2009 Annual (Tenth) Progress Report on Activities Implemented Under the United Nations Development Group Iraq Trust Fund (UNDG ITF) of the International Reconstruction Fund Facility for Iraq (IRFFI)

Health and Nutrition Sector Report

Multi-Donor Trust Fund Office
Bureau of Management
United Nations Development Programme
mdtf.undp.org

1.1 Health and Nutrition

1.1.1 Sector Outcomes and Outputs

Health and Nutrition	
Outcome 1	***Improved performance of the Iraqi health system and equal access to services, with special emphasis on vulnerable, marginalized and excluded persons***
Output 1.1	Service providers at health and health-related institutions, particularly in low coverage areas, are able to deliver improved services
Output 1.2	Iraqi people are better able to access quality health and nutrition practices
Output 1.3	Iraqi government and nongovernment institutions have an improved capacity to provide HIV/AIDS prevention, care, treatment and support services
Output 1.4	People most affected by emergencies and vulnerable groups have access to quality basic health and nutritional services, including psychosocial support
Outcome 2	***Health and nutrition policy makers and service providers at all levels have developed, reviewed and implemented policies, strategies, plans and programmes***
Output 2.1	Policy makers and other relevant stakeholders develop, review and update policies, strategies, plans and guidelines to conform to international norms and standards
Output 2.2	National, district and governorate officials have enhanced capacities in planning, implementation, and monitoring and evaluation in health and nutrition programmes
Output 2.3	Civil society and community members are empowered to effectively participate in planning, implementation, and monitoring and evaluation of health and nutrition programmes

1.1.2 Operating Context During Reporting Period

Background

Between 2004 and 2009, a number of UNDG ITF–funded projects/programmes have contributed to improving the health status of the Iraqi population. Despite tangible progress, however, the health status of the Iraqi population is still well below levels found in countries of comparable income. The under-five mortality rate (U5MR) currently stands at 41 per 1,000 live births[1] and the maternal mortality rate (MMR) is 84 per 100,000 live births,[2] double that of its neighbors, placing Iraq in the group of 68 countries that account for 97 percent of maternal and child deaths worldwide. There is a high prevalence of acute respiratory infections and diarrhoeal diseases, exacerbated by high levels of low birth weight and inadequate essential newborn care and infant/young child feeding practices. Routine immunization services have also deteriorated over the last several years as violence has restricted vaccination teams from reaching some segments of the population. In 2008, in 45 out of 114 districts, measles vaccination coverage dropped to less than 80 percent,[3] resulting in over 38,000 cases with nearly 200 deaths.[4]

Stunting remains the predominant feature of growth failure in under-five children (21.8 percent, with nearly half of them severe). Although the national average indicator for wasting Global Acute

[1] UNICEF, Multiple Indicator Cluster Survey, Round 3 (MICS3), 2006

[2] World Health Organization/Republic of Iraq, Iraq Family Health Survey (IFHS) 2006/2007

[3] WHO/UNICEF joint reporting, 2008

[4] Ministry of Health (MoH) weekly surveillance reports, 2009

Malnutrition (GAM) in under-five children remains relatively low (4.7 percent, below the cut-off level of 5 percent for GAM), 38 of 114 districts have GAM over 5 percent, ranging from 6 to 39 percent. Severe Acute Malnutrition (SAM) in these districts ranges from 1 to 14 percent. These observations are compounded by high rates of low birth weight (14 percent), inadequate infant and young child feeding practices (exclusive breastfeeding rate for infants under 6 months is 25 percent), and micronutrient deficiencies (e.g., only 28 percent of households use adequately iodized salt, and 38 percent of pregnant women have iron-deficiency anaemia).[5]

Overweight and obesity in children under five is emerging as an issue (more than 10 percent of children). Micronutrient deficiencies may worsen in some parts of the country as a result of increased food insecurity and lack of variety due to drought and subsequent challenges to household food production and access. Malnutrition rates are a concern in most of the Southern governorates.

Under these challenging circumstances, the Iraqi health system has managed remarkably well to respond to outbreaks and emerging diseases. It has kept the country polio-free since 2000, reduced incidence of malaria into the levels of elimination, and successfully mitigated and managed outbreaks of communicable diseases.

