EXTERNAL EVALUATION REPROT OF THE

World Health Organization (WHO)

For project:
Strengthening Primary Healthcare System in Iraq (D2-03) Phase-1

Presented by:
Stars Orbit Consultants and Management Development
SOC

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Executive Summary

Project Name: Strengthening Primary Healthcare System in Iraq (SPHCS)
Implementing Organization: World Health Organizations (WHO)
Responsible Iraqi Ministry: Ministry of Health (MoH)

Background

Over the past two decades, Iraq has been ground down by war, conflict, sanctions, and rigid authoritarian governance. According to the UN/World Bank Joint Needs Assessment (2003), funding for healthcare was cut 90% resulting in the deterioration of healthcare facilities and quality of services due to lack of maintenance and supplies. The health of the Iraqi people declined along with their care structure, with some regions ranking among the least developed nations in the world in the quality of their healthcare.

The United Nations/World Bank Joint Iraq Needs Assessment (2003) indicated that a significant obstacle to restoring the Iraqi healthcare system is the centralized, hospital-oriented healthcare framework. This system proved to be both expensive and logistically problematic, resulting in a distribution of services that was inefficient and provided inequitable access to low-income earners. Against this background, there was a need to increase the capacity of the Iraqi healthcare system and access to health services. WHO, in cooperation with the MoH implemented, the SPHCS project as "a response to identified priorities and the recommendations of the UN/WB Iraq Joint Needs Assessment and along with the global movement to shift into Primary Healthcare which was adopted by the Iraqi MoH."

The original start date of the project was June 2004[1] with projected completion by December 2005. The duration of the project at approval was set for 18 months. The completion date was subsequently revised to March 2008. The total implementation delay was 27 months, with the duration extending to approximately 45 months.

The project was implemented through the MoH in collaboration with the following ministries: Higher Education, Education, Agriculture, Environment, Municipalities, Planning, Finance, and Human Rights. Other partners included parliamentarians, civil society and private contractors. Other UN sister agencies have also complimented WHO work such as UNICEF and UNFPA, as well as the World Bank and USAID. Finally, some activities were implemented along with NGOs such as MERLINE.

The collaboration, coordination and information sharing with other UN agencies working within the Health and Nutrition Sector such as UNOPS, WFP, UNIDO, UNDP and others, in addition to intra-sector collaboration and coordination, were ensured through the UN Health and Nutrition Sector Outcome Team Forum, the Peer Review Coordination Forum, and other UN Sector Outcome Teams.

The specific goals of the project were as follows:

1. Establish 19 model PHC districts that are sustainable and functioning (including a functional referral system) in one district in each of the 18 governorates (with two in Baghdad), which provide a basic health package to the population they serve.
2. 2,000 trained health professionals at all levels.
3. A family physician and nurse practitioner model initiated.
4. Enhanced community participation in health activities.

[1] This is in accordance with the estimate provided in the Scanteam's January, 2009, report and does not coincide with official start dates.

Building on the achievements of SPHCS Phase I and in order to continue WHO support to the MoH, SPHCS Phase II was developed to further contribute to the development of the Iraqi healthcare system at the levels of national policy and health service delivery.

Evaluation

Evaluation of the project was conducted by Star Orbit's Consultants and Management Development (SOC) and is intended to build on the independent review of SPHCS Phase I, which was conducted by the Scanteam, as a third party evaluation to compliment WHO and MoH evaluations. While the Scanteam evaluation focused on the southern region of Iraq due to military activity in other parts of the country, the current review was implemented in all 19 of the model PHC districts.

This evaluation included all activities that were implemented across all 19 model PHC districts and was designed to assess the project's output on both direct and indirect beneficiaries. It consisted of desk review, stakeholder feedback (collected through surveys and interviews), and field visits to all 19 model districts. Some 36 SOC evaluators visited health facilities in all governorates. These visits included 33 PHCCs in rural and urban areas. During the evaluation convention, DoH officials were interviewed in all governorates, as well as doctors, patients, and community leaders. During these visits the evaluation team examined the supplied medical equipments under this project and rehabilitated buildings that were provided by the project. These evaluation visits were facilitated in part through cooperation between WHO focal points and the SOC evaluators. Evaluators met with WHO focal point staff prior and during the evaluation convention, WHO focal points provided valuable information about the project implementation and helped to facilitate interviews with DoH personnel.

All key components of the project design were examined, as addressed in the "Evaluation Purpose and Scope" section. The evaluation included all major stakeholders and partners, with specific attention given to gender balance, both in regards to the SOC team and to the stakeholders surveyed and interviewed. Special attention was also given to the inclusion of ethnic and religious minorities as well as other vulnerable groups.

The evaluation convention was implemented by 36 highly trained field evaluators supported by project manager / analysts experts; project coordinator; reporting specialist, logistics and administration to coordinate, support and leads the field evaluation team and liaison with the WHO in Amman. The supporting team was based in Baghdad, Erbil and Amman.

The evolution took also into consideration the effect of unstable security situation in Iraq during the project implementation period, and the remote nature of managing, implementing and monitoring the project activities inside Iraq from WHO – Iraq, based in Amman, Jordan. This resulted in further challenges and difficulties during project implementation.

In order to launch the evaluation convention and ensure effective cooperation between SOC, WHO, and MoH, three meetings were held. These took place on 18 October 2009, 22 October 2009, and 5 January 2010. These meetings were attended by key MoH officials including Ministry of Health and two Deputies for the Ministry of Health and many Director Generals as well as key WHO included WR Dr. Naeema Al-Gasseer and Deputy WR Dr. Omer Mekki of the WHO. The meetings served to achieve the following goals:

- Launch the evaluation convention
- Insure the support of the minister of health and his deputies in supporting of the evaluation convention.
- To orient the Ministry of Health counterparts on the Terms of References for the independent evaluation including the evaluation purpose, scope, objectives, methodology and management arrangements.
- SOC to update the meeting on the methodology and the data collecting tools to be used during the field evaluation.
- To agree on the fieldwork plan.
- Establish an agreement on the implementation timetable among all concerned parties.

The evaluators visited 33 PHCCs across all 19 governorates;[2] PHCCS were selected so as to cover both rural and urban areas. The evaluators interviewed over 250 community leaders, MoH, DoH, and PHCC personnel. They also interviewed more than four hundred members of targeted communities[3].

