



WHO contribution in Armenia 2020–2024

Evaluation report brief



Evaluation purpose and scope

This independent evaluation assessed the **extent to which WHO's cooperation contributed to Armenia's national health reforms and strengthened institutional capacities in the period 2020–2024**. The evaluation reviewed cooperation implemented through three Biennial Collaborative Agreements (BCAs) and applied the Organisation for Economic Co-operation and Development – Development Assistance Committee evaluation criteria (relevance, coherence, effectiveness, efficiency and sustainability), together with the transversal criteria of gender equality, disability inclusion and the principle of leaving no one behind. These dimensions provided the analytical framework for assessing the effectiveness and added value of WHO's cooperation, as well as its alignment with Armenia's national health reform priorities, the United Nations Sustainable Development Cooperation Framework 2021–2025 (UNSDCF) and WHO's normative role in advancing the highest attainable standard of health for all.



Methods

The evaluation employed a **participatory, utilization-focused, mixed methods design** anchored in a reconstructed theory of change, aligned with WHO's evaluation policy (2018, 2025), the *Framework for evaluations of WHO's contribution at country level* (2022) and the United Nations Evaluation Group norms and standards (2020). Data collection comprised a **systematic review of over 150 documents**, including the WHO BCAs, national health strategies, and reports from the World Bank, Asian Development Bank (ADB) and other United Nations agencies; this was complemented by triangulation of WHO financial and programme data with national health statistics. Primary qualitative evidence was gathered through **30 key informant interviews and one focus group discussion** (43 participants in total: 30 female, 13 male), encompassing national authorities, WHO staff, development partners and civil society representatives. Field visits to the National Centre for Disease Control (Ijevan branch) and selected primary health care (PHC) facilities allowed direct observation and validation of findings. Analytical methods combined **triangulation, thematic coding, contribution analysis and theory of change reconstruction** to test plausible contribution pathways. Methodological rigour and independence were assured through structured internal peer review and quality assurance by the WHO Regional Office for Europe, thereby preserving full independence of the external evaluation team.



Key findings

Relevance – highly satisfactory

WHO's cooperation **consistently aligned with national reform priorities** through jointly developed BCAs that mapped onto Armenia's strategic pillars. Alignment with the WHO Thirteenth General Programme of Work (GPW 13), the emerging Fourteenth General Programme of Work (GPW 14) and the European Programme of Work, 2020–2025 (EPW) was strong, with particular coherence in universal health coverage (UHC) advancement, PHC renewal, emergency preparedness, and noncommunicable disease (NCD) prevention.

Responsiveness to emergency needs. During the coronavirus disease (COVID-19) pandemic, WHO mobilized extensive technical and operational support, including the delivery of essential medical supplies, adaptation of national surveillance and infection prevention protocols, and large-scale training of contact tracers to strengthen Armenia's preparedness and response capacities. During the 2023 mass displacement from the Karabakh region, WHO co-chaired the health sector response, coordinated emergency medical teams, and integrated 80 000 refugees into the ArMed platform, demonstrating strong responsiveness to unforeseen challenges.

Gaps identified. Emerging priorities such as elderly health were insufficiently reflected in BCAs, while medicines policy and digital health governance remained only partially integrated into national strategies.

Coherence – satisfactory

Vertical coherence. The BCAs effectively translated global and regional frameworks into nationally owned priorities, ensuring consistency across planning levels. Cooperation was consistent with WHO's leadership role under the UNSDCF's joint outcome architecture.

Horizontal coherence. WHO exercised a strong convening role, particularly during emergency response through co-chairing the Health Sector Working Group with the Ministry of Health and the International Organization for Migration. Sustained United Nations Country Team participation embedded cooperation within the UNSDCF results architecture. Joint programming with the World Food Programme (nutrition), the United Nations Development Programme (emergency logistics) and the Food and Agriculture Organization (One Health) demonstrated effective complementarity and reduced duplication.

Principal constraint. Coordination with international financial institutions (World Bank, ADB) remained largely ad hoc and bilateral, rather than structured through government-led platforms. The absence of a permanent ministry-chaired policy finance forum raised transaction costs and created duplication risks, though strategic dialogues launched under the UHC Partnership represent a promising foundation that requires formalization.

Effectiveness – satisfactory

These results reflect WHO's normative and technical role in shaping national policies and facilitating uptake by partners.

Health financing. A universal health insurance concept was developed, legislative drafting supported, and capacity-building delivered; institutionalization of National Health Accounts allowed routine monitoring of financial protection.

PHC. An integrated PHC service model was developed and subsequently adopted by World Bank and ADB operations as their design framework, demonstrating how WHO's upstream work facilitated partner-financed implementation.

