1	Dohuk	50 (20 adults, 15 boys and 15 girls)
Shariya	Dohuk	49 (21 adults, 13 girls and 15 boys)
Qushtapa	Erbil	55 (20 adults, 15 boys, 20 girls)
Baharka	Erbil	55 (20 adults, 15 boys, 20 girls)
Sheikhan	Nineveh	53 (18 adults, 15 boys, 20 girls)
Hasansham U3	Nineveh	52 (19 adults, 13 boys, 20 girls)
ASHIT	Sulaymaniyah	57 (22 adults, 20 girls, 15 boys)
TOTAL		**371 (140 adults, 103 boys, 128 girls)**

75. **Data Analysis**. Data analysis was conducted throughout the data collection phase and afterward through a combination of synchronous and asynchronous exercises. The national consultants were involved in the data collection and assessment of preliminary findings through guided facilitated discussion with one of the international team members. Subsequently, the international team participated together in a multi-day debriefing and analysis exercise. For the synchronous exercises, sessions were held combining Zoom verbal communication with Mural[65] for visual organization. In the asynchronous work, team members were invited to do their own "homework" in Google Sheets set up against the evaluation matrix and in Mural in advance of each meeting. This approach allowed members to have time to reflect as well as to brainstorm together.

76. The evaluation team reviewed the responses from stakeholders, the quantitative data, and the document review to generate findings and conclusions against the EQs. All three main types of data (document, quantitative, and qualitative) had their accompanying management and analyses. Data analysis methods employed descriptive and comparative quantitative analysis, thematic narrative analysis, qualitative iterative data analysis, and contribution analysis. Key thought units were identified in interviews and then clustered into categories. Emergent themes from each category were selected for further analysis and re-categorization to identify key patterns. All methods were triangulated both internally and across methods as feasible. Triangulation involved comparing

[64] Some of the respondents who filled out the online survey were also part of the remote interviews.

[65] Mural is an online platform which functions as a virtual flipchart where the team could post their thoughts on virtual "sticky notes" which could then be moved and organized by categories and clusters. Constructing the Mural together allowed each team member to have ownership in the process.

information from different sources, collected by different evaluators, and obtained from different methods.[66]

77. Due to the importance of the triangulation of findings from different sources, a vital component of the data analysis was two debriefings carried out at the end of the data collection phase for feedback and external observations. The first was with UNICEF and CP sub-cluster stakeholders and the second was with a newly formed UNICEF Youth Reference Group. These two briefings were used to substantiate the findings and to develop conclusions and recommendations in response to the EQs.

78. In alignment with utilization-focused principle, the first debriefing presented initial findings and conclusions that were shared with UNICEF personnel, and representatives from implementing partners and government through a virtual online presentation at the end of the data collection phase. The purpose was to elicit an opportunity for correction of facts, general feedback, and to promote discussion and reflection on implementation possibilities. The second briefing was a presentation of preliminary findings to a newly formed UNICEF Youth Reference Group (YPAG)[67] to solicit observations on the recommendations from a youth perspective. Although the YPAG was not involved in the programme, they served as an important external perspective to triangulate whether findings, conclusions and recommendations were understandable and relevant to outside stakeholders.

79. **Limitations to the study**. The COVID-19 pandemic forced adaptations to the evaluation design including using remote data collection methods when in-person methods were initially planned. These adaptations were described in detail in the Inception Report and agreed to by UNICEF Iraq. The evaluation process was able to keep to the adapted plan and the evaluation team is confident in the robustness of the identified results.

80. Nonetheless, limited availability of quantitative data to track progress on SPSS outcomes constrained the degree to which quantitative data could be used in the findings.[68] 2019 is the only year when the programme was able to be implemented as envisioned because 2018 involved the start-up of the programme and 2020 included the COVID-19 pandemic, resulting in massive adjustments across the entire humanitarian system. Evaluating a programme on one year of implementation may not allow for time to see the full effect of the contributions. Furthermore, there were limitations in the potential analysis of the Child Protection ToC for guiding contribution analysis since outcome level data on the contributions of SPSS for child wellbeing or case management referrals was absent. In terms of the camp site visits, although care was taken to ensure that the selection of camps reflected the diversity and representativeness of all sites where SPSS had been implemented, and with the types of implementing partners, a site visit to seven camps is perforce not a statistical survey and data extracted from the visits should be considered indicative rather than representative. However, despite the COVID-19 restrictions and ongoing changes to context, the overall data collection process went smoothly. Furthermore, the ET did not encounter challenges to independence, impartiality, or conflicts of interest during the implementation of the evaluation exercise.

4 Evaluation Findings

81. The evaluation findings are organized according to the evaluation criteria of relevance, efficiency, effectiveness, the nexus, and gender as per the ToR. For narrative flow, the treatment of gender considerations is integrated into the effectiveness section. The review of the programmatic

[66] See ALNAP. Evaluation of Humanitarian Action: Pilot Guide, ODI, 2013:140 for definitions of each type of triangulation.

[67] Title: Young People Advisory Group (YPAG)

[68] Further details found in Effectiveness section.

adaptations taken in response to the COVID-19 pandemic in 2020 is integrated as a cross-cutting theme throughout the dimensions of Relevance, Efficiency, and Effectiveness.

4.1 Relevance[69]

82. This section explores whether the SPSS materials, modules, and activities were appropriate to the needs of the affected children and parents. Of particular interest are the degree to which the materials and activities were tailored by partners to the specific context and the degree to which socio-cultural barriers may have affected consistent implementation by SPSS partners. The relevance of adaptations to the COVID-19 restrictions is also explored. Overall, the evaluation found that there is considerable variation in how the SPSS material and modules are being used across partners, with a lack of a common agreement over the relative weighting of SPSS for its contributions as an entry to the CP systems versus as a mechanism for building resilience. There were also limited evidence of in-depth needs assessments with specific cohorts being done before implementation. This combined with the modules being developed for a different context, reduced the relevance of the materials. Despite this, the potential barrier of mental health stigma was addressed by partners to ensure relevance of materials to overcome socio-cultural barriers. Partners also undertook relevant pro-active innovations to provide some form of SPSS support during the COVID-19 pandemic.

4.1.1 Tailored to needs?

83. When considering relevance and tailoring to needs, there are two distinct components for evaluation – design and implementation of a programme. Design relates to the theoretical and conceptual basis behind the design of a programme, while implementation relates to the relevance to needs during the actual implementation of the programme in the field.

84. **The design of the SPSS is well conceptualized and coherently integrated into the overall CP TOC and its nine-dimensions**. The SPSS modules are primarily focused on the dimensions #2 and #3 of the CP TOC (Positive relationships and Skills Development) described in Section 2.4.1. The parents' module contains elements related to TOC #4 and TOC #5 although these modules were not implemented by all NGOs.[70] Implementing partners that did include the parents modules reported that the self-care aspect in the modules was not usually covered in the parents' sessions because of time and interest constraints. The linkages to the TOC are more clearly connected to the SCF resilience modules which were the more commonly used than the WarChild modules as cited by IPs.

85. **The main modules were considered *generally* appropriate, but the modules were not considered to be *specifically* adapted to the Iraq context or the reality experienced by the participating camp children**. The modules were originally developed for use in refugee and IDP contexts – usually in Africa. While adapted to children and youth experiencing displacement, there is a gap in tailoring the materials to the Iraq context. The modules were imported from other conflict and IDP contexts in Africa and depict pictures and stories that were not updated to reflect the Iraq reality. When asked why subsequent local adaptation did not happen, respondents pointed to the fact that these materials were owned by two of the CP sub-cluster organizations and that these organizations had withdrawn their PSS technical specialists from Iraq shortly after the introduction of the SPSS modules. This slowed down the process of further adaptation to the Iraq context. PSS facilitators in the field stated that they would often do direct adaptations at the point of carrying out a specific session. However, as is noted in more detail in the Nexus sections, few of the local level PSS facilitators interviewed reported having received training on the modules and many expressed a lack of confidence in knowing how they were supposed to adapt the modules to make

[69] This section is to profile the alignment of the SPSS to the needs of context, sociocultural barriers that may have impeded uptake, and the overall partner usage of the cluster-approved modules.

[70] Some NGOs also included positive parenting training using a different curriculum than the modules under review further complicating the potential to draw linkages to the CP TOC.

them more relevant to the context. Limitations in module adaptation affected the degree to which resilience building is maximized in the SPSS activities because of the cultural disconnect experienced by children. This is discussed further in the effectiveness section.

86. **The implementation of the modules was affected by incomplete adaptation of the modules to the context, gaps in coordination, project management and socialization**.[71] These factors are covered again in more detail in later sections, but in summary, throughout the period under evaluation, there were significant number of vacant positions within UNICEF and the CP sub-cluster that impeded adaptation and uptake of the SPSS. For example, during the implementation period, the CP sub-cluster co-chair position funded by UNICEF was vacant, PSS technical specialists were removed from Iraq, and subsequent turnover in personnel participating in the trainings led to reduced institutional memory of SPSS expertise among IPs and local field PSS facilitators. The evaluation team observed significant variability within and among partners regarding the module usage as well as an absence of a shared and common understanding among CP actors, PSS facilitators and beneficiaries regarding the purpose of the SPSS activities or the desired potential outcomes. These system vacancies were partial contributors to the incomplete adaptation for relevance of the SPSS, reducing the degree of resilience built through participation in the activities.

87. **Although SPSS can support multiple objectives, the SPSS project management system reduced the potential of SPSS to maximize psycho-social wellbeing changes.** Interview with CP stakeholders identified an important conceptual divide about the purpose of SPSS. Although there is no specific outcome objective or indicators associated with SPSS, it is assumed that SPSS contributes to one of two MHPSS outcomes – increased protection or increased resilience. SPSS can contribute to CP outcomes either through its intrinsic value (for emotional wellbeing of children and youth) or through its functional value (as an entry point to the child protection system and more accurate referrals and case management). Among interviewed CP stakeholders there was not a clear and common agreement over the relative importance of these two roles - Whether the primary SPSS activities were for improving the emotional well-being of specific children or whether the primary justification of the SPSS activities were to allow for creating a smoother referral system leading to increased referrals and more successful case management. The relative weighting of the intrinsic value of the SPSS activities (for emotional well-being) versus the functional value (more accurate referrals) changed considerably from stakeholder to stakeholder interviewed. In general, the closer to the field level activities in the camps a stakeholder was, the greater the importance placed on the intrinsic value of SPSS.

88. Project cycle management processes and de facto practices can subtly shape programme outcomes in ways different from the aspirations of the stakeholders involved. Currently, project processes are set up limit contributions to psycho-social well-being in participating children and youth and the degree to which adaptive management can occur to strengthen resilience building. For example, partners had autonomy in the actual application of the SPSS activities, leading to a high degree of variability in application of the resilience modules. Partner reports and information management did not always differentiate between unstructured and structured PSS activities. Selection of children to be involved in SPSS emphasized reaching as many as possible across as broad a region as possible rather than on specific targeted needs, there were no outcome level indicators for resilience defined or measured for SPSS activities – even as the number of referrals were tracked. The combination of these factors, and others, implicitly inclined the programming more towards a CP referral system rather than a resilience building system. This had an unintended effect on reducing the actual quality of support in the programme for building resilience in children and youth. The implications of these factors are detailed further in following sections.