Achievements

In order to achieve its goals, 15 activities were as a part of the SPHCS project. These activities and their results were as follows:

1. Rehabilitation/Construction of Health Facilities: This included the restoration of 129 PHCC buildings, serving approximately 19 million people, and the construction of 19 training halls. The PHCCs and training halls were located across all 19 target districts. Training halls will be dedicated to provide education to 5,000 DoH and MoH staff on a yearly basis in various primary health care issues.
2. Capacity Development of PHCCs: Provided PHCCs and training halls with new supplies, medical equipment, and an expanded staff consisting of qualified professionals. PHCCS received medical equipments, supplies, drugs, kits, furniture, and information equipments such as computers. Training halls were supplied with 1,216 teaching resources including TVs, data collection recorders, digital cameras, and other items.
3. Professional Training: Provided medical and administrative staff with training in a range of skill sets. Some 4,004[4] people received training under this activity. This training covered a wide range of subjects relating to healthcare policy, the use of medical equipments, diagnosis of diseases, diseases' treatments, management of health facilities, and community outreach. It also included the training of trainers in the techniques of teaching these subjects.
4. Family Physician Model (FPM): Implemented a pilot program which introduced a family physician and nurse practitioner care model in three target PHCs. The three pilot PHCCs experienced a significant increase in the number of patients who made use of their services.
5. Referral System: Established a referral system allowing for the transfer of patients from PHCCs to district hospitals, and vice versa, according to the individual's medical needs. This referral system proved to be highly effective, improving the efficiency of the PHCCs and participating hospitals.

[2] See Annex C for a list of all PHCCs visited
[3] See Annex BV for a list of all interviews with MoH, DoH, WHO, PHCC and other medical personal and community leaders
[4] This number is based on the Scanteam's January, 2009 report

6. Health Information System: Provided equipments and training necessary to establish a computerized information sharing system between the MoH and each governorate's DoH. All of the hardware equipments for this system was installed and a dedicated space were at each health directorate were allocated; however, as of yet it is not operational due to software and managerial challenges.
7. Public Health Activities: Support was provided for the prevention and control of leishmaniasis, tuberculosis, nasocomial infections, to improve the Expanded Program on Immunization (EPI), and bolster various public health labs and the central blood bank. This activity significantly increased the capacity of the health labs, one of which had been completely destroyed. Additionally, the areas that were affected by the disease control and prevention projects experienced declines in the prevalence of these diseases. This activity may have contributed to this decline.
8. Action Oriented School Health Curriculum (AOSHC): This activity assessed teachers' knowledge regarding health issues and school facilities for health hazards. While the assessment was completed.
9. Health Sector Reform: Developed national policies regarding a number of issues aimed at improving the management of the healthcare system. This originally included the development of financing options for Iraq's health sector, a nursing and midwifery strategy for Iraq, an IMCI plan of action, and the establishment of national health accounts. Of these reforms the national health accounts were not enacted due to changes in MoH priorities. A policy regarding financing options is under review and the other policies have been enacted.
10. Iraq Family Health Survey (IFHS): Conducted the first national IFHS. This survey gathered information on the health of 9,345 households and 14,675 women of child- bearing age. The information has been made available to MoH and MoHK staff.
11. Basic Health Service Package (BHSP): Developed a BHSP consisting of health education, maternal and newborn health, child health, CD treatment and control, NCD prevention and control, emergency care, nutrition, essential medicine, immunization, diagnostic services, and mental health components. The BHSP has yet to be implemented. This will take place as a part of SPHCS Phase II.
12. Primary Healthcare Manuals: Drafted nationwide PHC training manuals regarding reproductive health, child health and epidemiology, CD, NCD, school health, oral health, mental health, environmental health, PHC management, and nutrition and food safety.
13. Integrated Management of Childhood Illness (IMCI): Combated the mortality rate of children under five years of age through targeting the main causes of death for young children: acute respiratory tract infections, acute diarrheal diseases, and malnutrition. This was accomplished through training PHCC staff regarding diagnosis and treatment.
14. Community Based Initiative (CBI): This activity oversaw the development of partnerships between community leaders, CSOs, MoH, DoH, and other ministries, which developed a range of projects addressing specific community needs. Examples of these included income generation projects, the repair of damaged septic systems, and the paving of roads.
15. Emergency Response: Supplies and medicine were distributed to 57 hospitals in 2005.

While these activities met with varying degrees of success depending on their locations and other challenges associated with their implementation, review of project documents and interviews with stakeholders indicated that all of them had a positive impact on PHCC capacity, use of PHCCs, MoH and DoH policy and management, and the general health of the Iraqi population.

Challenges

SPHCS project implementation witnessed a complex and volatile security situation. The 2005-2007 time-periods is referred to as a highly insecure period with high numbers of incidences of violence. The fragile situation resulted in massive turnover in the government in general and in particular the MoH staff at all levels; this situation was complicated by attacks against health professionals and migration of the skilled health professionals away from unstable areas, lack of MoH operational running costs, and the security situation on the ground (not allowing for freedom of movement). These challenges contributed to issues that affected the effectiveness of the individual activities. The most significant of these were insufficient oversight of implementation and inadequate maintenance or supply of facilities.

Recommendations

Recommendation for the WHO

- Provide more technical support for the MoH regarding the rehabilitation and supply of PHCC facilities.
- Provide follow- up training sessions and implement new sessions on Primary Health Care topics.
- Support the MoH in extending the implementation of FPM and the referral system.
- Support the MoH in providing capacity building for new staff related to FPM and referral systems.
- Follow-up with the MoH to ensure the activation of the HIS and overcome technical difficulties.
- Support further CBI activities.
- Support the MoH in establishing a system for conducing IFHSs at regular intervals.

Recommendations for the MoH

- Continue maintenance and re-supply of PHCC and laboratory buildings and equipments.
- Provide more support for the rehabilitation and supply of PHCCs so as to facilitate the transition from a hospital-based to a PHC based system. Also provide staff with the necessary training to enable them to use the newly distributed equipment.
- Conduct more training sessions for health staff to update on new primary health care issues and build their capacity. When selecting participants, take care to ensure gender balance.
- The FPM and referral system activities should be expanded to other governorates.
- Work to build a closer relationship with the MoE so as to increase the impact of the AOSHC.
- Address the problem that has prevented the operation of the HIS.
- Expand CBI activities to other areas.
- Establish a system for conducing IFHSs at regular intervals.

Recommendation for Donors

- Maintain the support to WHO to continue supporting and upgrading MoH in areas including:
    1. Staff capacity building on new and updated PHC topics.
    2. Extend CBI activities.
    3. Provide technical support on rehabilitation and supply of urgent medical equipment.