Other key aspects of the operating context are that a large number of health workers have fled the country and the shortage of qualified physicians, nurses and midwives is unlikely to be solved in the short term. The procurement and distribution system for pharmaceuticals and medical equipment is largely dysfunctional. The Ministry of Health (MoH) has high turnover of staff, limited capacity to formulate national policies and programs, and little control of and access to information on issues affecting the governorates. Despite these substantial challenges, until the recent past Iraq had a well-developed health care system, and potentially has the resources and the capacity to rebuild it. With the return of political stability and security, the coming period of reconstruction and development will provide a critical window of opportunity not only to rebuild but also to upgrade a system that had been in attenuation for the past decades. The Health and Nutrition Sector Outcome Team (HNSOT) will continue to support the Government of Iraq (GoI) in its efforts to reform and modernize its health system.

Main sector issues

With the improved security and political stability, the Government is expected to enter into a period of intensive reconstruction, rehabilitation and overdue reform of the health sector. This will require an articulated National Health Strategy that sets the national priorities and vision for the health sector based on the drafted Nation Development Plan (2010–2014) and identifies specific short and medium-term investment programs and reform agenda. Although it initiated a national dialogue in 2009, the MoH still needs to strengthen its capacity to steer the health sector.

[5] MICS3, 2006

Excessive centralization in the MoH and limited capacity to maintain uninterrupted communication with provincial authorities is resulting in lack of ownership at the peripheral level and transmission of incomplete or inaccurate information to the central level. Issues related to accountability and transparency of central level managers combined with complex rules and ineffectual committees hamper decision-making processes in the public sector. The MoH is making efforts to address these governance issues.

Massive exodus of professional staff during the last few years is severely limiting the ability of both government and nongovernment sectors to provide urgently needed basic health services as well as to develop and implement a program of reform.

Allegations of large-scale corruption and fear of being accused of corruption have hindered effectiveness of services, and this has contributed to lack of trust in the central government to undertake reforms.

Access to quality health services has been identified by the international community as a critical concern in a number of districts and also in areas proven to have low access to and use of vaccination services and other health and nutrition services, particularly those with a high prevalence of chronic malnutrition. Through funding provided by ITF and the Consolidated Appeals Process (CAP), HNSOT has been providing support to MoH to improve the provision of basic health services in areas where access is limited.

Government programme and reform objectives

In the National Roundtable on Health that took place in 2009, the MoH identified the following six priority areas for the health sector reform:

- Meeting urgent needs of the population and improving basic health services.
- Strengthening management of the health system.
- Developing and implementing a master plan for reconstruction of the health care delivery system.
- Training and capacity building in public health programs and management of health services.
- Reforming the pharmaceutical sector.
- Developing public-private partnerships in the provision of health services.

Given its current capacity, the MoH still needs substantial technical assistance and capacity-building support from the HNSOT to translate these broad priorities into actionable programmes and measurable results in the short and medium term.

1.1.3 Implementation Constraints and Challenges

The main challenge for HNSOT partners during 2009 was the severely limited access of UN international staff to project sites due to security issues. Although significantly improved compared to 2006–2008, security has continued to be a considerable overarching operational constraint, especially for international staff. To address the situation, HNSOT partners have been steadily moving toward a re-established permanent international presence in Iraq. However, logistics constraints still limit the number of international staff who can move permanently inside Iraq. The progressive return of international staff has increased the interactions with national counterparts and project monitoring visits, but a remote management system in which many noncritical staff remain based in Amman is likely to continue for some time.

Another major constraint has been funding shortfalls, which continue to hinder realisation of the HNSOT goals for 2009 of improving access to quality health and nutrition services, particularly when it comes to responding to emerging humanitarian needs which cannot be addressed through funds allocated to individual UNDG ITF–funded projects. The HNSOT has attempted to address these funding shortfalls through the consolidated appeal process mechanism, but only very limited contributions were received to address identified humanitarian needs. In this context, it should be noted that 2008 and 2009 have witnessed a major measles outbreak and sporadic cholera cases were reported in 2009.

Centralised decision-making within the MoH has continued to delay the smooth implementation of capacity-building programmes, requiring nomination of candidates long time before the actual training. In some cases, opportunities for capacity building were lost due to late changes of priorities, and weak coordination among ministries has delayed implementation of some joint activities.