Communicable diseases. Tuberculosis (TB) care reoriented to outpatient management and WHO-recommended regimens were adopted; human papillomavirus (HPV) vaccination coverage increased from 8% in 2018 to 26% in 2023 following provider training; a multisectoral antimicrobial resistance (AMR) strategy for 2024–2027 was adopted, with over 1600 PHC providers trained in rational antibiotic use.

Emergency preparedness. An Emergency Operations Centre was established; mental health and psychosocial support (MHPSS) was integrated into PHC; during the 2023 displacement, emergency medical teams performed approximately 600 surgical procedures, with trauma/NCD kits supplied to maintain service continuity.

NCDs. The 2020 tobacco control legislation was enacted with WHO technical leadership; nutrition policy (salt reduction, trans-fat elimination) was advanced; cancer control was strengthened through impACT mission follow-up.

Limiting factors. The GPW 13-aligned BCA matrix lacked clearly defined output and outcome indicators, baselines and targets; there was leadership discontinuity in the WHO Country Office; earmarked funding was not consistently matched to disease burden; macrofiscal constraints slowed policy implementation.

Efficiency – moderately satisfactory

Strengths and **enabling factors.** Strategic alignment with government priorities concentrated resources on high-leverage workstreams; platform-based partnerships (United Nations Country Team, Health Sector Working Group) reduced coordination costs; selective outsourcing preserved technical capacity for policy work; external finance was effectively leveraged.

Constraints. Absence of an established government-led coordination mechanism with international financial institutions raised transaction costs and increased risks of duplicated analytics; frequent leadership changes in WHO's Country Office disrupted programme cadence and partner relationships; monitoring gaps limited ability to track timeliness, unit costs and contribution; earmarked funding constrained redeployment towards higher-burden areas (notably NCDs); surge modalities sometimes extended beyond normative remit without clear reversion protocols.

Sustainability – moderately satisfactory

Strengths and **enabling factors**. Policy/regulatory anchoring (2020 tobacco law, 2024–2027 AMR strategy, rehabilitation strategy) provided a durable foundation; institutionalization of functions (National Health Accounts unit, Emergency Operations Centre, ArMed platform expansion to all facilities, Mental Health Gap Action Programme integration into PHC) demonstrated ownership transfer; capacity retention through structured training programmes (immunization, TB, MHPSS) strengthened workforce competencies.

Vulnerabilities. Functions established during emergencies (MHPSS hotline, mobile teams) remained project-funded after unsuccessful attempts at domestic budget integration; the Refugee Response Plan had received only about 20% of required health funding by late 2024; the 2021–2022 STEPS (STEPwise approach to NCD risk factor surveillance) round was cancelled because of financing gaps; workforce retention challenges in rural areas undermined training investments; TB laboratory/information technology integration was incomplete; digital governance frameworks remained under development.

Cross-cutting dimensions – partially achieved

Equity and the principle of leaving no one behind were **consistently present in normative guidance and particularly visible during the displacement response**. Operational commitment to health for all were demonstrated by capacity-building for implementing partners in protection from sexual exploitation, abuse and harassment, disability-sensitive rehabilitation integrated into burn care, and mobile MHPSS teams reaching 11 000 refugees and 4500 host community members. However, **systematic operationalization remained limited**. Cross-cutting commitments were not embedded as disaggregated indicators in BCAs; routine disaggregation was uneven; and there was limited capacity to demonstrate distributional results or steer resources towards underserved groups.



Conclusions

WHO's cooperation with Armenia in the period 2020–2024 was strategically relevant, technically robust and institutionally valued. Through the BCAs, WHO ensured alignment with the Government's Health System Development Strategy 2023–2026, advancing reforms in health financing, PHC, quality of care and workforce development, consistent with GPW 13, GPW 14 and the EPW. Results were most evident where global guidance translated into national policy and institutional reform, as in the case of the PHC model, outpatient TB care, the 2020 tobacco control law, the 2024–2027 AMR strategy and MHPSS integration into PHC. Sustainability was strengthened through institutionalization, including the National Health Accounts unit, the Emergency Operations Centre and expansion of the ArMed digital health platform, though continued progress will depend on domestic financing, workforce stability and integration of project-based functions.

Equity, gender equality, disability inclusion and the principle of leaving no one behind were normatively embedded but insufficiently measured. Overall, the evaluation confirms that WHO's cooperation provided a significant and sustained contribution to Armenia's health system reform, underpinned by WHO's comparative advantage in normative guidance, technical stewardship and its convening role within a multipartner environment.