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Acronyms

AOSHC: Action Oriented School Health Curriculum
BHSP: Basic Health Services Package
BDN: Basic Development Needs
BOQ: Bill of Quality
CBI: Community Based Initiative
CD: Communicable Diseases
COSIT: Central Organization for Statistics and Information Technology
CSO: Civil Society Organization
DEX: Direct Execution Project
DoH: Director of Health
ECG: Electro Cardio Graph
FPM: Family Physician Model
GoI: Government of Iraq
HCG: United Nations Humanitarian Coordination for Iraq Health Coordination Group
IFHS: Iraq Family Health Survey
IMCI: Integrated Management of Childhood Illness
IRFFI: International Reconstruction Fund Facility for Iraq
KRG: Kurdish Regional Government
KRSO: Kurdistan Regional Statistics Office
M&E: Monitoring and Evaluation
MERLINE: Medical Emergency Relief, International
MoA: Ministry of Agriculture
MoE: Ministry of Education
MoEnv: Ministry of Environment
MoH: Ministry of Health
MoHK: Ministry of Health for the Kurdistan Region
MoL: Ministry of Labour and Social Affairs
MoPDC: Ministry of Planning and Development Coordination
NCD: Non-Communicable Diseases
NGO: Non-Governmental Organization
OECD-DAC: Organization for Economic Co-operation Development- Development Assistance Committee
PHC: Primary Healthcare
PHCC: Primary Healthcare Centre
PO: Project Objective
SOC: Stars Orbit Consultants and Management Development
SPHCS: Strengthening Primary Healthcare System in Iraq
ToR: Terms of Reference
UN: United Nations
UNDG-ITF: United Nations Development Group-Iraq Trust Fund
UNDP: United Nations Development Program
UNEG: United Nations Evaluation Group
UNFPA: United Nations Population Fund
UNICEF: United Nations Children's Fund
UNIDO: United Nations International Development Organization
USAID: United States Agency for International Development
WFP: United Nations World Food Program
WHO: World Health Organization

Introduction

Over the past two decades, Iraq has been ground down by war, conflict, sanctions, and rigid authoritarian governance. According to the UN/World Bank Joint Needs Assessment (2003), in the wake of these sanctions, funding for healthcare was cut 90% resulting in the deterioration of healthcare facilities and quality of services due to lack of maintenance and supplies. During this time funding was allocated based on ethnic and political biases rather than human need. Additionally, many of the nation's health professionals immigrated to other countries, leaving the MoH understaffed and resulting in reliance on under-trained healthcare providers.

Unsurprisingly, the health of the Iraqi people declined along with their care structure, with some regions of the country ranking among the least developed nations in the world in the quality of their healthcare. From 1990-1996, infant mortality rates more than doubled. The country is also suffering from growing rates of infectious diseases such as diarrheal diseases, acute respiratory infections, malaria, tuberculosis and leishmaniasis. Cardiovascular diseases, diabetes, and cancer are also significant health concerns. Furthermore, deteriorated security and increased gender violence following conflict resulted in the prevention of many women from seeking medical care. Maternal mortality tripled, with 30% of women giving birth without the care of a qualified professional.

The United Nations/World Bank Joint Iraq Needs Assessment (2003) indicated that a significant obstacle to restoring the Iraqi healthcare system is the centralized, hospital-oriented healthcare framework. This system proved to be expensive and logistically problematic, resulting in a distribution of services that was both inefficient and provided inequitable access to low-income earners. This assessment was confirmed by the 2005 Cabinet Committee on Security, which was established by cooperation between the WHO, other UN aid agencies, and the MoH.

The result of these conditions was a national scenario in which many Iraqis did not have access to adequate medical care. This access is a fundamental human right, as expressed in article 25 of the Universal Declaration of Human Rights and reiterated in the 1979 International Covenant on Economic, Social, and Cultural Rights, as well as in the Declaration of Alma-Ata. The WHO has been working in Iraq since 1960 implementing projects working to provide Iraq with the necessary resources and know-how to provide its people with the rights outlined within these documents.

Against this background, there was a need to increase the capacity of Iraqi healthcare and access to health services. The WHO and MoH chose to focus on developing the Primary Healthcare System within 19 model districts, one in each governorate and two in Baghdad, as well as improving capacity and equipment in the healthcare system overall. The SPHCS project was designed to facilitate these goals.

This report provides the results of this evaluation. The document is laid out as follows:

- Project description
- Evaluation purpose
- Evaluation methodology
- Major findings
- Results achieved
- Lessons learned
- Recommendations
- Annexes

1. Project Under Evaluation Description

1.1 Project Under Evaluation Background

According to the "D2-03 Final Narrative Report," the aim of the SPHCS project was to "facilitate the transition of the Iraqi healthcare delivery system from curative and hospital basis, into a decentralized Primary Healthcare (PHC) based system, with a focus on community outreach and community involvement." This goal was in line with targets set by the MoH, and was perused through the implementation of 15 activities across Iraq. These addressed issues related to infrastructure, the capacity of MoH staff, supplies, policy, developing an accurate understanding of the health issues facing Iraq, and community participation.

SPHCS was implemented during the period of July 2004-July 2008 at a national level in a total of 19 districts. It was funded by UNDG-ITF with a total budget of USD $37,363,515. The targeted districts included: Tilkeif, Dakok, Beiji, Ba'aquba, Heet, Mahmoudia, Madaen, Swera, Amarah, Zubair, Suk Al Shyouk, Alurmaitha, Diwania, Manathera, Hindia, Al Musaiab, Akra, Shaklawa, Dukan.

The original start date was June 2004[5] with projected completion by December 2005. The duration of the project at approval was set for 18 months. The completion date was subsequently revised to March 2008. Total implementation delay was 27 months, with the duration extending to approximately 45 months. This delay of the completion of the project was the result of the Instability and violence throughout Iraq, which restricted movement and contributed to high turnover rates of MoH personnel.

The project was implemented through the MoH with WHO support, in collaboration with the following ministries: Higher Education, Education, Agriculture, Environment, Municipalities, Planning, Finance, and Human Rights. Additionally, parliamentarians, civil society and private contractors participated in the project. Other UN sister agencies have also complimented WHO work such as UNICEF and UNFPA, as well as the World Bank and USAID. Finally, some activities were implemented along with the NGOs such as MERLINE.

Collaboration, coordination and information sharing with other UN agencies working with the Health and Nutrition Sector such as UNOPS, WFP, UNIDO, UNDP and others, in addition to intra-sector collaboration and coordination, were ensured through the UN Health and Nutrition Sector Outcome Team Forum, the Peer Review Coordination Forum, and other UN Sector Outcome Teams.