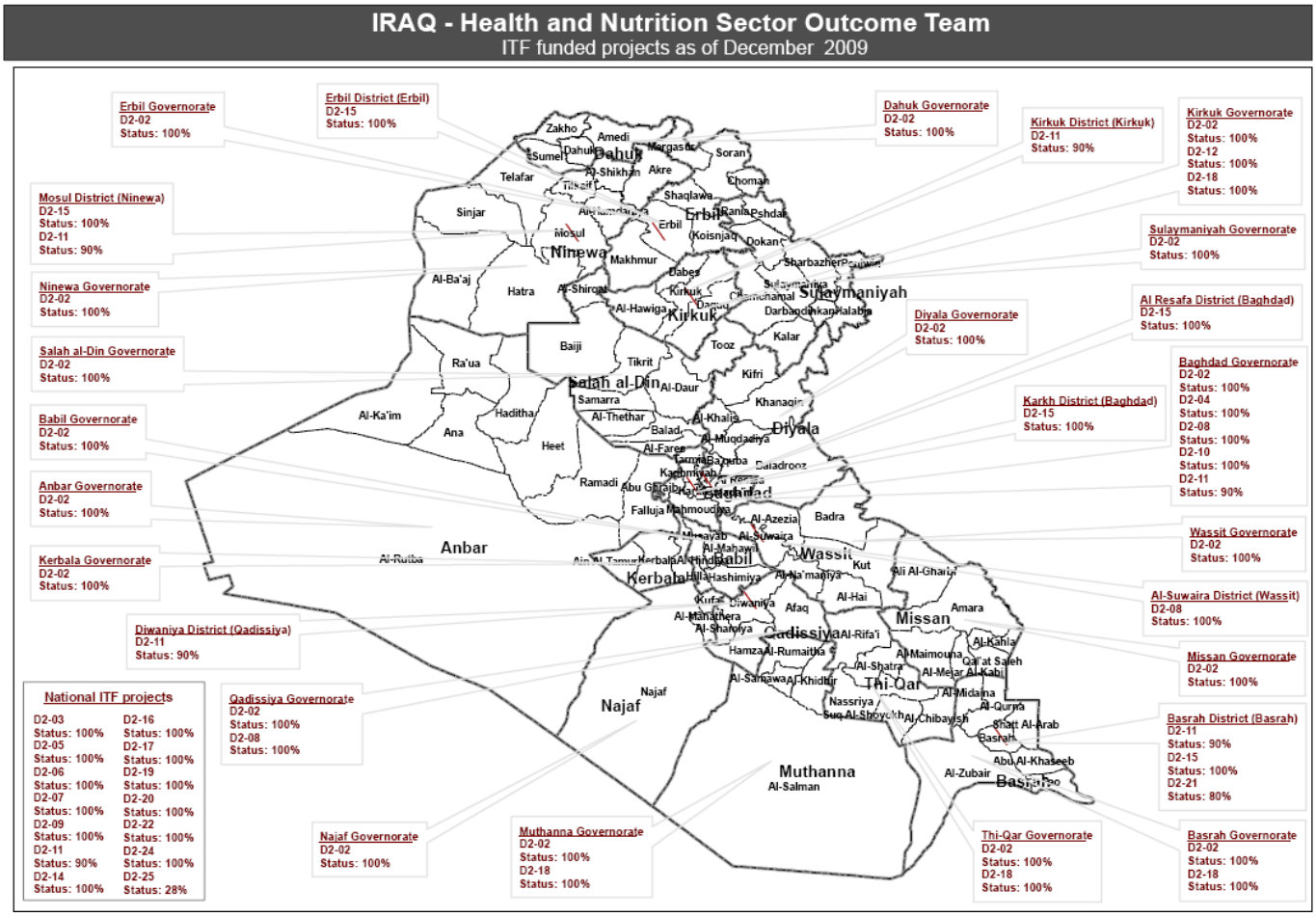
Although several workshops and meetings were organised in 2009 inside Iraq, these activities are increasingly difficult and expensive to hold due to the security standards required. GoI officials have been vocal regarding the difficulties they face reaching the international green zone, where most meetings are held.

1.1.4 Coverage and Counterparts

During the reporting period, HNSOT projects covered a wide range of topics, most of which have a national scope. In summary, the HNSOT supported institutional strengthening of the MoH for better governance, contributed to policy development addressing enforcement and regulations, and promoted equity in health services financing and provision. Large programmes implemented included strengthening the primary health care system; preventing communicable diseases and strengthening immunization services; improving maternal and child health, including reproductive health and emergency obstetric care aimed at decreasing the maternal mortality rate and the infant mortality rate; and increasing food safety by enhancing food-borne disease surveillance and prevention, improving agricultural practices, and establishing good manufacturing practices in food industries. Also, programmes focusing on national medicine policy based on the concept of essential medicines, including their safety and quality, have been supported at all levels.