[71] For the purposes of this report, the term ***socialization*** refers to the entire range of orientation, training, coaching, mentoring, and certification activities involved in building the capacity of field level personnel to carry out SPSS activities with children.

89. **Even within the perspective that SPSS is intended to contribute to psycho-social well-being, there were different interpretations among stakeholders regarding what this meant**. The CP TOC describes three outputs that are implicitly considered to be affected by SPSS and contribute to children's and adolescents' psycho-social wellbeing: nurturing environment, positive relationships, and stimulation/learning. When interviewed, many of the CP cluster level stakeholders cited elements that were connected to these outputs such as social relationships or skills acquisition. However, the closer to the field the stakeholders were, the greater the variety in interpretations of what constituted psycho-social wellbeing for children and adolescents. In the camp FGDs, parents and children would often state that the most positive effects of the SPSS activities were related to improved cleanliness, respectfulness, timeliness, or punctuality and self-discipline. In addition, during the interviews, field-level actors often posited different aims for the activities such as "*rehabilitation of children and behavioural change*" to "*help children forget what they went through*". Indicators of psycho-social well-being also varied in interviews from "*children becoming clean and well-behaved*" to "*children are in a happy mood and helpful around the house*". All of these elements are useful and valuable but reflect multiple interpretations of what is intended to be achieved. If there is no commonly shared vision of what is intended by psycho-social well-being, then there will be substantive challenges in determining whether it is being achieved or not. Further, these multiple interpretations also create conflicting programming choices, indicator selection, and variation in the relative attention to programme components by stakeholders.

90. **There is little evidence to suggest that in-depth needs or strengths assessments were carried out prior to module application.** Although partner project proposals show a general description of needs of affected populations, there is little record of an in-depth wellbeing assessment related to the PSS dimensions among affected populations being carried out as part of the project proposals by implementing partners or the design of the delivery of the modules. Partners invariably reported the need for PSS in their project proposals, but usually without detailed assessments highlighting the specific needs and resources or the cultural and experience specificities in a particular camp's community. This was often a practical result of the need to quickly roll-out programmes to support incoming populations within the camps, but it limited the degree to which activities could be specifically tailored to beneficiary needs. Functionally, partner reports treated SPSS as a general service provided in camps but the potential contribution to psycho-social wellbeing is not maximized for individual cohorts, since no time was allocated to assessment. Greater resilience could be built if the activities were predicated on better understanding of beneficiaries' specific needs.

91. **Input from beneficiaries on the design and application of SPSS has not been extensive**. Stakeholder interviews cited seeking input from beneficiaries during post-session FGDs as part of the monitoring process. However, there appears to have been limited participation of children, youth and parents in the design or potential adaptation of the modules at the beginning. There are some examples of beneficiary participation during implementation, but these are not systematically noted. There are child protection committees – usually composed of the in-camp service providers – and for the PSS that is implemented through the schools, some partners did report engaging with PTAs to gather feedback and adjust programmes. One example was using the Mukhtar (a local leader) residence as an acceptable place for gathering children. Other partners reported that the regular engagement with parents enabled adaptations, as necessary. There are some examples of broader beneficiary consultation such as a CP beneficiary satisfaction survey piloted in one Governorate regarding CP services. However, these examples are initiated as ad hoc opportunities rather than as part of a structured system for beneficiary participation in design and monitoring. The limited input from beneficiaries reduced the practical effectiveness of the activities and reduced the degree of participation and ownership in the activities by community members.

92. **The combination of these factors - the provision of PSS as a service without a specialized needs assessment and with few adaptations – lead to a gap in addressing psycho-social health needs for more traumatized communities**. One of the implications of a lack of an in-depth

psycho-social needs assessment prior to the application of the modules is that need-specific adaptations of the SPSS modules have not been made to tailor to the specific identified needs of the children, youth, and caregivers. This has led to gaps in meeting psycho-social health needs.

93. In the MHPSS pyramid, the use of SPSS is intended for those experiencing mild to moderate stress. The CP TOC itself does not strongly articulate trauma and psycho-social health support although it is implied in the first four dimensions. Furthermore, although components TOC #4 and TOC #6 in the UNICEF CP TOC do focus on trauma processing for the caregivers themselves, and these components are reported by stakeholders to be in the manuals, IPs and SPSS facilitators noted that these modules were rarely covered because of limitations to time and the fact that the caregivers would often stop coming before these modules were presented.

94. During the field visits, it was noted that stakeholders from camps where the entire community had experienced a high level of trauma, felt that the SPSS modules were less effective. It was suggested that these groups required more specialized attention to the long-lasting negative consequences of adversities at family and community levels that could be achieved from the SPSS activities. In other words, that the cohorts involved were in a higher level of the MHPSS pyramid then the recommended level for employing SPSS activities.

95. The expectation was that people requiring higher levels of attention for trauma would be addressed through the referral system. However, the current referral system is set up to identify *individuals* within a cohort who may require more specialized attention for referrals or case management. This approach assumes that there will be a few referrals for case management identified out of a larger cohort of mildly stressed – but 'normal' individuals. Consequently, between the generalized needs assessments, limited application of the trauma modules, and a case-by-case approach to trauma, there is a systemic under-attention to understanding the way that traumatic events may be experienced collectively by an entire community, and how it can affect the impact SPSS with children.

4.1.2 Sociocultural barriers.

96. **There were relatively few socio-cultural barriers reported to the *uptake* of the PSS approach.** While respondents identified many barriers that impeded or affected children's well-being, there were only two barriers to the uptake of the SPSS approach. The main issue was girls' access to the activities. The partners and other stakeholders reported ways that they collaborated and discussed improving girls access including carrying out household-to-household awareness raising activities or engaging local religious leaders to host the activities.

97. **There were barriers related to mental health stigma among the communities**. The second potential barrier, although less prominent, related to ongoing reluctance to discuss mental health issues and an overall stigma – especially among the youth – of being labelled with a mental health issue. Respondents noted that they often addressed this barrier though framing the SPSS activities more as a training rather than as PSS. Beneficiaries reported that these activities were for life skills, empowerment, or educational activities. In this way, there was more acceptance, and less stigma. The avoidance of mental health stigma may have been a contributing factor for why the two approved modules were based on skill development and training rather than processing emotional well-being or trauma and why many beneficiaries framed the SPSS modules as 'alternatives to school'.

98. **The modules had different degrees of acceptance among the stakeholders.** Both the SCF and WarChild modules were oriented to provide training to children which helped avoid the mental health stigma cited in the previous paragraph. However, the SCF modules were reported by PSS facilitators as being more user friendly and easier to use in the context. Respondents were particularly appreciative of the modules for adolescent girls which were seen as important for providing important life skills. So much so, that respondents reported the need for an equivalent curriculum for adolescent boys. However, there were also some concerns that the Warchild mental

health modules, imported from other country contexts, had not been sufficiently tested in Iraq before use.

99. The WarChild modules – especially the Little Fellow segment – were seen as not being adapted to the potential trauma that may be experienced by children in the camps. The Little Fellow segment is intended for younger children and describes a child encountering several experiences that would have been common to IDP or refugees. There were some comments from PSS facilitators that when applying the 'little fellow' module, they were concerned that the module was leading to remembrance of difficult moments, causing children to lose focus, or refusing to continue the sessions. Some of the children were reported to have reacted in highly emotional manner and were disturbed by the images presented in the module.

100. During interviews, PSS facilitators reported that children became very agitated during these sessions with many being referred after the sessions. Some facilitators reported bribing the children with the promise of candy or other treats in order to continue to attend the 'little fellow' sessions. Other PSS facilitators reported that the module was more complicated to apply because the children were not understanding the guidelines of the exercises. As one PSS facilitator noted "*it is a very nice tool, but its author wrote it for educated children who would benefit from more skills in their normal life, not for children who lost everything and who are coming from rural areas in Iraq*."

101. **There is some indication of reluctance to use SPSS in schools – likely because of insufficient socialization.**[72] Although not a socio-cultural barrier per se, there was some reported reluctance among teachers to use SPSS in their classrooms. The rollout of SPSS was primarily within the camps, but some IPs carried out activities within the schools located near the camps. It was reported that in some cases, the educators were not clear on what the purpose of the SPSS activities were. Some teachers wanted to attend the sessions themselves because they didn't want the children speaking about them behind their backs. These observations only came from a few partner interviews, so it cannot be confirmed if this was a system wide reluctance or particular and anecdotal. However, supplementary information, during the field interviews with facilitators and monitors, indicated that school violence (from teachers) was mentioned as a barrier.[73] Similarly, FGDs mentioned that there were examples of children refusing to go to school because they felt they were better treated in the SPSS activities in the camps than in the schools. The exact percentage of children could not be calculated from qualitative reports, but the frequency of reporting (in six of seven camp visits) of this issue suggests it may be important for further attention.

4.1.3 Module Usage

102. **From an information management perspective, there is no consistent tracking of the variations in module usage, nor which modules are used by which partners by UNICEF.** There are some examples of partners explaining how they used the modules in individual implementing partner reports, but these are not consolidated or systematically collected. As a result, partners are left with a high degree of flexibility for determining module usage and agreements are elaborated on a partner-by-partner basis with distinct variations among the agreements on the module usage depending on the type of partner and their targets.

103. **Implementing partners reported using one of the approved modules for SPSS, but actual ways of usage vary widely.** Although the COVID-19 pandemic forced programmatic adaptations in 2020, IP interviews and the review of partner reports, indicate there was widespread, almost universal, use of the SPSS modules in 2019. The KIIs reflected an appreciation for having a structured system for providing PSS support. Furthermore, PSS and SPSS are primary points of attention among partners. Significant amounts of budget, staffing, and time is devoted to

[72] For the purposes of this report, the term ***socialization*** refers to the entire range of orientation, training, coaching, mentoring, and certification activities involved in building the capacity of field level personnel to carry out SPSS activities with children.
[73] This was mentioned in five of the six FGDs

implementing SPSS and it is considered by implementing partners to be an important foundation for subsequent CP programming in the humanitarian context.

104. However, there are significant variations in the actual usage of modules – both in the specific modules that are used, and in the way those modules are used. Neither of these variations are tracked systematically. There is a variety of CP Sub-Cluster approved modules available and *which* module used by implementing partners varied significantly – not only from partner to partner but also from camp to camp within a single partner.