SPHCS project implementation witnessed a complex and volatile security situation. The 2005-2007 time period was referred to as the most insecure period with high numbers of incidences of violence. The fragile situation resulted in massive turnover in the government in general and in particular MoH staff at all levels; this situation was complicated by attacks against health professionals and the migration of skilled health professionals away from unstable areas, a lack of MoH operational running costs, and the security situation on the ground, which often did not allow for freedom of movement, have also affected the implementation of this project.

[5] This is in accordance with the estimate provided in the Scanteam's January, 2009 report and does not coincide with official start dates.

Finally, building on the achievements of SPHCS Phase I and in order to continue WHO support to the MoH, SPHCS Phase II was developed and designed to contribute to the development of the Iraqi healthcare system at the levels of national policy and health service delivery.

D2-03 is a Direct Execution Project (DEX), managed by the WHO in collaboration with Iraqi Ministry of Health. According to documentation:

- The WHO had responsibility for overall implementation including financial management, procurement, monitoring of implementation and reporting to donors.
- The project was designed to work closely with government systems for planning and service delivery through capitalising on and developing the capacity of relevant Iraqi ministries.
- The Ministry of Health maintained oversight of activities and assumed responsibility of their maintenance upon their completion.
- The project did not have a management team embedded in government, though the WHO provided support for MoH and other ministry officials who were in charge of managing the implementation of various activities.
- WHO had national and international staff in Amman providing this project management support, and a network of 100 nationals inside Iraq.
- Governorates worked with the MoH/district director through teleconferencing and direct meeting in Amman.
- The WHO network of staff, logistics and telecommunication was put at the disposal of the MOH, expanding project capacity.

The D2-03 Project document does not contain a detailed risk analysis although the following risks were discussed:

- Political instability, including changes in senior MoH personnel and how that may adversely impact implementation.
- High turnover rates in the MoH resulting in the loss of key management and technical staff.
- Field operations impaired by increasingly dangerous security conditions.

1.2 Project Under Evaluation Activities

SPHCS included the following activities:

1. Rehabilitation/Construction of Health Facilities: Included the restoration/construction of 19 training halls in all target districts.
2. Capacity Development of PHCCs: Provided PHCCs with new supplies, medical equipment and expanded staff consisting of qualified professionals.
3. Professional Training: Provided medical and administrative staff with training in a range of skill sets.
4. Family Physician Model (FPM): Implemented a pilot program which introduced a family physician and nurse practitioner care model in three target PHCCs in Baghdad, Basra, and Mosul.
5. Referral System: Implemented a pilot program which established a referral system allowing for the transfer of patients from PHCCs to regional hospitals, and vice versa, according to the individual's medical needs. The target areas included PHCCs in Baghdad, Basra and Mosul.
6. Health Information System: Provided equipment and training necessary to establish a computerized information sharing system between the MoH and each governorate's DoH.

7. Public Health Activities: Support was provided for the prevention and control of leishmaniasis, tuberculosis, nasocomial infections and to improve the Expanded Program on Immunization (EPI), as well as support various public health labs and the central blood bank.
8. Action Oriented School Health Curriculum (AOSHC): Assessed the condition of school facilities from a health-oriented perspective.
9. Health Sector Reform: Developed national policies regarding a number of issues towards improving the management of the healthcare system.
10. Iraq Family Health Survey (IFHS): Conducted and published the results of the first national Iraq Family Health Survey.
11. Basic Health Service Package (BHSP): Developed a BHSP consisting of health education, maternal and newborn health, child health, CD treatment and control, NCD prevention and control, emergency care, nutrition, essential medicine, immunization, diagnostic services, and mental health components.
12. Primary Healthcare Manuals: Drafted PHC training manuals regarding reproductive health, child health and epidemiology, CD, NCD, school health, oral health, mental health, environmental health, PHC management, and nutrition and food safety.
13. Integrated Management of Childhood Illness (IMCI): Combated mortality rate of children under five years of age through targeting the main causes of death for young children: acute respiratory tract infections, acute diarrheal diseases, and malnutrition.
14. Community Based Initiative (CBI): This activity oversaw the development of partnerships between community leaders, CSOs, MoH, DoH, and other ministries which developed a range of projects addressing specific community needs.
15. Emergency Response: Supplies and medicine were distributed to 57 hospitals in 2005.

1.3 Project Under Evaluation Objectives

The SPHCS project was developed with the mission to "facilitate the transition of the Iraqi healthcare delivery system from curative hospital based into a decentralized PHC based system with a focus on community outreach and community involvement." With this in mind, the SPHCS project perused the following objectives:

1. Establish 19 sustainable and functioning model PHC districts (including a functional referral system), with one district in each of the 18 governorates (two in Baghdad), which provide a BHSP to their population
2. 2,000 trained health personnel at all levels.
3. A family physician and nurse practitioner model initiated.
4. Enhanced community participation in health activities.

The expected outcomes of the project were as follows:

1. All PHCCs are to be rehabilitated, refurnished and operational.
2. All PHCCs are to provide the Basic Health Service Package.
3. Human resources for health capacity building are to be completed for the 19 model districts.
4. The initiation of family physician practices.
5. Ensured community participation in decision-making and health service provision.

The following assumptions underlying the project objectives and expected outcomes were stated in the Project Document (2004):

1. Security situation remains at the same level.
2. The political situation stabilizes, and that stability is maintained.
3. There are no frequent changes in the organizational structure of MoH, especially at the General Director level.
4. WHO national staff network are able to move and work, delivering support to MoH.
5. Costs and inflation do not adversely affect the project budget.

2. Evaluation Purpose and Scope

This evaluation was conducted by Star Orbit's Consultants and Management Development (SOC) and is intended to build on the independent review of SPHCS Phase 1 which was conducted by the Scanteam, as a third party evaluation to compliment WHO and MoH evaluations. While the Scanteam evaluation focused on the southern region of Iraq due to military activity in other parts of the country, the current review was implemented in all 19 of the model PHC districts. It focused on both direct and indirect beneficiaries, as well as implementing partners, including MoH officials at central, governorate, and district levels, community representatives, contractors, and WHO staff.

The evaluation examined all aspects of project design including:

- Rehabilitation/construction of health facilities
- Capacity development of MoH officials
- Family physician model
- Referral system
- Health information system
- Public health activities
- Emergency response
- School health
- Health sector reform
- Iraq family health survey
- Basic health service package
- Primary healthcare manuals
- Integrated management of childhood illness
- Community Involvement and decision making process under Community Based Initiative Approach.