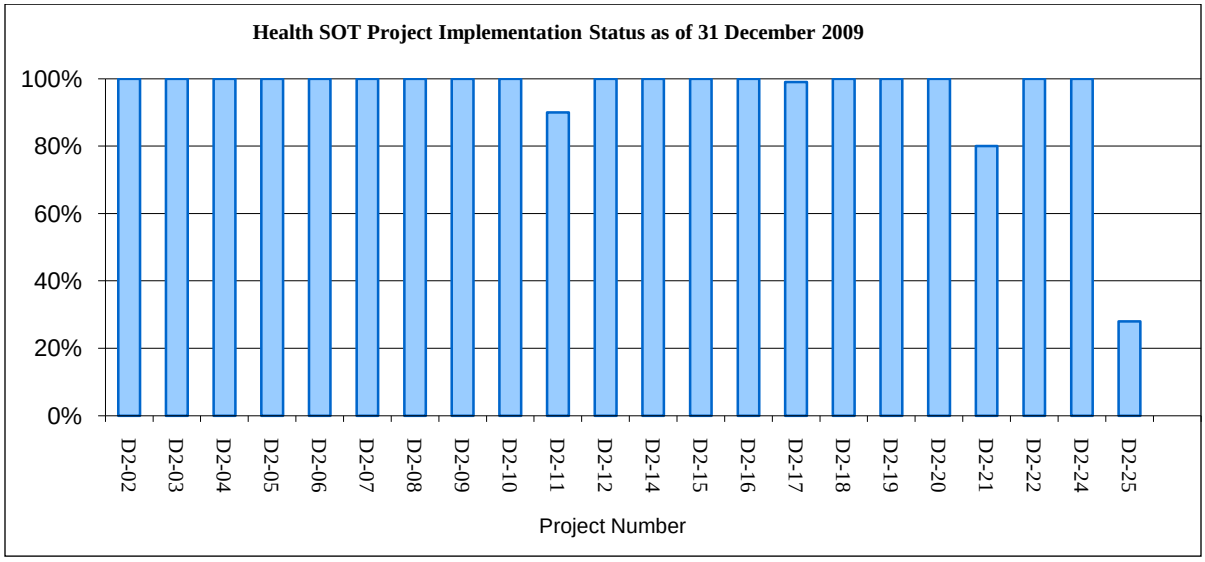
The main counterparts are the MoH and Departments of Health (DoH) at the governorate levels, as well as other line ministries that are partners in health and nutrition such as Ministry of Environment, Ministry of Higher Education, Ministry of Education, Ministry of Women Affairs, Ministry of Agriculture and Ministry of Industry. UN agency members of the HNSOT are also partnering with all the major international nongovernmental organizations (NGOs) and civil society organizations (CSOs) that are active in health in Iraq.

Figure Error! No text of specified style in document.**–1 District Level Map for Health and Nutrition Sector**



1.1.5 Results

Figure Error! No text of specified style in document.**–2 Project Implementation Status for Health and Nutrition Sector**



1.1.6 Narrative Explanatory Summary of Results

The health and nutrition sector has 22 UNDG ITF projects, of which 3 are active and 19 are operationally closed at the time of reporting. In addition there are 6 projects in the pipeline that are expected to receive funding in early 2010. Since 2004, the sector has received a cumulative total of $173.19 million in funding (14 percent of total portfolio), with $156.50 million (90 percent of the total amount received by the sector) in contract commitments and $134.12 million (77 percent) in disbursements.

The HNSOT has been working with the GoI toward revitalization of the primary health care system in Iraq. Sector support included infrastructure rehabilitation and construction of facilities, provision of supplies and equipment, training of staff, revision of policies and strategies, and more. The HNSOT contributed to enhancing the management and maintenance system at all medical equipment repair shops at the DoH level through international and in-country training, training of trainer (ToT) workshops, provision of informatics, sharing of information and experience, and setting up guidelines and policies. Still, whilst major achievements have been documented in 2009, the need for continued support by the HNSOT remains immense.

Maternal and infant care

The maternal mortality rate (MMR) in Iraq is the highest in the region. Incidence of women dying during or shortly after pregnancy has been flagged by the MoH as a key health care priority. Iraq is now giving precedence to achieving the fifth MDG: to reduce the maternal mortality by three quarters between 1990 and 2015.