Lessons learned

Strategic alignment and national ownership. WHO's cooperation was most effective when it was codeveloped with the Ministry of Health through the BCAs, thus ensuring legitimacy and alignment with Armenia's reform agenda. Sustaining this joint creation model, while integrating emerging areas (such as healthy ageing, medicines policy and digital governance), is essential for continued relevance.

Monitoring, indicators and evidence for accountability. Visibility of WHO's contribution was strongest where intermediate indicators and baselines were in place, allowing evidence-based course correction. Where absent, results and value for money remained less discernible. Future cooperation must embed a streamlined, equity-sensitive results framework – jointly defined with the Government and grounded in routine data systems – to ensure credible measurement, accountability and adaptive learning.

Funding flexibility and alignment with national priorities. Earmarked resources advanced technical priorities but constrained responsiveness to shifting needs. Flexible and predictable funding enabled WHO to adapt swiftly during the COVID-19 pandemic and the 2023 displacement. A balanced and diversified funding mix is critical for sustained alignment with national priorities.

Institutionalization and government commitment. Reforms embedded in legislation, strategies or institutional frameworks – as in the case of tobacco control, the AMR strategy and the PHC model – proved durable, whereas project-based functions remained fragile. Technical assistance should therefore be systematically linked to institutional anchoring and recurrent budget commitments.

Workforce capacity and retention. Capacity-building strengthened competencies across PHC, immunization and MHPSS, but gains were eroded where workforce stability was low. Training must be coupled with deployment incentives, supervision and equitable career pathways to ensure retention and sustained service delivery.

Clarity of roles, communication and coordination. WHO's performance improved when mandates, boundaries and coordination mechanisms were explicit. Structured communication reduced duplication and enhanced efficiency, particularly under surge conditions. Clearly defined roles and communication channels are vital for operational coherence.

Leadership continuity and institutional memory. Frequent leadership transitions disrupted programme cadence and dialogue with national counterparts. Formal handover processes, documentation protocols and stable leadership are necessary to maintain institutional memory and partner confidence.

Partnerships and comparative advantage. WHO's normative and convening roles were most effective when combined with the leverage of international financial institutions and the operational reach of United Nations partners. Strategic role differentiation under government leadership amplifies collective impact and system coherence.

Transition from emergency surge to systemic resilience. Emergency interventions were timely and robust but must evolve from temporary surge mechanisms into permanent health system capacities. Embedding these functions institutionally will consolidate resilience.

Multisectoral and cross-cutting integration. Multisectoral collaboration strengthened effectiveness, particularly through partnerships in nutrition, tobacco control and the One Health agenda. However, equity, gender, disability and digital inclusion were insufficiently measured. Embedding disaggregated indicators in monitoring frameworks is essential to evidence equitable outcomes and direct resources to underserved populations.



Recommendation actions

- 1. Align the next BCA cycle more tightly with emerging reform levers where WHO has comparative technical value.** WHO, jointly with the Ministry of Health, should extend the scope of the next BCA beyond the established pillars to include other critical areas, such as healthy ageing within PHC models and digital health governance. For each domain, WHO's role is to codevelop Armenia-specific options, adapt global standards and facilitate expert dialogue under Ministry of Health leadership so that technical products are owned, implementable and used in partner-financed programmes.
- 2. Make WHO's contribution more visible and learning more systematic by embedding a compact results spine.** To address GPW 13 monitoring gaps (such as lack of output/outcome indicators), WHO should, with Government and partners, agree a small set of intermediate indicators, disaggregated where relevant for equity, gender and disability inclusion and sourced from routine systems. A concise portfolio theory of change should link deliverables to these indicators and provide for regular joint review and adjustment.
- 3. Consolidate sustainability by supporting institutional embedding of functions and preparedness capacities.** Normative and technical support should prioritize institutionalization of functions that are piloted or project-dependent, quality measurement, digital health stewardship and routine preparedness. A light sustainability rubric, policy/regulatory anchoring, recurrent budgeting, explicit institutional home and capability maintenance arrangements should be applied in design and review so that sustainability is considered from the outset and tracked over time.

- 4. Enhance coherence and delivery through predictable participation, role clarity with financiers and stable technical capacity.** WHO should establish systematic participation in Ministry of Health-led forums to make advisory inputs predictable and reduce transaction costs. Comparative roles with financing institutions (World Bank, ADB) should be formalized so that policy advice is sequenced to loan/grant decision windows, limiting duplicated analytics and rework. Internally, continuity of country leadership and access to regional technical expertise should be maintained to ensure consistent, high-quality normative support. Clear engagement protocols with financiers and documented handover/continuity arrangements will strengthen reliability and reduce risks observed under ad hoc coordination and leadership turnover.