As expressed in the ToR, information garnered through the evaluation is intended to "provide recommendations to enhance operational and programmatic effectiveness of similar initiatives in comparable situations," as well as SPHCS Phase II.

3. Description of Evaluation Methodology

3.1 Evaluation Objectives

In accordance with the ToR (annex A) the evaluation focused on the following objectives:

- To assess and showcase the achieved progress and results against stipulated project objectives and outputs for a strengthened primary healthcare model in Iraq.
- To assess the efficiency and effectiveness of the 19 model PHC districts.
- To assess the relevance of project components in strengthening the primary healthcare delivery in Iraq vis-à-vis needs in the catchment areas of the 19 PHC model districts.
- To understand the extent to which this project has contributed to forging a partnership with MOH at different levels, the Government of Iraq (GoI), and civil society and UN/donors.
- To appreciate the management arrangements put in place by the GoI and/or the beneficiary communities towards the sustainability of various project-initiated services and benefits.
- To generate lessons on good practices based on assessment from the aforementioned evaluation objectives, and to provide recommendations to GoI and WHO on how to maximize the output from similar initiatives in comparable situations.

3.2 Evaluation Methodology

In order to achieve the objectives discussed above, SOC used the following techniques:

- Desk review: This included a thorough analysis of all project documents (see annex B III for a list of desk study documents) in order to extract information, identify trends, and develop key questions and criteria for analysis. Documents regarding national strategies were also examined in order to identify connections between project objectives and national priorities.
- Stakeholder Feedback: Stakeholders were identified by SOC in consultation with the WHO. Once identified, their feedback was gathered through interviews, focus group discussions, observations, and questionnaires (see annexes B IV, B V and G for lists of preliminary, in-depth interviews & field evaluation guidelines and questionnaires). These included WHO and MoH staff, DoH personnel, patients, and relevant members of other Iraqi ministries.
- Field visits: SOC field visits were conducted by two evaluators in each governorate. Methods of collecting information included:

    1. Field visits with MoH including group discussions with central level staff
    2. Field visits to the DoH in relevant governorates including the distribution of questionnaires, group discussions, interviews, and site observations
    3. Field visits to facilities using questionnaires, group discussions, interviews, and site observations
    4. Focus group discussions with community leaders
    5. Questionnaires distributed to beneficiaries of capacity building activities

3.3 Pre-evaluation Meetings

Prior to the start of SOC's evaluation, three meetings took place with the purpose of ensuring the effective coordination between the WHO, MoH, and SOC. These meetings laid the groundwork for the evaluation of SPHCS and served to introduce SOC team to key staff within the MoH and WHO. The following is a summary of these meeting's goals and the people in attendance.

On 18 October 2009, the first meeting took place in Al Rasheed Hotel – Baghdad, this meeting was attended by more than 75 participants and was covered by more than 10 news and media agencies.

The main objectives of this meeting were:

- Lunch the evaluation convention.
- Insure the support of the ministry of health and his deputies in support of the evaluation convention.
- To orient the Ministry of Health Counterparts on the Terms of References for the Independent Evaluation including the evaluation purpose, scope, objectives, methodology and management arrangements.

- SOC to update the meeting on the methodology and the data collecting tools that will be used during the field evaluation.
- To agree on the implementation timetable

Below were the attendants of this meeting:

MoH	WHO	SOC
• Dr. Amer Al Khzay- • Dr. Mohammed Jaber- • Dr. Ihssan Jaafar-DG of PH • Dr. Hanan Hashim- Head of PHC • DoHs focal points- to be invited by MoH • Representation of DG Planning/ Inspector General Office • Dr. Ahlam Aziz- Office of Deputy Minister for Donors Affairs	• Dr. Naeema Al-Gasseer-WR • Dr. Omer Mekki-Deputy WR • Dr. Moayad Lutfi-OIC Baghdad Office • Ms. Lamia Rantissi-Technical Officer	• Mr. Basil Sadik-Director • Project coordinator • Field evaluators

The second meeting was conducted on 22 October 2010 In Al Rasheed Hotel – Baghdad, this meeting was attended by more than 26 participants and the main objectives of this meeting were:

- To orient the Ministry of Health Counterparts on the Terms of References for the Independent Evaluation including the evaluation purpose, scope, objectives, methodology and management arrangements.
- SOC to update the meeting on the methodology and the data collecting tools that will be used during the field evaluation.
- To agree on the fieldwork plan.
- To agree on the implementation timetable among all concerned parties.

Below were the attendants of this meeting:

MoH	WHO	SOC
• 19 senior staff from MoH representing all health directorates in Iraq (except KRG). • Representation of DG Planning/ Inspector General Office • Dr. Ahlam Aziz- Office of Deputy Minister for Donors Affairs	• Dr. Omer Mekki- Deputy WR • Dr. Moayad Lutfi- OIC Baghdad Office • Ms. Lamia Rantissi- Technical Officer	• Mr. Basil Sadik- Director • Project coordinator • Field evaluators

The third meeting took place in Erbil on 5 January 2010 at Erbil Ministry of Health; this meeting was attended by MoH representative in KRG as well as WHO representative and SOC evaluation team.

The main objectives of this meeting were:

- To orient the Erbil / Ministry of Health Counterparts on the Terms of References for the Independent Evaluation including the evaluation purpose, scope, objectives, methodology and management arrangements.
- SOC to update the meeting on the methodology and the data collecting tools that will be used during the field evaluation.
- To agree on the fieldwork plan.
- To agree on the implementation timetable among all concerned parties.

Below were the attendants of this meeting:

MoH-KRG	WHO	SOC
Senior staff from MoH representing health directorates in Sulymania, Erbil and Duhuk.	Senior staff from MoH representing health directorates in Sulymania, Erbil and Duhuk.	Field evaluation team

3.4 Evaluation Field Activities

The evaluation convention was implemented by 36 highly trained field evaluators supported by project manager and analysts experts; project coordinator; reporting specialist, logistics and administration to coordinate, support and leads the field evaluation team and liaison with the WHO in Amman. The supporting team was based in Baghdad, Erbil, and Amman.

The evaluators visited 33 PHCCs across all 19 governorates;[6] PHCCs were selected so as to cover both rural and urban areas. The evaluators interviewed over 250 community leaders, MoH, DoH, and PHCC personnel. They also interviewed more than 400 beneficiaries from the targeted communities[7].