To address these challenges, the government has initiated a Community Midwifery Education Programme to build the capacity of midwives to deliver effective maternal health care to preserve the lives and health of pregnant women. This 18-month skills-based training programme has been successful in other post-conflict states and has contributed to a reduction in maternal morbidity and mortality rates in other countries. The MoH also collaborated with the World Health Organization (WHO) in 2009 to implement the Integrated Management of Childhood Illness (IMCI) strategy in 8 governorates, 18 districts and 59 health facilities. A total of 356 Iraqi doctors and nurses received training on child health approaches and the skills required for the successful implementation of the three components of IMCI strategy. In December 2009 the MoH conducted a four-day workshop in Baghdad with the participation of over 100 experts from all governorates and ministries to update the National Maternal, Child and Reproductive Health Strategy for 2010–2015.

Furthermore, a rapid assessment of newborn care services at maternity hospitals was conducted. The assessment involved all governmental hospitals that provide both prenatal and newborn care services. As an intervention to strengthen the maternal surveillance system, MoH (in collaboration with WHO) implemented a confidential enquiry into maternal deaths as a pilot study in six governorates.

Access to quality health and nutrition practices

Several programs have contributed to the effort to improve access of the Iraqi population to quality health and nutrition practices. In a pilot project at 41 primary health clinics (PHCs) in 2008–2009, WHO initiated services for the early detection of diabetes and hypertension. Such services are now being provided by 25 percent of PHCs in each of the 19 DoHs. The MoH has decided to extend the services to involve 50 percent of PHCs during 2010–2011, based on successful previous experiences. Specific monitoring and reporting tools were developed in support of this project.

The 'Enhancing the Iraqi Institutions' Capacity in Analyzing and Reporting Food Security and Vulnerability in Iraq' project, which ended in 2009, helped identify the locations of the most food-insecure people. For the first time, this survey involved the Kurdistan Regional Government (KRG) and covered all 18 governorates of Iraq.[6] The data can be used to reform the Public Distribution System (PDS) to target only the most food insecure—currently, the PDS aims to deliver a monthly food ration to all citizens.

Providers able to deliver improved health services

Biomedical engineers under training

During the first quarter of 2009, the 'Strengthening Medical Equipment Management and Maintenance System Across Iraq' project was completed.This project helped to improve and upgrade skills of 621 biomedical engineers and biomedical equipment technicians (473 male and 148 female) through attending international and national training courses. The courses provided theory and practice to: (i) update the technical skills and abilities of biomedical engineers and biomedical equipment technicians for management and maintenance of biomedical equipment and (ii) use biomedical test instruments for preventive maintenance sessions and/or repair activities. The project also addressed having a system to assess medical equipment in the planning, procurement and management cycle and introduced a computerized management database of medical equipment. In addition, seven central maintenance repair shops in Baghdad (Kimadia, Karkh, Rasafa, and Medical City), Basrah, Erbil and Ninevah have been renovated and equipped.

Improved capacity to address HIV/AIDS

With regard to improved capacity to provide HIV/AIDS prevention, care, treatment and support services, it must be noted that, as in most countries in the Middle East, little is known about the HIV/AIDS situation in Iraq.[7] UNAIDS estimated the HIV prevalence among adults (15–49 years) to be less than 0.2 percent[8] with a higher reported number of cases in certain regions.[9]

The index case of HIV/AIDS was recorded in Iraq in 1986. Since then the number of cases has had a slow but steady increase. The total number of HIV/AIDS cases registered in the period from 1986 to 2007 is 269. The peak of cases in Iraq was seen in 1987 when contaminated imported blood led to infections. Among the registered cases, 85 percent are males; 77 percent were hemophiliacs who got infected through the contaminated blood products. Sexual transmission accounts for only 18 percent of registered cases, and 5 percent of the cases were through vertical transmission from infected mothers to their newborns. No cases of men having sex with men (MSM) or injecting drug users (IDUs) have been

[6] Central Organization for Statistics and Information Technology (COSIT)/Kurdistan Region Statistics Office (KRSO)/Iraq Ministry of Health/UN World Food Programme, 'Comprehensive Food Security and Vulnerability Analysis' (CFSVA), November 2008. Available at http://documents.wfp.org/stellent/groups/public/documents/ena/wfp192521.pdf.