105. Furthermore, the number of sessions and number of participants varies widely from partner to partner. The structured modules often suggest having a maximum number of 12-20 children in a group with two facilitators. However, the way the modules were applied varied widely. For example, in the interviews, it was reported that the number of children involved in each cohort varied from 12 to 52, and often with just a single facilitator. The number of sessions used for each module also varied from 8 to 22 sessions. The selection and coverage criteria also varied. Sometimes the SPSS activities were integrated into additional IP programming that included informal PSS, and sometimes it was a standalone activity. Sometimes parent sessions were included while other times not. Sometimes the SPSS selection criteria were based on mental health needs, other times it was open access to all children or sometimes only to children who were living in the tents immediately surrounding the activity centre.

106. **Interviews with PSS facilitators and the camp visit FGDs indicated that the selection of topics implemented in the sessions also varied.** The specific topic selected seemed to be based on the facilitator's final judgment or their knowledge of the topics. Some facilitators reported including new topics that they considered more relevant such as "*not going to cafes where shisha and cigarettes are available*" or "*how to forget about things that are painful*" or *"why youth should not play electronic games."*

4.1.4 COVID-19 Adaptations

107. **The COVID-19 pandemic had a significant effect on the implementation of the SPSS programming throughout 2020** along with most other UNICEF and other humanitarian activities. The social distancing regulations and camp access restrictions required adapted approaches. The three most significant adaptations were the development of the PSS Family Kits, shifting to remote sessions with children and youth, and IPs employing household to household visits to distribute the PSS kits and encourage the households to make use of these, and organizing one-to-one support to selected children.

108. **The distribution of PSS 'kits' to individual households served as one of the primary adjustments to reach targeted children**. The PSS kits were a set of materials distributed to targeted households as a response to the social distancing measures taken during the pandemic by some of the implementing partners. The kit included a set of activities that families could do together for improving psycho-social support as well as additional messaging related to the COVID-19 pandemic and safety measures. The kits were developed with support from UNICEF and distributed through the IPs to households. While the language in the kit was simplified for household use, the kits required a basic level of literacy before they could be used. FGD participants in the camp visits affirmed that they appreciated the kits, and that the material was relevant to their needs.

109. During periods of social isolation, households considered it highly relevant to have family activities that could be done together. The PSS kits were particularly appreciated in camps where parents had previously been actively integrated into the SPSS activities suggesting that these could be an important supplementary component for post-module follow-up with children even in normal situations.

110. Adding information specifically about the pandemic was also considered relevant for the households. Interviews identified an unanticipated benefit of the tent-to-tent approach for kit distribution and awareness raising, in that previously unidentified vulnerable children were able to be reached.

4.2 Efficiency[74]

111. This section explores the degree to which planned activities were implemented in a timely manner and how well resources were used to reach affected populations. It includes an assessment of the number of beneficiaries reached and whether the costing of the SPSS activities is appropriate to generate a positive return on investment. Overall, the evaluation found that although there are high numbers of children reached, limitations to the structure of the information management system for SPSS limits the capacity to assess the quality of the applied interventions. Also, the current financial tracking system limits the degree to which investment can be cumulatively tracked. This prevents a determination of cost-effectiveness.

4.2.1 Numbers Reached

112. **UNICEF is the main actor in SPSS in Iraq and supports a high number of children in youth in PSS – most of whom are though SPSS.** There are multiple agencies and donors which fund implementing partners carrying out PSS activities in Iraq. UNICEF is the primary supporter of PSS among these entities. UNICEF's supports between 70-80 per cent of all children reached through PSS activities in the two humanitarian mechanisms tracked on the Child Protection dashboard with all other actors combined supporting the remaining 20-30 per cent of children reached.

113. The 2020 numbers and targets were affected by the pandemic and the distribution of the PSS kits became one way of reaching the HRP targets, along with providing remote sessions with children and youth through WhatsApp or Zoom. Table 7 and Table 8 provide a summary of the dashboard results for PSS activities in 2018-2020 for the HRP plus the data abstracted from UNICEF's internal Standard Monitoring Questions (SMQ) which are reported to headquarters. Overall, these tables, in combination with Tables 3 and 4 in the context section on UNICEF partners, show that since 2018, UNICEF's share of support to implementing partners has increased and the share of children and youth receiving structured PSS has increased. Furthermore, according to the CP Sub-Cluster dashboards, in 2019, the number of children and youth reached with PSS activities exceeded the target by 19 per cent.

Table 7: PSS Activity Achievements 2018-2020 in HRP[75]

Achievement	2018	2019	2020
PSS HRP Target	NA[76]	208,085	190,000
PSS HRP Reached	334,149	247,622	99,032[77]
PSS reached through UNICEF	190,207 (57% of all reached)	181,283 (73% of all reached)	69,091 (70% of all reached)
PSS Kits UNICEF	NA	NA	105,426 (68%)
Structured PSS from UNICEF[78]	133,650	169,145	134,631

[74] This section assesses the degree to which resources are used for SPSS programming that allows for cost monitoring and maximum achievement per dollar of investment.

[75] From Child Protection Sub-Cluster Dashboard: https://www.humanitarianresponse.info/en/operations/iraq/child-protection

[76] Targets were not included in the CP dashboard for 2018.

[77] As noted in the programme description section, COVID-19 restrictions forced implementing partners to adjust how they reached beneficiaries in 2020. PSS beneficiaries reported here are a combination of those who were able to meet with face to face (before the restrictions began) and then subsequent participation through online activities as implementing partners adapted their ways of working – combined with implementing partner door-to-door campaigns and additional small group meetings still carried out within camps.

[78] From UNICEF SMQ Data

Percentage of PSS children who received structured PSS[79]	62.3	86.2	74.2

Table 8: PSS Activity Achievements 2018-2020 in 3RP[80]

Achievement	2018	2019	2020
PSS 3RP Target	25,000	NA[81]	25,500
PSS 3RP Target Reached	24,464	22,389	11,279[82]
PSS 3RP reached through UNICEF Partner	NA[83]	15,002 (67% of all reached)	6,968 (62% of all reached)

114. It should be noted that one limitation to the overall information management system is that the dashboard combines informal and structured PSS activities under one heading and the number of children reached only through SPSS activities is not tracked consistently in the CP dashboard data. However, inferences can be made on the percentage receiving structured PSS through comparisons of dashboard results with the UNICEF's Standard Monitoring Question internal data.

115. When comparing the SMQ internal data with the dashboard data, it is possible to infer what per cent of coverage of structured SPSS was included in the dashboard. For example, in the UNICEF SMQ for 2019, 169,145 children are reported to have received ***structured*** PSS (of which 47 per cent were girls). The CP dashboard reports that UNICEF supported PSS activities overall in 2019 reached 181,123 children in the HRP and 15,002 in the 3RP. If these values are reported correctly in the dashboard and SMQ, then it implies that in 2019, more than 86 per cent of the children that partners reported in the CP dashboard as having received PSS services, had received structured PSS activities. The 2020 records from SMQ consider the distribution of PSS kits from UNICEF as part of structured PSS. Using this criterion, about 74 per cent of children in 2020 who were reported to have received PSS services received structured PSS. The patterns suggest a sharp increase in the application of SPSS between 2018 to 2019. The percentage of children receiving PSS who received structured PSS increased nearly 25 percentage points (62% to 86%). This declined markedly in 2020 due to the pandemic but does suggest that implementing partners are making more consistent use of SPSS in their activities.

116. **One limitation in the reporting structure is that while the numbers of children and youth reached is reported, the *quality* of the interventions is not assessed in the standard reporting**. Each partner will report to UNICEF against the overall CP programme document they sign each year with UNICEF. Some of these reports will report anecdotal information regarding the quality of the interventions, but this is not systematic across the entirety of the reports and quality assessment is not combined in any consolidated measure. Therefore, while the numbers reported generally show targets being met in 2019, the quality of the programmes cannot be determined from available data.

4.2.2 Costing and Returns on Investment

117. **Tracking SPSS costing is not possible within the current financial and programme reporting systems with partners**. UNICEF funding to IPs is not specific to structured PSS. Partners undertake a broad spectrum of CP activities which are funded under the same partner agreement. The only funding data made available to the evaluation team is for CP services in general (Table 9). Funding for CP increased substantially from 2018 to 2019 but declined again during the COVID-19

[79] Including the children in 3RP as well.
[80] From Child Protection Sub-Cluster Dashboard: https://www.humanitarianresponse.info/en/operations/iraq/child-protection
[81] In 2019, the Sub-Cluster Dashboard did not show targets for the 3RP.
[82] As noted in the programme description section, COVID-19 restrictions forced implementing partners to adjust how they reached beneficiaries in 2020. PSS beneficiaries reported here are a combination of those who were able to meet with face to face (before the restrictions began) and then subsequent participation through online activities as implementing partners adapted their ways of working – combined with implementing partner door-to-door campaigns and additional small group meetings still carried out within camps
[83] Dashboard did not differentiate by donor in 2018.

pandemic in 2020. This 2019 increase may have been associated with increased confidence from donors in SPSS compared to PSS. Interviews with IPs indicate that SPSS activities occupy a significant amount of their resourcing time and energy, which could imply that a shift to SPSS was associated with this funding increase, but this cannot be confirmed based on the available financial data disaggregation.

Table 9: Funding required and received by the CP sub-cluster.

	Required USD Millions	Received USD Millions	COVID-19 Supplementary Funding Required USD M/Received USD M/%	Coverage of Funding Requirements %
2020	39.2	14	5.1/3.3/65	35
2019	39.9	31.3		78
2018	22.2	10.9		49

118. **Costing calculations are available for individual activities – including SPSS - standardized by the CP Sub-Cluster**. Prior to the rollout of the SPSS in 2018, the CP Sub-Cluster with the support of the PSS Task Force developed Activity Based Costing (ABC) parameters for all CP related programming. These were intended to help donors, IPs, and UN agencies to have a common framework for setting budgets and targets. The Sub-Cluster ABC for SPSS was set at 45 USD/child. However, UNICEF CP Officers reported that they encourage partners to use an ABC of 27 USD/child and that they work with the partners to adjust and adapt the proposed budgets. Interviewed KII respondents did not have a clear and common understanding for why the UNICEF guidelines were different from the CP Sub-Cluster ABC. Responses reflected a range of speculations ranging from perhaps the Sub-Cluster ABC was for international NGOs which were allowed to charge HQ administration costs to UNICEF having pressure to expand targets by reducing costs per child, and other speculations. The correctness of the different interpretations is less important than the observation that stakeholders do not share a clear and common understanding regarding SPSS costing rationale.

119. **Investment per dollar of PSS cannot be tracked and are not sufficiently fine-tuned in terms of their concepts**. To address whether SPSS has been worth its investment, it must first be determined whether the return on the investment is to be measured in terms of *numbers* reached or in terms of *quality* of change achieved. Unfortunately, neither concept can be assessed with the available systems for SPSS. Targets for achievement are framed as numbers in need and numbers to be reached. Partner reports almost exclusively focus on the number of children reached for PSS support.