This evaluation included all activities that were implemented across all 19 model PHC districts and was designed to assess the effect of project's outputs on both direct and indirect beneficiaries. All key components of the project design were examined as addressed in the Evaluation Purpose and Scope section. The evaluation included all major stakeholders and partners with specific attention given to gender balance, both in regards to the SOC team and stakeholders surveyed and interviewed. Attention was also given to the inclusion of ethnic and religious minorities as well as other vulnerable groups.

These activities were coordinated through meetings and interviews with members of the WHO focal points. The focal points worked closely with the WHO to monitor and follow the fieldwork as the SPHCS was implemented.

The focal points also supported and facilitated SOC evaluation through providing information about the SPHCS project implementation and arranging interviews with health officials. Below is a list of WHO focal points participated in supporting the evaluation activities:

Mr. Kawa Ma'ruf	Medical Officer	Duhuk
Mr. Feras Mustafa	Medical Officer	Mosul
Mr. Najm Addin Ahmad	Public Health Officer	Sulaymania
Mr. Nawroz Said	Medical Officer	Sulaymania
Mr. Mouayad Lutfi	National Professional Officer	Baghdad
Mr. Samson Samuel	National Professional Officer	Basra
Mr. Yassin Asaad	National Professional Officer	Erbil

3.5 Limitations

All assessments of the state and development of the SPHCS project and related assets, as they existed before the beginning of the SOC monitoring, was based on the study of documentation and interviews. The accuracy of this assessment is thus limited by the accuracy of these sources.

The SPHCS project began in 2004, nearly six years before the SOC evaluation took place. During this time, the MoH and other relevant bodies experienced high turnover rates. Many of the staff members that were interviewed were not involved in the entirety of the implementation of some activities. As a result of this some of the interviews reflected on only the outcomes of the activities, rather than the implementation process.

[6] See Annex C for a list of all PHCCs visited
[7] See Annex BV for a list of all interviews with MoH, DoH, WHO, PHCC and other medical personal and community leaders

3.6 SOC Background

Star Orbit's Consultants and Management Development is an external monitoring and evaluation organization; its strength lies in the long experience of the corporate management team and its employees. SOC's mission is to achieve professional M&E aiming to evaluate the past, monitor the present, and plan for the future.

Between 2004 and 2009, SOC successfully performed M&E activities on more than 200 programs and grants on behalf of donors and international organizations in various parts of Iraq including Baghdad, Basra, Missan, Thi Qar, Mothanna, Qadissiya, Najaf, Babel, Karbala, Anbar, Mosul, Salahaldin, Diyala, Kirkuk, Erbil, Sulaimanyia and Duhuk. The M&E activities have been carried out by more than 40 qualified, well-trained, and professional employees stationed in all the 18 governorates.

The SOC team is trained in UNEG Norms for Evaluation, UNEG Standards for Evaluation, and UNEG Ethical Guidelines. SOC's evaluation procedures are informed by these standards of quality work and ethical conduct. SOC is careful to include a wide range of demographics in their evaluation process. Special attention is given to gender balance, both in the composition of the SOC team and the inclusion of beneficiaries in the evaluation.

4. Evaluation Findings

4.1 Achievements and Results

In accordance with the terms of reference the analysis of the project's relevance should address the following questions:

- How did the project components contribute to the realization of underlying project objectives as perceived by the beneficiaries?
- Has the project been able to achieve the stipulated project results?
- How has the project contributed to the strengthening of the PHC model in the selected governorates?
- What has been the contribution of this project towards national priorities?

Evaluation Results by Activity:

Rehabilitation/Construction of Heath Facilities and Capacity Development of PHCCs:

These consisted of the rehabilitation, re-supply, and expansion of the staff of 129 PHCCs spread throughout the 19 model districts. The rehabilitation activities implemented under this project mostly consisted of repair or replacement of service systems (e.g. electric or sanitation systems), general repairs (painting, tiling, plastering, roofing, etc.), provision of generators, and the replacement of windows and doors. This rehabilitation and capacity building was 100% completed. These facilities were also provided with medical equipments, supplies, drugs, kits, furniture, and information equipments such as computers. The staffs of these facilities have also been expanded. These PHCCs comprise 7% of all PHCCS and serve roughly 19 million people.

SOC field visits to 33 PHCCs and interviews with PHCC staff and beneficiaries confirmed that this rehabilitation and re-supply had taken place. Rehabilitation was found to be of a quality and in line with the BOQ. According to the evaluation interviews, both staff and beneficiaries confirmed to have a significant increase in the quality of the care provided by these facilities, which was associated with an increase in PHCC use. The addition of new medical specialists, with dentists and maternity care specialists specifically noted and was mentioned as contributing directly to these improvements. However, in interviews the staff of many facilities indicated that MoH was not adequately replenishing their medical supplies or maintaining their facilities. SOC evaluators noted little damage to the rehabilitated facilities in some governorate, thus confirming this lack of maintenance.

Interviews indicated increased PHCC use in all districts, with some districts reporting 100-200% increases in use. Field visits and interviews indicated that this was largely due to the increase in the quality of medical care provided by the PHCCs and expansion of PHCC services resulting from the increase in PHCC staff.

PHC Project activities also provided for the construction and supply of 19 training halls, one of each district. According to SOC evaluation field visits, all 19 facilities were successfully constructed and supplied. Supplies provided to these facilities included 1,216 teaching resources (TVs, cassette recorders, digital cameras, etc.). These centres continue to be in operation and are expected to provide continued medical education for at least 5,000 health professionals.

Professional Training:

According to SOC evaluation; the goal of this activity was to create 2,000 trained healthcare professionals (physicians, nurses, health facility managers, administrators, laboratory technicians etc.) and trainers able to facilitate ongoing education of MoH and DoH personnel regarding medical, management, and technical issues. This training of trainers included MoH and Ministry of Higher Education personnel.

The evaluation results show that; this activity was 200% completed, providing training to 4,004 individuals. Trainings took place across Iraq and in 16 different countries including Jordan, Egypt, Syria, Lebanon, Oman, Bahrain, Tunis, Saudi Arabia, UAE, Morocco, UK, Italy, Sweden, Holland, Thailand and Switzerland. These included 605 fellowships and a wide range of topics covering more than 30 different issues. These training sessions included:

- Access to Quality Healthcare, access to quality control labs, strengthening PHC, essential medicines, nursing, health research system, health information system.
- Social Determinants of Health, food safety, health education, nutrition, promotion of healthy lifestyles including oral health, environmental health policies and risk analysis, and health research.
- Prevention and Control of NCD, prevention & control of cardiovascular diseases, diabetes, cancer, Thalasemia, and respiratory conditions, mental health and substance abuse.
- Prevention and Control of CD, HIV/STD, disease surveillance and control, Vector Control, Malaria, leshamnia and schimotasiss, polio eradication, Immunization & development of disease.
- Mother and Child Health, IMCI.
- Human Resource Development, human resources policy, planning & management, family medicine.