[7] MoH/UNICEF/COSIT/KRSO, Iraq Multiple Indicator Cluster Survey (MICS)

[8] UNAIDS, '2008 Report on the Global AIDS Epidemic,' June 2008

[9] National AIDS Program, Annual Report, 2008

reported yet in Iraq. Post 2003, Iraq has witnessed the reporting of 53 cases and, unlike the previous cases, sexual transmission appeared as an important mode of transmission.[10]

Alarming indicators on HIV knowledge, attitudes and behaviours were shown by the Multiple Indictor Cluster Survey (MICS 2006) and the Iraq Family Health Survey (IFHS 2006/2007). The MICS revealed that the percentage of women who have heard of HIV/AIDS is 41 percent, and knowledge of all three main ways of preventing HIV transmission is only 8 percent. Only one in five women in rural areas has heard of HIV/AIDS, compared to one in two in urban areas. Only 7 percent of women reject the two most common misconceptions (HIVAIDS can be transmitted by mosquito bites and by sharing food) and know that a healthy-looking person can be infected. Comprehensive knowledge of HIV prevention methods and transmission is very low (3 percent of women aged 15–49, and 2 percent of young women aged 15–24). Only 19 percent of women know the three ways of mother-to-child transmission of HIV; 9 percent did not know of any specific way. The survey has also shown that stigma and discrimination are high in Iraq, with 92 percent of Iraqi women aged 15–49 who have heard of AIDS agreeing with at least one discriminatory statement and only 8 percent agreeing with none. In addition, utilization and awareness about HIV services were shown to be very low—only 6 percent of women know where to be tested, and only 3 percent have actually been tested.[11]

Using core resources, UNICEF and WHO supported the HIV/AIDS national program in the area of prevention and awareness-raising through the development of an HIV/AIDS communication strategy. At the time of writing this report, a specific project on HIV/AIDS, funded through ITF, has been approved and its implementation has started in 2010. This project includes several UN agencies and will support several ministries under the leadership of the MoH. In addition, the United Nations Population Fund (UNFPA), jointly with WHO and UNICEF, is supporting a national youth survey (with a sample of 20,000 youth); HIV/AIDS issues were integrated within the questionnaire and will provide crucial information for HIV/AIDS youth programming. A national survey on women's health and social status is being finalized, to be conducted jointly by COSIT, MoH, MoLSA and MoWA early in 2010; this survey will provide additional information about sexually transmitted infections, HIV/AIDS and reproductive health concerns among women during their whole life cycle (12 years and above).

Mental health initiatives

With regard to improving access to quality basic health and nutritional services, including psychosocial support to people most affected by emergencies, the first-ever Iraqi Mental Health Survey (IMHS), published in March 2009, has revealed that 16.5 percent of Iraqis have suffered from a mental health disorder during their lifetime but only 2.2 percent had received medical treatment. The survey was conducted by the Iraqi Ministries of Health and Planning and compiled by a team of Iraqi experts working in an extremely challenging security environment.

The survey found that while effective and inexpensive treatments for mental and psychological disorders are available in Iraq, the vast majority of people suffering from stress-related ailments and mental illnesses had not undergone any form of treatment or therapy. According to Iraq's Minister of Health, this factor is mainly due to the societal stigma associated with mental illness in Iraq. The MoH is working to address the results of the survey. In 2009 health authorities established 14 new community-based psychiatric facilities. Seven other facilities in areas such as Erbil, Najaf and Nasariyah have also been

[10] Ibid.

[11] National AIDS Program, Annual Report, 2008

renovated. General practitioners and nurses have received mental health and psychiatric training, enabling them to provide primary care for patients suffering from psychosomatic ailments in all governorates.

Communicable diseases and emergency needs

WHO/ UNICEF Measles vaccination campaign 2009

With regard to disease outbreak response, measles remains a threat to the health of Iraqi children. Increased population movement—an outcome of the improved security situation—has resulted in higher exposure to the disease. In addition, many children have over the past few years missed out vaccination because the security situation has prevented them from going to health centers, and health workers have been unable to reach children in the affected areas. Great numbers of unvaccinated children are getting exposed to the disease. The MoH has announced outbreaks of measles infections in 13 of 19 governorates throughout the country. In 2008, 8,134 suspected cases were reported. The outbreak continued in throughout most of 2009 but emergency vaccination conducted with support of the UN Central Emergency Response Fund (CERF) helped to contain the spread of the outbreaks. The campaign succeeded in preventing the spread of the measles outbreak to the four targeted provinces. Some 30,328 suspected measles cases were reported in Iraq in 2009. The three northern governorates and Najaf reported 634 cases (2% of country total) and only 7 cases were reported after the campaign. This is all clear evidence of the positive impact of the measles campaign in preventing the spread of the outbreak to the targeted provinces.