120. **There is some concern that the emphasis on achieving targets to improve coverage has reduced the quality of the interventions provided**. Interviewed PSS facilitators reported involving up to 52 children in one group with a single facilitator to reach the targets. Others reported bringing in different children for different sessions or delivering the session's key messages verbally to increase numbers. In addition, partners reported reducing the number of sessions per cohort to reach more cohorts and to include rotating sessions to reach more children than a single stable cohort.

121. **UNICEF and partners had different opinions about the feasibility of achieving the target numbers**. UNICEF noted that the strategic targets had been revised downward between 2018 and 2019 because of feedback that the initial targets set for SPSS had been too ambitious. In contrast, some IPs reported increasing their targets each year as they felt that their funding for PSS for the next project cycle was dependent on them demonstrating achievement of targets – rather than demonstrating quality of interventions applied.

122. **According to partner interviews, the costing of SPSS activities does not cover all the ancillary activities associated with SPSS project management, and these are required for measuring higher level outcomes on resilience**. For example, while the ABC costing includes monitoring activities – reporting on numbers – it does not include funding to support national NGO administration or longer-term outcome level measurements. This is important because these latter elements would be those that can better track quality of interventions or develop consolidated outcome measures. Because of this limitation, the opportunities for local organizations to invest more long-term evaluation or tracking of children beyond the specific PSS activity are impeded.

4.3 Effectiveness and Gender

123. This section addresses the effectiveness for improving outcome level changes for both the individuals involved (improving the psycho-social well-being of targeted children and youth) and for the organizational structures (improvements in community-based child protection mechanisms). The effectiveness of programming implementation for achieving coverage, duration, and targets is also included here. For organizational flow, the gender question from the ToR is also included in this section because it explores the effectiveness of the SPSS for addressing gender issues. Overall, the evaluation found that although SPSS coverage is aligned with humanitarian targets, the needs of the population are extensive; more than existing SPSS services can meet. Furthermore, while there is consensus that SPSS is effective for both supporting psycho-social wellbeing, and acting an entry point to the CP system, there is limited evidence to confirm this at outcome level. Also, participation of girls in the SPSS activities has been promoted, but there is limited evidence that the SPSS facilitators themselves have been trained on gender sensitive approaches.

4.3.1 Coverage

124. **Coverage of SPSS is evidence based and aligned with the Humanitarian response targets but only reach a fraction of those in need.** According to CP system stakeholders, coverage, and distribution of SPSS activities in the camps is based on the Humanitarian Needs Overview (HNO) and the HRP. The number of children and youth in need is then further refined with set targets for SPSS support overall. Based on these overall needs and targets, the CP Sub-Cluster actors allocate relative targets and coverage to the respective agencies. UNICEF provides the bulk of the coverage of the HRP identified targets within this CP Sub-Cluster agreements. UNICEF then elaborates annual programme documents with IPs in the designated regions to provide SPSS services based on the HRP (or 3RP).

125. UNICEF does reach its intended targets and coverage as defined by the HRP. However, the HRP cites far greater numbers of children and youth in need of PSS than is then targeted in the HRP. For example, the 2019 HRP targets about 60 per cent of children and youth reported in need of PSS and the 2020 HRP targets only about 41 per cent of the same. The HRPs do not describe the rationale for the gaps between PSS needs and targets and these are decisions taken beyond the UNICEF management of the SPSS programme (usually based on estimations of anticipated funding availability from donors for different activities). However, what the patterns do show is that based on the HRPs, there is still considerably more need for PSS services than is currently being supplied by the system.

126. **Even within the relatively limited confines of the camps, there were challenges in accessing remote families**. The SPSS activities were usually carried out in a permanent activity tent near the centre of the camp. All interviewed PSS facilitators noted that the children recruited for the activities were often those living close to the main activity tent set up by the IP. In some of the FGDs in the camps, parents interviewed claimed that children might walk up to an hour to reach the activity tent. This may be an exaggeration but interviewed partners also agreed that there are challenges for them to access children in areas not served by the common central facility. Further, outreach and awareness activities for recruiting for the SPSS activities did not always reach the parents in the remoter areas of the camps. Children with disabilities – even if identified by the local

NGO – were often excluded from activities simply because of the logistical barriers to travel to the activity site. Previous evaluation reports[84] on PSS activities also note that sometimes children reported harassment when passing through the camps to go to the activity tents, resulting in parents refusing to send their children. Also, if the child arrived at the wrong time, or for the wrong group, they may be put into the session that is running, even if it was different from the cohort and module that they were originally included in – somewhat negating the potential of the structured module with a single cohort to build child and youth resilience.

127. **Who should have access to SPSS?** One of the ongoing debates among the interviewed stakeholders about SPSS programming has been to what degree all children should have access to it. On the one side, partners reported that they are interested in having these services available to all (and therefore serve as a pipeline to referrals and the CP system). On the other side, partners also reported an interest in prioritizing those children and youth with the greatest psychosocial needs. The most common prioritization was towards maximizing inclusion for all, to better meet the targets set by UNICEF and donors. Some IP interviews noted that they provided unstructured PSS to all children available, enabling screening of children showing higher signs of distress, and identification of children who went through severe adversities and losses. These children were then referred to the structured PSS activities. However, this practice was not consistently reported among the interviewed partners, and it is not clear what happens to children once they complete SPSS activities. The IASC recommended practice is that children who are referred to the structured or specialized services should then be re-integrated into the unstructured activities including family and community support levels.

4.3.2 Improvements in psycho-social well-being.

128. **SPSS is considered more effective than unstructured PSS activities.** Despite consistency challenges and training gaps, stakeholders within and outside of UNICEF almost universally believe the SPSS is having positive results and contributing to improved psychosocial well-being of children. Stakeholders cited a range of factors that lead to positive outcomes including: i) the opportunity for longer term engagement with targeted children and youth through the SPSS modules, ii) the availability of a systematic guided framework for capacity building of children and youth through the application of the modules, iii) better recruitment and retention of children and youth in the SPSS activities (and therefore keeping them away from protection risks in the camps) and iv) a complementary effect of the structured activities serving to provide a substitute for school activities for those children who have been out of school for several years under the ISIL.

129. **However, there is limited evidence for SPSS effectiveness.** The primary form of describing the success of SPSS rests on the human-interest stories included in partner reports. Measuring changes to psycho-social well-being beyond the anecdotal success stories of individuals or groups is not consistent or well developed. There are no outcome level indicators (visible behaviour changes) that are used for tracking SPSS effectiveness and beyond the success stories, reporting is largely limited to 'efficiency' criteria reporting the numbers of children and youth reached rather than assessing the quality of the service or the visible behaviour changes.

130. IPs reported that they are required to include success stories in their reports to UNICEF. UNICEF stakeholders in the CO noted that the reporting format includes: i) project results, ii) bottlenecks and challenges, iii) proposed actions, iv) success stories, and v) future plans. Implementing partners noted that a limitation of this is the emphasis on describing only success stories without mentioning the protection or mental health challenges in the camps.[85] For example, during FGDs with IPs, six cases of adolescent suicides were mentioned in the 2020 period, but there is no systematic tracking of these. As one IP stakeholder noted, "*there is an awareness in the organization that these suicides*

[84] See Psychosocial Support Programme Review. Triangle Generation Humanitaire, IRAQ. April 2019.

[85] Note that the bottlenecks and challenges section of the report is perceived to be targeting only implementation challenges, rather than negative stories.

exist and that the numbers increased during the pandemic, but we are not asked to report them – we only document the success stories". UNICEF National Office CO personnel claimed that partners are not required to submit human interest stories.

131. **Some outcome level self-reporting tools have been developed, but there are limitations to their use.** Two of the interviewed partners[86] reported elaborating a pre-post questionnaire that is administered to children and youth at the onset of the modules and then after the modules have been completed. The CPSC-PSS Task Force has reviewed the feasibility of applying these tests more broadly, but the current information management system in UNICEF does not track how many of the 40-60 partners each year are reporting pre- post- results.

132. The pre-post questionnaire uses 12-24 self-report questions to measure five dimensions of psycho-social well-being: i) self-esteem/confidence; ii) problem solving; iii) supportive social relations; iv) supportive family environment; and v) support school or community structures.[87] The data available suggests improvements in these dimensions for participating children. According to the Minutes from a 2019 CPSC-PSS Task Force Meeting, results of pre- and post- assessments showcased improvements for both 10-14 years old and 15-20 years old PSS participants. For the younger children, there was an average 12-point increase in pre-post measures (69.34 to 78.88). For the older youth, there was an increase of an average of 4 points (51.78 to 55.97).[88]

133. However, although this data does show increased well-being, stakeholders expressed concern over the reliability of these measures for tracking mental and emotional well-being. First, the questionnaire is based on self-reporting by the children and youth and a review of the PSS programme by Triangle Generation Humanitaire (TGH) and UNICEF (April 2019) questioned the appropriateness of the pre and post-test as providing a reliable measure for emotional well-being. Further, while the questionnaires are based on the emotional dimensions, the self-report format and the length of the questions made it more challenging for younger children or those who had been out of school for a few years due to ISIL to fill them accurately.[89]

134. The Child Protection Sub-Cluster meetings had also noted concern that these same two groups did not understand the questions, which could lead to inaccurate reporting. Minutes from the PSS task force of the Child Protection Sub-cluster recommended shortening the questionnaires used for pre and post-test were shortened to reduce the complexity.[90] Adjustments were taken at the discretion of each IP – as well as whether the pre-post testing would be used at all. One interviewed partner did report making adjustments, but the degree of adjustments or usage for all partners is not tracked consistently in the system.

135. Secondly, the survey only measures the dimensions immediately after the modules have been completed but does not track the cohorts of children and youth over time to assess whether these gains have been sustained. Finally, the existing tools are only tracking positive indicators, even though general survey design guidelines for these types of self-report tools suggest that they should contain a combination of both positive and negative statements as reliability controls.[91]

136. **Despite these limitations, the pre-post measurements could be used to track the effectiveness of IPs, but not all partners use or report on these measures to UNICEF, and appropriate systems would need to be developed.** Partner reports to UNICEF are generally compilation summaries of all CP activities carried out in the signed programme document rather than a specific assessment of SPSS reporting. A selected sample of partner reports show that some

[86] Including VOP and TGH

[87] These dimensions take into consideration the application of SPSS in schools and are not linked specifically to the UNICEF TOC for Child Protection although the concepts do overlap.

[88] Different tools were applied to the two age groups; therefore, the scoring system cannot be compared between the two groups.

[89] TGH and UNICEF, 2019, Psychosocial Support Programme-review

[90] Iraq CPSC-PSS Task Force, Minutes of Meeting May 15, 2019

[91] For example, see Rubin and Babbie, 2017: Research Methods for Social Work. Sage Publications

partners allocate significant attention in their reporting to SPSS, but this is not standardized, so some partners do not report any of these measures. UNICEF stakeholders noted that they do not have access to IP databases even for those that do track these measures over time and only receive summaries of changes in the IP reports if partners choose to add this information.