- Health Policy Planning and Sustainable Development, national health policy and planning, CBI, health research system.

Family Physician Model (FPM):

SOC evaluation teams confirmed that, FPM sought to improve the quality of health services through the introduction of a family medicine approach to care. This activity introduced FPM to three PHCCs, spread throughout Iraq, as a pilot project, which was intended to provide a model for the implementation of FPM on a national level. The selected PHCCs were as follows:

- North: Al Qudus PHCC in Al Aysar District-Mousel (Mosul), serving around 3,678 families
- South: Ez Al Deen Saleem PHCC-Basra, serving 4,927 families;
- Centre: Al Salam PHCC in Karkh District-Baghdad, serving 6,400 families8

This activity oversaw the rehabilitation of the PHCCs, training of PHCC staffing in the family practice, the training of trainers in the practice of family medicine, establishment of a database of health information for the catchment population, establishment of a record keeping system that is appropriate for FPM, and the enhancement of the quality of PHCC care and management through focusing on team work and the integration of psycho-social care.

SOC evaluators visited the three selected PHCCs. Interviews with the staff and beneficiaries of these facilities indicated the pilot project was successfully implemented and that the quality of the services within the facilities greatly increased as a result of the implementation of FPM. An increase in number of patients visiting the PHCC use was also noted. Additionally, the security situation inhibited the implementation of the activity through constraining movement. It also impeded the process of gathering health information, as many people were afraid to give their name to the surveyors.

Referral System:

This activity was a pilot project establishing a referral system designed to facilitate the transfer of patients from PHCCs to local hospitals and then refer them back to their initial contact depending of their need. This pilot project was implemented in the same three PHCCs that were selected for the FPM pilot. The activity also supported these PHCCs through procuring and delivering 19 four-wheel drive ambulances, 38 four-wheel drive pickup trucks, and 300 motorcycles. According to SOC evaluation teams' review of receipts indicated that these vehicles were delivered as planed.

SOC field visits to the PHCCs indicated that the referral system was functioning effectively in all three of the PHCCs. Interviews with staff indicated that the referral system increased cooperation between hospitals and PHCCs, thus increasing their efficiency and the quality of care provided to the local population. However, it was also noted that the system initially caused confusion among patients, though this was significantly reduced by community awareness sessions which provided information about the change. Also, the effectiveness of the referral system was limited by the security situation, which prevented patients from moving between PHCCs and hospitals.

Additionally, the evaluation results indicated that a draft policy for the creation of a national referral system was prepared by the MoH and reviewed by WHO. This policy has yet to be implemented.

[8] Information taken from the "D2-03 Final Narrative Report

Health Information System (HIS):

This activity provided a framework for organizing information, managing documents, and facilitating efficient coordination between users (physicians, PHCC management, mental health works, and other DoH and MoH personnel). SOC evaluation indicated that the project included the following three components.

- Information technology infrastructure that included procurement of 1.6 million USD worth of data network infrastructure and HIS equipment. This equipment was procured, delivered to the end user, and installed. Additionally, 19 engineers underwent oversees training to support this system.
- Software applications included database management software for health records, health statistics, surveillance and mapping. This software was installed and capacity building activities were conducted to train 21 statisticians on the use of the software applications.
- The Telecommunication and connectivity the network connectivity between MoH Baghdad and DoHs

SOC evaluators met with health officials in the MoH and DoHs related to this activity. These interviews indicated that that the system is not yet operational. These interviews also suggested a widespread application for the importance of the HIS, as well as a need for further training of staff in the use of the system.

Public Health Activities:

This activity provided technical and logistical support to prevent and control leishmaniasis, tuberculosis, and nasocomial infections. It also supported the developed of more effective MoH vaccine management, the implementation of the Expanded Program on Immunization (EPI), and surveillance systems to counteract public health threats. Training regarding these issues was also provided. Additionally, this activity supported the public health labs in Baghdad, Erbil and Mosul, the central blood bank, National Drug Quality Control Lab, and food safety. This was accomplished through training of staff, rehabilitation of buildings, and/or provision of equipment.

SOC evaluation interviews with MoH, DoH, and lab staff indicated that the project provided the expected support and that it was particularly effective in improving the distribution of vaccines, as well as the quality of maternal and child health. All of the laboratories indicated receiving the necessary support and supplies. All labs are currently operational. However, it was also indicated that lab facilities were in need of maintenance and were not receiving adequate replenishment of supplies. Additionally, evaluation interviews indicated that the areas affected by this activity experienced a decline in all of the diseases that it targeted. It is likely that the activity contributed to the decline.

Action Oriented School Health Curriculum (AOSHC):

SOC evaluation results indicated that; WHO supported the study proposal on the second assessment of the AOSHC, submitted by the MoH/Health Education Unit at the directorate of Public Health and Primary Healthcare. Through the efforts of 64 survey teams, the assessment evaluated the knowledge of families of students and teachers regarding health issues. It also examined school facilities in order to identify any health hazards.

SOC interviews with staff related to the activity indicated that despite the difficult security situation, the assessment was successfully implemented. One of the most important results of this assessment was the identification of a number of health hazards resulting from damaged and poorly maintained school buildings.

Health Sector Reform:

According to SOC evaluation, under this activity the MoH, with WHO support, developed several polices facilitating the shift to a PHC based healthcare system. The policies that this activity intended to enact and the degree to which this was success are as such:

- Establishment of national health accounts: Program was cancelled due to changing priorities in the MoH and the poor security situation.
- Development of financing options for Iraq's health sector: Policy was developed and amendments are under review.
- Development of a nursing and midwifery strategy for Iraq: This strategy was developed and implemented. This included training sessions and the distribution of instructional booklets regarding these subjects.

- Development of an IMCI plan of action: This policy was developed (see activity 13 IMCI for more details).

Iraq Family Health Survey (IFHS):

Consistent with SOC evaluation; this activity represented the first comprehensive family health survey ever conducted in Iraq and was successfully completed. The purpose of the survey was to provide researchers and decision makers with a relevant database of information regarding the health of the Iraqi population for use in the development of health policy. Some 9,345 households and 14,675 women of reproductive age were included from all governorates.

SOC assessment of the activity indicated that the IFHS was successfully conducted. The information has been compiled and published in a booklet that is available to MoH and MoHK personnel.