Substantive progress has been made in regard to preparedness to pandemic influenza. Centrally, the Iraq Pandemic Influenza strategic plan has been developed with full technical support from WHO and endorsed by the High National Pandemic Influenza committee. Capacity-building has been provided through fellowships and workshops, including more than 80 training workshops on pandemic influenza rapid response. Orientation activities to workers in health facilities have been conducted. Also, lab capacity for testing influenza specimens has been upgraded and the Iraq National Influenza Center has been recognized by WHO. Iraq has started to share influenza isolates with WHO reference labs. Media and health-education activities are ongoing.

The HNSOT continued to support the MoH in responding to emergency needs. WHO has delivered staged partial shipments of essential emergency medicines and supplies with a total value of over $1 million, including anesthetics, sutures and pain killers for use in intensive care units and operations rooms. This was done using reprogrammed funds from the medical oxygen project for Baghdad, Kirkuk and Mosul governorates.

Policy and strategy

In the area of the Essential Medicine Programme, the HNSOT has continued to assist the MoH to develop the National Medicine Policy, for which a draft is available at the MoH. Similar work has been achieved in the area of food safety—WHO, the UN Industrial Development Organization (UNIDO) and the Food and Agriculture Organization of the UN (FAO) have been assisting concerned ministries to review and update food safety laws and regulations. Similarly, HNSOT continued to support the GoI to develop, review and update policies and strategies for non-communicable disease (NCD) that are consistent with regional and international norms.

HNSOT, with WHO leadership, has advocated at different levels and provided needed policy, technical and logistic support to ensure proper implementation of International Health Regulations (IHR) 2005 in Iraq. In March 2009, more than 45 government officials from different ministries and Iraq parliament and representatives from all provinces participated in a four-day meeting in Amman with WHO experts to establish a commitment to conduct a full assessment of core capacities needed for the implementation of IHR 2005 at local, intermediate and national levels. Many consultation meetings have been conducted inside Iraq with full technical support from HNSOT to finalize the assessment of core capacities and the plans of actions needed for the implementation of IHR 2005. Revision of Iraq's public health laws and legislation in line with IHR 2005 was one of the main recommendations of the Amman meeting. The first draft of the revised public health laws and legislation was ready on 28 October 2009.

Empowerment of civil society

Equity and equal access have always been given high consideration by the HNSOT. One example of equal access and innovative intervention was the provision of fully equipped boats to the Marshland areas of Iraq. The 19 mobile clinics established by WHO is another example of ensuring delivery of basic health services to poor, remote and underserved population of the country.

At the time of finalising the present report, there are new projects funded through ITF whose implementation will enhance community participation in planning, monitoring and evaluation. These include MICS4, Micronutrient Deficiencies: Assessment and Response, and the Iraqi Women Health Survey. These surveys will be conducted during 2010 and will provide updated indicators for assessing progress toward 2015 as well as providing evidence for actions to intensify progress toward attainment of MDGs.

1.1.7 Other SOT Major Contributions and Implementing Partners

Many projects undertaken through the Water and Sanitation and Education sector teams, as well as through the Expanded Humanitarian Response Fund (ERF), are critical contributors to HNSOT outcomes. Numerous additional contributions to the HNSOT were not funded through the UNDG ITF, and results and activities have therefore not been reflected in this report. Partners include, but are not necessarily limited to: national and international NGOs, Red Cross/Crescent movements, private contractors, volunteers, and consultants from various national medical and nursing schools. They continue to be key partners in reaching the objectives of the SOT, and many have been frontline operators during the large vaccination campaigns and awareness-raising initiatives and partners during recent assessments. Many of these partners also play a critical role in supporting experts such as specialized surgeons or logisticians to provide training and technical support to hospitals, clinics and other parts of the Iraqi health system.

It should be noted also that bilateral funds from various donors (European Union, Japan, Netherlands, Australia, USAID, Norway, contributions to CAP 2009, agency core funding, etc.) have been used to address needs in the health sector. These were critical to the work coordinated through the HNSOT.