137. **FGD data triangulates with these perceptions on the contributions of the SPSS for psycho-social wellbeing**. The field FGDs indicate that social well-being among those children and youth involved in the FGDs improved in six of the seven camps visited. In addition, all the FGDs showed that the children were empathic and willing to help other children in need.[92] Regarding emotional well-being, the children and youth reported that they were happy to be part of the activities where they felt that they had friends and had fun, but long-term changes in emotional well-being were only observed in two of the seven camps. These two camps were also the camps that had a significant degree of parental engagement in the SPSS activities including implementing the full caregiver modules.

138. **There were distinct differences among respondents regarding *what* had changed in terms of skills and knowledge**. Children and youth and parents in some of the camps reported that the children had become more respectful and cleaner because this was a constant message in the sessions. However, in one of the camps visited, it was reported that the PSS facilitators visited parents of children who were not wearing shoes and told them that the police would arrest the children in case the hygiene of the children did not progress. This is obviously inappropriate and indicates the lack of training of PSS facilitators.

139. The most commonly acquired skills reported in six of the seven camps visited were an increased awareness of Child Protection Issues and children and youth stating that they knew that they were not supposed to talk to strangers and that they were to reach out to the IP if needed. In some cases, partners reported seeing the benefits for children, and parents and teachers reported seeing the benefits of the SPSS activities in changing the behaviour of the children in the classrooms. In some camps, it was reported that parents are now more aware of the need to send their children to school after awareness raising for education was carried out in the SPSS programmes.

4.3.3 Effectiveness for Referrals

140. **SPSS increased CP system effectiveness for referrals but tracking this contribution is limited**. The SPSS activities are well linked within the overall TOC to the larger CP system and the activities in the field have been integrated into the CP routes of attention within the camps. PSS facilitators are aware of the need to be attentive to identify children and youth for ongoing referral from the SPSS activities. Stakeholders across the CP system in UN agencies or IPs were able to articulate the referral process and case management approaches. The CP Sub-Cluster had established a Case Management Service Directory for the camps which respondents reported as being useful for identifying where to refer identified cases and which implementing partner would address which types of cases.

141. Referrals are generally tracked on the CP Sub-Cluster Dashboard and the UNICEF SMQ, but these are not linked to whether the referral came from an SPSS activity. For example, the following table 10 describes the number of partners and number of referrals reported for 2018-2020 in the HRP per the CP Sub-Cluster Dashboard. There is an increase in referrals in 2019, the year of full implementation of SPSS and there is a gradual increase in partners supported by UNICEF reporting referrals. It ***could*** be that this increase in referrals, case management, and partners involved are a result of the application of SPSS, *this is what is believed by most of the CP stakeholders interviewed in the evaluation*, but without specifically linking in the information management system whether the referrals and case management came from the SPSS activities, it cannot be confirmed.

[92] In the current configuration of the pre-and post- tests, empathy is not one of the dimensions measured - it cannot be determined if this was a ***pre-existing condition*** among the children or a ***result*** of the SPSS activities.

Table 10: Number of UNICEF CP led referrals and case management – HRP[93]

Referrals and Case Management	2018	2019	2020
All UNICEF CP Partners	30	35	46
UNICEF CP Partners in SPSS	30	34	44
Number of Partners reporting referrals	21	24	26
Total number beneficiaries referred	4,752	7,656	4,264
Number of partners reporting case management	22	30	27
Total number beneficiaries receiving case management	7,328	18,985	18,194

142. **Degree of demand exceeds capacity to respond to CP issues.** There are still concerns that the overall CP system is not able to adequately respond to the demand for children and youth identified for referral – especially for trauma and mental health attention. Most of the interviewed stakeholders were aware of possible routes of attention for referral. However, it was reported that in practice, most case management was handled internally by the IP sponsoring the SPSS activities. There are also concerns that the more significant mental health needs cannot be adequately addressed through this system of engagement with paraprofessionals – both in terms of the available time to address case management, but also in terms of the level of specialization or capacity of the service providers for more extreme mental health needs.

143. **Camp beneficiaries are aware of the most basic CP risks but vary widely in terms of more complex CP knowledge**. Among the interviewed children and parents in the camp visit, almost all of the interviewed persons were aware of the most common CP issues and that they need to 'protect their bodies'. However, beyond this basic level, there was considerable variation from group to group and camp to camp in terms of awareness – even among the PSS facilitators who are usually persons from the camps who are contracted and trained to carry out SPSS activities by the respective implementing partners. Social norms were also observed to vary significantly among the camps in terms of CP elements such as physical abuse, child marriage or child labour. Children interviewed in the FGDs could articulate at least one route for attention if they saw a friend who was sad or going through difficulty – although this was usually to bring this friend to the IP because the facilitators had said that they could help them. While limited, it does show that the children are aware of a trusted adult to whom they can communicate concerns about protection.

144. There were also reports from IPs and PSS facilitators of efforts to work with community and religious leaders and household decision makers to change the social norms and acceptance of the CP services. However, the degree to which these stakeholders were engaged with varied from partner to partner and camp to camp.

4.3.4 Gender Integration

145. **Gender issues are considered to some extent both in the participation of the SPSS and in the content of the SPSS modules**. Due to community concerns about the mixing of older girls and boys, separate sessions were set up for boys and for girls to participate in SPSS. At the activity level, the partners report on the number of girls and number of boys participating. However, because of social and logistical constraints, there is an observed pattern of boys being disproportionately represented in the SPSS activities. For example, according to the CP Dashboard for the UNICEF supported PSS activities within the HRP, about 53 per cent of the participants were boys.[94] One interview noted that the PSS Task Force was concerned about this disproportionate representation of boys but did not identify action steps that were taken to change gender participation. At the field level, the PSS facilitators and IP noted that one practice was to engage

[93] Source: CP Sub-Cluster Dashboard – HRPs

[94] Gender disaggregated data is not available for 2020 on the CP dashboard.

the residence of the Mukhtar[95] as a safe space to encourage parents to allow their girls to come to the activities.

146. **One of the most accepted and effective resources was the SCF Resilience Toolkit.** PSS facilitators reported that the SCF Resilience toolkit is very user friendly to implement. **Even more positively perceived was the separate UNICEF/UNFPA Adolescent Girl's toolkit which is not part of the standardized SPSS curriculum**. The UNICEF/UNFPA resource is primarily used in GBV interventions but also was used by SPSS partners. It was cited as the best resource for increasing awareness of girls' issues. An equivalent 'adolescent boys' toolkit was highlighted as a need from the KIIs with CP partners and there was interest in expanding into this sector. However, beyond this anecdotal description of the content, there is little documentation evidence of how gender issues are addressed that can be observed from the reporting system. Individual partner reports do provide sex and age disaggregated data (SADD) on participation, but not on outcomes. For example, partner reports do not consistently provide SADD on the pre- and post- test results (when they are reported). In addition, there is little evidence in the reporting of how the SPSS activities may have been contextualized to consider specific gender issues and there is little evidence of the SADD being used for analysis and implementation adjustments – beyond an analysis of steps for increasing inclusion.

147. **There is little evidence that the field level PSS facilitators have been trained on gender awareness**. Field facilitators, as mentioned earlier, are usually locally contracted camp residents. The Implementing partner reports to UNICEF do not consistently catalogue the gender and number of all IP-contracted local PSS facilitators. Based on the selected FGDs carried out with PSS facilitators as part of the evaluation, there appears to be a larger number of male facilitators but little reporting on gender awareness being included in the trainings for the facilitators before carrying out the activities. Girls in some of the interviews in the camps noted that they were told by the facilitator to be strong and forget about what had happened, or that their fears did not exist. Other girls reported that the facilitator messages emphasized that they should be organized and helpful in their tents after PSS and to be ready to have a family. These types of messages are inconsistent with the messages intended in the resilience manuals and imply that the facilitators are adapting messaging in their sessions without sufficient training on the intentions of the manuals themselves.

148. Overall, while the trainings that have been disseminated through the CP system have reached UNICEF, CP Cluster, and some IP specialists, there is some concern that the actual PSS facilitators in the field carrying out the activities have not had sufficient training in the SPSS modules, their possible adaptation to context, or their adaptation for gender sensitivity.

4.4 Nexus Considerations[96]

149. This section explores the degree to which SPSS has been successfully institutionalized within the humanitarian context. It includes the capacity development efforts to SPSS stakeholders and the potential of transitioning SPSS implementation to the development context after suspension of the humanitarian response in Iraq. The evaluation questions implicitly assume that capacity development in the humanitarian context would be effectively transferable to the development context. However, the evaluation found that this may not be the case. The section therefore explores the gaps identified in the current capacity building efforts with children and youth. It then highlights additional considerations for the application of the SPSS in a development context and the relative feasibility of transferring existing capacity to the development context.

[95] Local religious leader in the camps.

[96] This section describes the degree to which the capacity and institutionalization for SPSS has been established both for within the humanitarian sector and in anticipation of transition to the development context.

4.4.1 System Capacity in Humanitarian context.

150. **The humanitarian system capacity for SPSS has been initiated through UNICEF's support, but it is not yet sustainable**. There is a well-developed humanitarian architecture for humanitarian actor coordination on SPSS including the CPSC and the PSS working group. There is also an adequate policy environment to support humanitarian actions for SPSS, including support from State actors (primarily DOLSA). However, the practical limitations to sustainability of SPSS institutionalization include not only human and financial resourcing (expertise and funding) but also the absence of a system for continuous orientation, training, mentoring, and coaching of SPSS to mitigate the effects of constant turnover and ensure consistency of SPSS implementation - especially at the field level and the direct interface with affected populations. At field level, the relatively structured and organized environment of the camps and the establishment of camp coordination committees for service providers, enables good coordination among CP actors.

151. UNICEF capacity building also includes support to the Government, in legal reform, institutional reform, and technical assessments of curriculum. The consensus among interviewed stakeholders is the policy and institutional components for building capacity on SPSS are already in place. Field level capacity strengthening efforts supported by UNICEF include sponsoring trainings, and training of trainer sessions, technical assistance to implementing partners through monitoring and reporting, and supporting the DoLSA through covering salaries for CP Officers.

152. While these efforts have contributed to capacity strengthening, the rapid turnover in personnel at field, IPs, and the CPSC, and the under-funding to DoLSA has minimized the degree to which these capacity efforts have led to long term sustained changes in capacity. Furthermore, there are weaknesses in the system due to continued reliance on external donor funding to maintain SPSS programming support in the absence of the humanitarian system.

153. **Although the larger institutional architecture exists for supporting SPSS (if not the resourcing), the quality of field level application of SPSS is constrained due to limitations in module adaptation and individual capacity building for SPSS facilitators.** The two NGOs that had originally supplied the cluster approved modules had removed their PSS technical specialists in 2019 and no other interviewed agency, including UNICEF, reporting having PSS technical specialists to support ongoing adaptations and trainings. Without PSS technical specialists being present in Iraq, IPs and UNICEF did not feel sufficiently informed to make adaptations to the imported modules themselves. As such, the manuals were distributed 'as is' to IPs with suggestions that the partners should take their own adaptations, as necessary. This approach has been met with limited success and has led to wide variations in how the manuals are actually used including occasionally with inconsistent messaging brought in by local contracted PSS facilitators.

154. **There are two ways to use expertise to build a capacity development system, but neither is fully applied in the Iraq SPSS programming.** As a general summary, there are two types of approaches that can be taken for ensuring the provision of quality services, contextualized for the needs of the specific target populations.

- Non-Specialist Application with extensively crafted materials: The first approach is to have high level technical expertise combined with non-specialist local facilitators. This approach assumes that the highly trained technical experts will support the ongoing development and adaptation of the modules and develop modules that are easy to be applied in the local context. The technical experts also support a system of ongoing socialization of the non-specialist field facilitators.
- Specialist Application with general materials: The second approach is to have highly trained field personnel who are specialists in MHPSS and who therefore have the technical expertise to make adaptations and adjustments to general, basic materials. This approach assumes that the materials do not have to be completely adapted, because the expertise is on the ground and the facilitators can be depended on to adjust and adapt to the needs they see.

155. There are practical barriers that preclude using highly skilled specialists at the point of interventions for SPSS. These include budget constraints, the relative scarcity in Iraq of high-level technical specialists, and access and security constraints limiting movements between camps. However, the system could still rely on the delivery of PSS through non-specialist field facilitators AND include higher level PSS technical expertise in the system to support non-specialists and the adaptations of materials and tools. However, these higher-level specialists are not currently present.

156. As a result, the current configuration of training, and the location of expertise for SPSS in Iraq combines the least effective components of each of these philosophies. The system relies on delivery by non-specialized facilitators, but without the high-level PSS technical expertise to make the necessary adaptations to the technical materials. Without one or the other of these conditions, the benefits of ongoing capacity development efforts will not be able to be sustained over time and raises questions regarding the quality of services provided in the sessions at the field level.

157. **Further, there is no documented strategy for PSS facilitator capacity building.** The field level capacity gaps are also highlighted because there is no systematic documentation of how much training is required for PSS facilitators, including who can train who, for how many hours, or criteria for success and so forth. Nor is there any tracking of how many new trainings are required each year or new personnel coming on board.

158. The absence of a systematic training process is a factor in the low numbers of PSS facilitators receiving capacity building. Also, although there is an understanding that the PSS manuals should be adapted to make the activities specifically relevant, this has not been done. The SPSS facilitators interviewed reported that they did not feel comfortable adapting the materials to the specific needs of the children because they felt they did not have enough expertise to know how to adjust the curriculum. All Implementing partners interviewed expressed a need for more trainings and technical support – '*we don't know if what we are doing is right*'.

159. **In the absence of a capacity development *system* for SPSS, there has been a reliance on large scale ad hoc training events but turnover within the system has reduced the institutional memory of these trainings and PSS field facilitators have not benefited from the cascade effect of these trainings.** However, turnover within the system has reduced the institutional memory of these trainings and PSS field facilitators have not benefited from the cascade effect of these trainings.

160. The evaluation explored the extent to which existing trainings have built and sustained individual technical capacity for the delivery of SPSS. Training on implementing SPSS was carried out in 2018 through two training events to train PSS facilitators in the modules and a training of trainers (TOT) exercise. PSS Facilitator training was initially conducted for over 100 people. A refresher training for 80 PSS facilitators was then organized for 2019 as it became apparent that there had been considerable system losses in terms of personnel and capacity to implement the SPSS. Based on the UNICEF participant lists, a total of 131 people received training. Trainers were supposed to be able to continue to provide new peer-to-peer trainings as new personnel and organizations began to use the SPSS curricula. The evaluation found that the training was well conducted with the majority of participants providing positive feedback. Table 11 shows the proportion of positive ratings from the 91 respondents returning surveys. According to the online survey responses,[97] respondents rated the original PSS facilitator training more positively than the TOT training. Annex 8 provides more details on the frequency results and analysis required.

Table 11: Frequency Responses[98] for TOT and PSS trainings

Element	PSS Facilitator Training		TOT Training	
	Per cent Positive Response	Per cent Very Positive	Per cent Positive Response	Per cent Very Positive

[97] See Annex 8 for the complete frequency responses of the surveys.

[98] Those responses that are very positive as opposed to somewhat positive.

Quality of the training	91.7	47.9	85.0	20.0
Relevant to Context	100	54.2	100	42.5
Referral guidance included	93.6	93.6	NA	NA
Referral guidance relevant to field realities	95.7	38.3	NA	NA
Worked as facilitator or trainer	81.3	81.3	71.4	71.4

161. Even though the trainings were rated positively, the cascade effect of these trainings have not systematically reached the PSS facilitators actually doing the SPSS activities. Instead, the people who attended the training were usually IP staff or agency representatives. The facilitators are normally locally contracted individuals from the camps, and their familiarity of the local context and their ongoing presence in the camp provides additional support for the SPSS activities. These are temporary appointments who may be different from the staff of the national IP.

162. During the FGDs with PSS field facilitators, only about half of the interviewed persons[99] reported having received any type of training and only one-quarter had received the full training.[100] All of the focus group respondents reported that some of their colleagues had also not received training.

163. Turnover among local PSS facilitators is common because IPs often have a practice of distributing temporary contracts to as many different people as possible in the camps to allow different households to benefit from the salaries on the position. While this is a laudable goal, it negatively affects the continuity and capacity of the facilitators who are the point of interaction with the targeted children.

164. Another limitation of the trainings was the inclusion of a self-care component that was not included in the training. As a result, all the interviewed PSS facilitators reported a need for self-care elements to be part of their training. This is especially important given that local PSS facilitators have often experienced the same trauma and insecurities as the targeted children and caregivers faced.

165. These issues indicate that the training has not have been sufficient to instil sustained individual technical capacity for SPSS delivery and the gaps in the system have impeded the field level capacity development of SPSS facilitators. This contributes to an over-reliance on self-training at field level.

166. The most frequent response when asked what training they had received was "they had trained themselves". This results in inconsistency of the modules being provided to beneficiaries. The more training-oriented manuals by SCF related to resilience were reported being easier to use without guidance which was important in the absence of training. The WarChild mental health manuals were considered more difficult to apply. This led to some gaps in the application of the principles with the children and youth themselves including being able to name a range of emotions. This is important for children and youth to be able to be able to express themselves and link them to specific situations.

167. **The gaps in the current system mean that it cannot easily be transferred to a development context. However, there are ongoing UNICEF efforts being explored to support SPSS capacity development that could become part of a capacity development system.** Two recent efforts cited in interviews could help support an ongoing capacity development of the SPSS programming. There have been recent efforts reported in interviews of working with DOLSA to re-activate a training unit within MOLSA that could continue to provide SPSS trainings and refresher trainings to NGOs and local service providers. There are also efforts reported in interviews of the MHPSS task force supporting government efforts to draft an MHPSS strategy – although reportedly UNICEF is not engaged in this process. An additional opportunity for capacity strengthening of PSS in the education system would be through the existing government policy of having a social worker

[99] 12 out of 22
[100] 8 out of 22

assigned to every school. This is not yet a reality in many schools, but the policy exists and could provide a venue for institutionalizing SPSS activities via the school social worker.

4.4.2 Institutionalization for Development Context and closing service gaps.[101]

168. The decentralized nature of the population and the existence of new actors and operating dynamics at the local level means that SPSS application in the development context will require establishing different government partnerships, a different modality of approach, further adaptation of the SPSS modules, and the establishment of new coordination mechanisms – especially at the community level.

169. A successful transition will require developing new system strengthening efforts including the formation of new partnerships and the establishment of new coordinating mechanisms beyond those that currently exist in the humanitarian context. The primary limitations to the transition of SPSS are less related to the national level policy environment and more related to inter-ministerial agreements, standard operating procedures, and the establishment of local level coordinating and service provision mechanisms to reach these decentralized populations. There will also need to be an elaboration of a new project cycle management system more adapted to the development context including new outcome level indicator development and the elaboration of longer-term change pathways.

170. **The gaps in the humanitarian context service exist but are manageable compared to the challenges to SPSS service provision in the development context**. Currently within Iraq, there is a shift towards eventually discontinuing the humanitarian response and shifting to support through development programming. The Government has begun to close some camps and re-locate IDPs to local host communities or return to place of origin. There is no exact timeline for this transition, but with the Humanitarian Response architecture under consideration for eventual discontinuation and a foreseen eventual dissolution of the camps and their coordination mechanisms - there is considerable interest among stakeholders in understanding the feasibility of transitioning the SPSS programming to the development context. Stakeholders noted that in the Humanitarian context, for all its inconsistencies, rolling out a structured support programme such as this is relatively easier than in the development context. Although not consistently applied, there is a structure to the approach within the humanitarian context – structured sessions, integration into the case management routes of attention, and team leads –supported by a cluster and sub-cluster network that enables inter-agency coordination. Within the camp context, potential beneficiaries are relatively well organized and registered, and operations happen within a distinct geographic area that is relatively easy for NGOs to access. In contrast, the equivalent structures and process in the development context do not exist. In addition, the humanitarian referral system appears to function to some extent organizationally. There is referral amongst organizations and case managers are part of the team involved in structured PSS. However, the referral mechanisms and mapping of services even in the humanitarian context is not sufficient in quantity or quality to address the number and type of needs among the referrals.

171. In contrast, the development context does not have the equivalent architecture for coordination and provision of services. Within the camps, there is a relatively high level of control over the intervention and the controlled context of the camp allows for more easy identification and outreach to families. Outside of the camp context, there is less control over the organization of services by CP actors. Further, the populations in the development context will be considerably wider dispersed than the camps, meaning that it will be more time consuming and expensive to track, reach, and work with cohorts of children and youth. There are several important implications of these conditions.

[101] This section combines EQ 8 and EQ10.

172. **UNICEF's primary government partner for SPSS has been DoLSA within the Humanitarian context but partnerships need to be expanded to other State actors in the development context for SPSS**. DoLSA serves as the primary mandate for child protection in the development context as well, but there are resourcing constraints on the department for the development coverage and stakeholders report challenges in financially sustaining an SPSS programme with staff salaries unpaid and salary freezes in the Kurdistan Regional Government (KRG) Governorates. Other ministries, such as education and health, could serve as the primary service providers for SPSS but there are currently no agreements between UNICEF and these ministries in the development context. To integrate SPSS into ministries outside of the humanitarian context would require assessing the policy environment, resourcing, technical training of staff, and the integration of SPSS into the SOPs of the education and health ministries. There are some UNICEF relationships already being established with other partners for MHPSS but not specific to SPSS itself (the point of focus in this evaluation). Expanding SPSS partnerships may be useful within the MHPSS frameworks.

173. Outside of the education and health systems, there are an array of child protection populations who could benefit from structured PSS activities and general MHPSS. Interviewed respondents listed children without registration papers, disabled children, children who were enrolled in armed groups, and children in conflict with the law. Support to these groups may be best provided through the Ministry of Justice and Ministry of Health.

174. **One important consideration on partnership is that within the development context, there are already actors engaging in MHPSS strategy development**. Of these, perhaps the most important is the MHPSS task force currently co-chaired by the World Health Organization (WHO) and MoH. Currently, there appears to be no engagement between these health actors and the MoLSA or UNICEF according to interviews. There is a risk that health engagement may be more inclined towards a potential 'over-medicalization' of the interventions, however, it is an opportunity for expanding UNICEF partnerships and engagements with non-CP actors for integrating SPSS into the development context.

175. **Cross-ministerial agreements could be an important aspect of system building but are not yet in place.** Interviewed stakeholders suggested that in the education system, Iraqi law dictates that all schools should have an associated social worker. This school social worker ***could*** become the primary focal point for SPSS – and referrals – in the development context. However, not all schools are allocated the funding for a school-based social worker. Furthermore, currently, the SOPs and the TOR for the school-based social workers do not include SPSS and many primary and secondary schools do not have a standard practice of employing a school social worker – or even a shared social worker among a group of neighbouring schools.

176. The majority of stakeholders reported that currently, there is limited case management SOP at the national level. While some respondents claimed there were strong case management SOPs including an inter-agency referral system, other respondents were not aware of these resources, claiming that cases that are identified are managed ad-hoc internally or with referral to mental health volunteers, other NGOs or to the tertiary government hospitals. Respondents noted that there is also a constant turnover on trained staff in the development context. Stakeholders noted that a potential gap of using the education system as the route to provide MHPSS services to children is that children out of school are likely to be missed. It would therefore be necessary to include some level of community outreach through centres or non-school service providers to reach out of school youth.

177. Informants reported that there are currently no cross-ministerial agreements in place to coordinate case management between the child protection systems of MoLSA and the education systems of the MOE or the primary health care in MoH. Stakeholders were not aware of any agency currently facilitating these inter-ministerial interactions among the key ministries and cited the

difficulties in inter-ministerial coordination and collaboration because of political interests.[102] However, given UNICEF's leadership role across the three sectors it is well placed to play this role. The WHO and UNICEF are involved in a joint global initiative on an MHPSS Minimum Service Package for the health sector, but there is limited coordination between UNICEF and WHO in Iraq on MHPSS. There is potential through leading the reform of MHPSS support to Government and after these elements are established, only then considering the piloting of the Minimum Service Package.

178. **The policy environment is not considered a bottleneck for SPSS application in a development context.** Most stakeholders considered the policy environment to be sufficiently developed for SPSS. The stakeholders interviewed emphasized a greater need to focus on resourcing, technical training, and SOP development as the important preparatory work before transitions to the development context could be achieved. The ministries of Health and Education are comparatively better resourced than MoLSA, but these resources are not currently allocated to SPSS despite reports of recent work on the drafting of a national MHPSS strategy. For SPSS to be implemented in these ministries, adjustments to the SOPs for the primary providers – teachers or primary health care (PHC) individuals – would be needed for SPSS to become institutionalized. Ongoing technical training of staff on SPSS would need to be integrated into the existing technical training curriculum for the primary providers – either through the University curriculum, teacher training colleges, or primary health care vocational training curriculum.

179. **The development context is missing community-based mechanisms[103] for CP and SPSS but the establishment of community-based coordination mechanism will be limited by resourcing.** In comparison to the camp context, where UNICEF supports a wide range of NGOs to provide local services including SPSS in the camps, there are no equivalent community level mechanisms for child protection. Direct service providers do exist, but there are currently no community-based mechanisms equivalent to the camp CP coordination committees or the sub-cluster. Government focus in the development context has been more on the development of tertiary level structures – mental health hospitals in centres – rather than the secondary level structures of community-based mechanisms. In Dohuk, respondents described an example of a centre that could serve to bridge the gap between the primary service providers and the tertiary institutions through social centres. However, this child and adolescent mental health centre is the only example of a community MHPSS structure noted by informants. The centre has been underfinanced and needs reactivation if it is going to play this community-based role. There would also be need to pilot support to such a centre and on success develop and expand a network of these community centres should they prove to be effective structures.

180. The speculations of how to establish these community-based mechanisms in the development context outlined by informants usually included the participation of NGOs and civil society organizations to serve as service providers and case management resources. One aspect noted by informants was that currently, Iraq law prohibits Government funding to these NGO service provides. Therefore, community-based mechanisms may require securing resourcing from private sector to be sustained.

181. **The SPSS modules themselves need to be further adapted to the development context**. As noted earlier, the SPSS modules are not yet completely adapted to the Iraq humanitarian context. However, the modules had developed with the consideration of the experiences of refugees and IDPs – often in camps – within a humanitarian response. So even though the stories and pictures are imported from Africa, they are referencing IDP and refugee situations. If the modules are to be applied to the development context, outside of the IDP and refugee situations, they will need to be even further adapted to be relevant references for children youth and parents outside of the camps.

[102] This is reportedly particularly related to the Federal Government of Iraq.

[103] In this case, Community based mechanisms do not refer strictly to community managed interventions but to the coordination of organizations at the local level for the provision of services.

For example, in the development context, some of the governorates with the greatest needs are actually located in the Southern part of Iraq. The modules have heretofore not been widespread applied in these regions because there are relatively few IDP/refugees in these governorates. However, they may become focus of increased attention in a development framework, and the models would need to be adapted to take into account these new situations where there are fewer IDP/refugee situations but greater poverty.[104]

182. **The project cycle management implications for SPSS will need to be further adapted to the development context**. It has already been noted that within the humanitarian context, the specific structure of the project cycle management processes de-prioritizes maximizing the potential impact of SPSS for psycho-social wellbeing. This includes the absence of outcome level indicators, tools for measuring changes, tracking cohorts over time, and establishing causal pathways linking activities to outputs to outcomes for an SPSS theory of change. To some extent, these limitations are reflective of the overall humanitarian project cycle management system which prioritizes reporting numbers reached and describing activity and outputs while minimizing longer term impact indicators. In contrast, within the development context, there is an expectation of a longer-term set of interventions with more explicit linkages to outcome and impact level changes. UN Agencies and implementing partners entering the development arena will need to adapt their existing SPSS project cycle management processes to adjust to these additional expectations.

183. There is currently no plan to institutionalize PSS in the development context, although respondents did point to the intention for transition that the pandemic delayed institutionalizing beyond the HRPs. **While the potential roadmap for SPSS transition to development exists, there is currently no roadmap or strategy developed and there may be some limitations on political will for expanding SPSS in the development context**. While most interviewed stakeholders could articulate a roadmap for achieving this transition – primarily through the Education, Health or CP sectors – the system is not yet developed enough to transition.

[104] World Bank, 2015, Where are Iraq's Poor: Mapping poverty in Iraq.

5 Conclusions and recommendations

5.1 Conclusions

184. The objective of the evaluation is to identify lessons for the continued implementation of SPSS within a humanitarian response and to provide observations on the potential of SPSS to transition to the development context. It is the judgment of the ET that SPSS presents a relevant opportunity in both humanitarian and development contexts. Although there are more elements in place within the humanitarian response architecture for institutional support, neither context has sufficient system readiness for institutionalizing SPSS. There are positive gains in the application of SPSS, but there are gaps within the system, project management, and capacity strengthening which would need to be addressed to further maximize the potential for psycho-social well-being. UNICEF is well positioned to play an important role in filling these gaps not only in the humanitarian context but also in the application of SPSS and its integration into the development context in Iraq.

185. **Conclusion 1: UNICEF plays an important leadership role in SPSS support and management that could be further expanded. However the system is not yet ready for UNICEF exiting the SPSS space – in either the humanitarian or development contexts**. SPSS is an integral part of the UNICEF 2018-2021 Global Strategic Plan and SPSS indicators are reported on by all Country Offices. Within Iraq, the SPSS is a foundational component of CP programming by the CP Sub-Cluster and IPs, and it is integrated into the larger CP TOC. UNICEF is the primary funder of SPSS activities in Iraq. As such, there is potential for UNICEF to play a larger role in leadership on SPSS. There are several factors that could increase UNICEF's influence in SPSS including filling the sub-cluster coordination role, providing technical expertise on PSS, and facilitating the establishment of evidence and knowledge management systems for SPSS institutionalization among SPSS actors.

186. **Conclusion 2: There are several dimensions of inherent tension within the application of SPSS programming in Iraq which UNICEF and other CP actors are constantly balancing however there is not a shared consensus on the appropriate weightings**. The dimensions include: i) emphasizing the child protection (referrals) value of SPSS against the child well-being values (social emotional improvement); ii) trying to reach as many children and youth as possible versus going in-depth with a smaller cohort for better results; and iii) enforcing a standardized process versus allowing for partner flexibility to adapt to their particular projects. Finally, there is also a wide variety of interpretations among and between CP actors, PSS facilitators and beneficiaries regarding the role of SPSS or what potential SPSS outcomes may be due to the lack of a specific articulated framework for an SPSS TOC. The CP TOC *could* be a unifying framework but lacks an articulated causal pathway and many partners and beneficiaries refer to other indicators for SPSS than those found in the CP TOC. The lack of a shared and common consensus among stakeholders on the relative weightings inhibits the consistency of application, reducing overall effectiveness.

187. **Conclusion 3: SPSS serves as an important entry point for CP interventions, but the CP system does not have the capacity to meet all the potential demand identified**. There is broad consensus among stakeholders that the SPSS activities provide a better opportunity for the identification of referrals and case management in the CP system because of the longer term, more structured interactions with SPSS facilitators. Within the humanitarian context, there is a coordinating committee of service providers and a service mapping to provide identified routes for case management referral. However, stakeholders voiced concern about the capacity of the case management system to handle the demand identified through SPSS activities and the perceived absence of an equivalent local coordination mechanism for the development context.

188. **Conclusion 4: SPSS in Iraq is more effective than informal PSS, but not yet sustainable or sufficiently institutionalized**. The structured SPSS is almost universally perceived by stakeholders to be more effective for achieving improved social and emotional well-being, even if this cannot be

evidenced from the available data. Triangulation of the few available outcome assessments show shifts in psycho-social well-being dimensions, albeit with an incomplete methodology. However, SPSS occupies a significant amount of time, targets, and budgets within IP programming and there is need for extensive further support before SPSS is fully institutionalized. The system is still heavily reliant on external donor funding to implementing partners with substantive support from the CPSC and there are still relatively low levels of institutional capacity to sustain SPSS programming without these continued external financial and technical inputs. The COVID-19 pandemic forced the adaptations to the SPSS approaches and way of working by implementing partners, delaying the implementation of many of the sustainability measures required for maintaining SPSS, both within the humanitarian response system and in the transition to the development context.

189. **Conclusion 5: The dual rationale for SPSS – intrinsic value and functional value - are both important but not enough emphasis was placed on maximizing the contributions of SPSS to wellbeing.** There is a multi-pronged logic for the value of SPSS combining the intrinsic value for ensuring the emotional and social well-being of the children and youth, with the functional value of sessions serving as an entry point into the overall CP referral system and case management. The default programming choices supported by UNICEF have unintentionally inclined the programme towards de-emphasizing the intrinsic value for maximizing psycho-social wellbeing. This implicit bias has been illustrated in the way that activities are tracked, programme reports generated, project documents elaborated, and indicators developed. Further, the wide variation in the application of SPSS by partners, the absence of a system for continuous process of orientation, training, mentoring, coaching, and review of SPSS, and the incomplete adaptation of the modules to context also limit maximizing the programme contributions for psycho-social well-being. These effects of programme management led to prioritizing access and breadth approaches and the application of the activities by non-specialists without upstream high-level technical support – reducing the effectiveness of the SPSS for psycho-social wellbeing and resilience.

190. Furthermore, even though there is a wide consensus among stakeholders on the importance of SPSS, the organizational infrastructure to support SPSS is not aligned with how important SPSS is. For example, the allocation of human resources is limited for maximizing the technical and knowledge management functions - such as the absence of any PSS technical specialists at any level. The absence left non-specialized, poorly trained field level PSS facilitators to adapt the materials. Adaptions were therefore either not done, or not done appropriately. Furthermore, the limited monitoring and information management platforms impede the quality of the tracking of outcomes and progress. The primary symptom of this discrepancy is the lack of evidence of both immediate effectiveness and longer-term impact, and the restrictions for scale up. Maximizing SPSS contributions to resilience requires increased organizational investments in staffing (PSS and Information Management Officers (IMO) specialists), systems building, clarifying outcome level objectives and causal pathways for SPSS, and resourcing beyond project activities to be able to effectively track immediate effectiveness and long-term impact changes in cohorts over time.

191. **Conclusion 6: The absence of a *system* for ongoing and continuous socialization**[105] **impedes the building of SPSS expertise among partners and PSS facilitators required for sustaining SPSS implementation**. The current de facto approach for socialization of the SPSS combines infrequent large-scale trainings sponsored by UNICEF with an array of partner-to-partner peer trainings. However, this approach has not been sufficient to ensure the construction of sufficient technical capacity for SPSS implementation in the field. The inclusion of beneficiary participation in decision making or adaptation of SPSS – for either constructing social and emotional well-being or for the CP system of case management and referrals - has been limited largely to participation in the activities themselves except for some input coming from the post-session FGDs during monitoring exercises.

[105] For the purposes of this report, the term socialization refers to the entire range of orientation, training, coaching, mentoring, and certification activities involved in building the capacity of field level personnel to carry out SPSS activities with children.

192. The establishment of a continuous *system* for socialization is needed, as are further adjustments and contextual adaptations of the modules. The participation of beneficiaries in this process of design and adaptation would be an important factor for UNICEF to continue to prioritize, ensuring more intentional inclusion of caregivers and community stakeholders in the SPSS activities by implementing partners. While the latter is already a component of the CP TOC, evidence suggests it is not consistently applied.

193. **Conclusion 7: The emphasis of the information management system towards counting beneficiaries rather than measuring effectiveness, means there is limited *evidence* for the effectiveness of SPSS towards achievement of outcomes or for measuring the *quality* of implementation**. At the output level, reporting has been limited to efficiency criteria of numbers receiving SPSS, but not differentiated by the type, quality, or duration of the SPSS. At the outcome level, limited measurements – or even agreement on outcome indicators – exists. The Pre-Post measures employed by some partners is a good start to building an outcome level evidence base, but more needs to be done, including longer term tracking of effectives over time with cohorts and developing similar tracking measures for the case management dimensions that come out of SPSS referrals. On the referral side, while partners track case management and referral numbers, the CP dashboards and larger information management systems do not distinguish the number of referrals that come out of SPSS activities versus other routes of attention – limiting the degree to which the effectiveness of SPSS activities for the CP component can be assessed as well.

194. The roles that UNICEF Iraq can play for strengthening the evidence base for SPSS effectiveness are wide ranging. These include systematizing and strengthening an information management platform that can be used by all implementing partners for generating summative data from the pre- and post-tests and other outcome level tools to roll out to partners for better tracking of effectiveness. UNICEF should also support the development of additional Iraq-appropriate outcome level tools to build on the self-reported pre-post-tests already trialled by some implementing partners.[106]

195. UNICEF can also play a role in supporting external research on SPSS effectiveness for wellbeing. The high degree of field variation in the application of SPSS can provide an important opportunity for UNICEF to sponsor more fine-grained differentiated assessments of the effectiveness of the different variations in how modalities were applied, which modules were used, and in what combination, to better understand which configurations maximize outcomes – and which outcomes are desired (increases in successful referrals or changes in social-emotional well-being for example). In addition, sponsoring long-term cohort studies with families, including children and youth for long term resilience and behaviour change would be important for understanding the sustainability of the gains over time.

196. **Conclusion 8: While the potential of SPSS exists for transition to the development context, there are significant institutional barriers preventing an effective transition. The existing humanitarian SPSS capacity is also not easily transferable – requiring the establishment of new partnerships, mechanisms, and even new project cycle management processes**. Even with the challenges within the humanitarian context for implementing SPSS, there are still systems and structures, such as the SPSS working group and the CPSC, to support SPSS implementation. Equivalent systems and structures are not yet in place within the development context. The most feasible roadmap is through the Education and Health Sectors (rather than solely through Child Protection), but little progress has been made yet in terms of institutionalizing SPSS within these systems or creating the necessary cross-ministerial agreements and SOPs for applying

[106] UNICEF globally *may* have supported the outcome level tools in other countries which could serve as a resource for outcome level measurements of SPSS in Iraq. Identifying global resources *could* be one approach to developing these measures and adapting them to the Iraq context. However, interviewed stakeholders were not aware of any outcome level tools currently available for SPSS outcome measurements.

SPSS outside of the humanitarian camp context. Within UNICEF, there is also still relatively little coordination between the health, education, and CP sectors.

197. UNICEF can therefore play an important role in the transition to the development context through expanded ministerial collaborations including the MoH and MoE. This would include working with the ministries of Health, Education and MoLSA for institutionalizing SPSS within the SOPs for the front-line workers, including establishing cross-sectoral integration agreements with MoE, MoH, and MoLSA for coordinated CP approaches involving SPSS. Collaborating and integrating more closely with ongoing MHPSS strategy development already in the development sector will be important. Coordination of approaches will also be an important role for UNICEF in facilitating the emergence of second level community-based CP mechanisms and bringing together NGO service providers and state institutions.

5.2 Recommendations

198. Too many recommendations can become unwieldly to formulate within a single management response. For this reason, the ET prioritizes the following 7 recommendations based on the findings and lessons learned from the SPSS programming 2018-2020. The recommendations are framed to highlight the role that UNICEF can play in strengthening SPSS in the humanitarian and development contexts. However, it is recognized that to achieve many of these recommendations, other actors would need to be involved in the actions. UNICEF's leadership role in supporting SPSS provides an opportunity for leveraging and mobilizing these resources for SPSS.

199. The recommendations address the three major gaps highlighted in the findings: smoothing out field level variations in SPSS application, building an evidence base for effectiveness, and system building for transition to the nexus. The first five recommendations are elements that need to be considered whether in the humanitarian or development contexts. The last two recommendations are specific for considerations on the transition to the development context.

200. Each recommendation is accompanied by a sub-set describing the actions that would need to be taken by the Country Office to implement a recommendation. The actions can be adjusted in the Country Office management response action plan. Annex 10 provides a more detailed description of the potential action steps associated with implementing each recommendation.

201. **Recommendation 1: UNICEF should provide expertise for Conceptual Coherence and Theory of Change**. UNICEF Iraq Office should provide enhanced technical, coordination, and information management expertise to support SPSS programming in Iraq in both the humanitarian and development contexts including strengthening a shared understanding of a common ToC and causal pathways for SPSS, including outcome level indicators and objectives.

202. **Recommendation 2: UNICEF should support SPSS Module Adaptation and Needs assessments**. UNICEF Iraq Office should continue to support the further adaptation and contextualization of the SPSS modules for Iraq context, based on needs assessments in both humanitarian and development contexts based on the experiences of structured PSS since 2018.

203. **Recommendation 3: UNICEEF should support the establishment of a continuous system for capacity development for both the humanitarian and development contexts**. The UNICEF Iraq Office should develop a framework that outlines the strategy, conditions, and procedures for a system of ongoing and continuous orientation, training, and certification for SPSS. The framework should be adjusted to be able to respond separately to the resources and partnerships in the different contexts – either through the relevant national ministries or in the humanitarian context with the CPSC partners, The systems would need to be different for the humanitarian and development contexts and utilize different pathways.

204. **Recommendation 4: UNICEF should support the development of a comprehensive system for measuring the effectiveness of SPSS**. The UNICEF Iraq Office should strengthen its role in the development of the evidence base to show the effectiveness of SPSS activities. This should be done

by supporting research and longer-term assessments into outcome level changes with a particular emphasis on articulating the long-term impact on resilience beyond the project cycle.

205. **Recommendation 5: UNICEF should strengthen both Partner Reporting and information management**. The UNICEF Iraq Office should strengthen both internal UNICEF monitoring and evaluation (M&E) and the quality of data collection and reporting from implementing partners. This will provide an enhanced and consolidated information management on SPSS outputs and outcomes that could be used to monitor progress of results achieved with a particular emphasis on data for adaptive management and learning.

206. **Recommendation 6: UNICEF should develop a Framework for Transition**. The UNICEF Iraq Office should develop a mapping framework that outlines the strategy, conditions, and procedures for uptake and adaptations to scale of SPSS to the development context. The framework should outline the linkages among the array of national and Governorate level actors and identify the factors that may prevent successful transition to the Nexus. The primary ministries for Nexus transition should be the Ministry of Education (MoE), Ministry of Labour and Social Affairs (MoLSA) and the Ministry of Health (MoH).

207. **Recommendation 7: UNICEF should develop Community-Based Coordination Mechanisms**. The UNICEF Iraq Office should collaborate with WHO and MoH to build on and strengthening existing community-based coordination mechanisms by service providers and institutions for child protection. In the development context these mechanisms can be used to strengthen community level delivery for psycho-social health and serves as a bridge between the primary service providers (teachers, PHCs, etc) and the tertiary centralized institutions (mental health hospitals).