Basic Health Service Package (BHSP):

Under this activity the MoH, with WHO support, developed a national plan to provide a BHSP. SOC evaluation results indicated that, the BHSP was designed to facilitate maximum gains in health status on the national level for the money spent."

The elements of this package includes: 1) health education, 2) maternal and newborn health, 3) child health and immunization, 4) communicable disease treatment and control, 5) food safety, 6) environmental health, 7) school health, 8) non-communicable disease prevention and control, 9) emergency care, 10) nutrition, 11) essential medicine, 12) immunization, 13) diagnostic services, 14) mental health.

This BHSP represents a vision for the services which will form the foundation of healthcare provided by the MoH under a PHC model. The BHSP has not yet been put into operation; its implementation will be a part SPHCS Phase II.

Primary Healthcare Manuals:

This activity created a set of PHC training manuals for use by the MoH and DoH across Iraq. These manuals consisted of ten training modules and were reviewed by 26 MoH experts and WHO technical staff to ensure scientific correctness and cultural appropriateness. Subjects covered by the manuals were as follows: 1) Reproductive Health, 2) Child Health and EPI, 3) Communicable Diseases, 4)Non Communicable Diseases, 5) School Health, 6) Oral Health , 7) Mental Health 8) Environmental Health 9) PHC Management guide 10) Nutrition and food safety.

SOC evaluation teams met with several of the MoH experts who worked on this activity. Interviews with these experts indicated that the manuals had been developed and are now in the process of being finalized. Additionally, the activity included the training of trainers in the effective use of the manuals. These sessions were said to be effective, though interviews indicated that some subjects were not given enough time.

Integrated Management of Childhood Illness (IMCI):

The main goal of this activity was to reduce the mortality rate of children less than five years of age by combating the most significant killers of young children: acute respiratory tract infections, acute diarrheal diseases, and malnutrition. The project focused on increasing detection rates and actions-

taken by healthcare professionals. It was implemented in 27 PHCCs in Baghdad, Mosel, and Babel. This was accomplished through providing training and training manuals for health staff.

SOC evaluation teams visited participant PHCCs in benefited governorates and met with MoH staff and project beneficiaries. These interviews indicated that the project had succeeded in increasing PHCC capacity, the diagnosis and treatment of childhood illness which resulted in improved medical care for young children.

Community Based Initiative (CBI):

CBI was planned to be initiated in nine areas spread through out Iraq. CBI was successfully introduced in all target areas with the acceptation of Al Anbar. Within the areas that the CBI activity was fully implemented, it established a working relationship between the MoH, DoH, CSOs, and local community leaders. This relationship facilitated the identification of pressing local needs and developed projects that addressed them.

SOC evaluation visits to all of these PHCCs indicated that the activity resulted in projects which provided the local people with better access to healthcare, removed or mitigated the effects of health hazards, and improved the economic potential of needy community members. The noted changes in people's health related behaviour, increased PHCC use, as well as the elimination of health hazards (such as unsafe drinking water) indicate that the project was effective at improving the health of the people in its target areas. Interviews revealed that the people in these areas increased their participation in the healthcare system and in maintaining their personal health9.

[9] For information regarding the output of CBI activities in each area see Annex D

Emergency Response:

Health Action in Crises is one the WHO's global priorities. As a result of this, emergency response was included in the SPHCS project. This consisted of the provision of medical supplies to 57 hospitals in order to assist them in responding to the spike in violence that took place in 2005. The supplies consisted of IV fluids, blood bags, laboratory diagnostic kits, water control kits, medical disposables, and other life-saving items.

According to SOC evaluation results, these supplies were successfully distributed in accordance with demand and the limitations of the security situation. All evaluation interviews confirmed this.

Discussion of Results in Light of Evaluation Questions:

The above activities led to full implementation of three of the five expected project outcomes. These included:

- The rehabilitation of all targeted PHCCs such that all facilities are now operational
- The development of human resources for health capacity building through training in many different activities
- Ensuring community participation in decision-making and health service provision through CBI and community education

The other expected outcomes were partially achieved and plans have been made complete implementation in SPHCS Phase II. These included:

- The initiation of a pilot program establishing a FPM in three target districts
- The development of a BHSP to be delivered in SPHCS Phase II

Through these activities, the project accomplished in part or in whole all of the stipulated results, including:

Outcome# 1:

Some 19 sustainable and functioning PHC districts in all 18 governorates were established, a BHSP was developed, and a pilot referral system was implemented.

Outcome # 2:

Some, 4,004 MoH and PHCC personnel received training, thus surpassing the target of further increasing this number.2000 people by more than 100%. Other activities also included training sessions, thus further increasing the number.

Outcome # 3:

A pilot program introducing a family physician and nurse practitioner model was initiated in three districts.

Outcome # 4:

Community participation in health activities was facilitated through CBI and numerous community education campaigns.

- The project activities were consistent with the priorities identified in the National Development Strategy for Iraq ,2005- 2007 and is expected to make a significant contribution towards achievement of the Millennium Development Goals ,in particular:

Goal # 3: promote gender equality, by providing equal opportunities for access of women and men to primary healthcare services.

Goal # 4: Reduce child mortality, by implementing effective interventions to combat acute respiratory infections, diarrhoeal diseases and malnutrition, which are leading causes of infant and child mortality.

Goal # 5: Improve maternal health, by improving access to basic health services and expanding the family physician model.

4.2 Relevance

In accordance with the terms of reference, the analysis of the project's relevance should address the following questions:

- Has the project been responsive to the overall issue of primary healthcare in Iraq and how?
- Were the project strategies tailored to the current Iraqi context and in line with the national policies and strategic plans?

The activities of this project corresponded with the national priorities (as laid out in the "National Development Strategy 2005-2007") of community involvement and population empowerment. This was accomplished thought the integration of community education programs and the use of CBI. They also addressed the goal of moving towards a system of integrated healthcare with an emphasis on primary care through developing the resources and quality of care provided by PHCCs. The training sessions that took place under many of the activities related to the national priority of human resource development.

The project also addressed many of the major concerns outlined in the "United Nations/World Bank Joint Needs Assessment," which were confirmed by the MoH. All of the activities were oriented towards facilitating the recommended shift from a hospital-oriented system to a more decentralized PHC system. They also developed partnerships between the MoH and stakeholders at local, governorate, and national levels.

All activities were implemented with consideration given to providing healthcare to Iraqis of all religious, ethnic, and social backgrounds.

SPHCS drew on the insights from the "United Nations/World Bank Joint Needs Assessment," enabling its activities to address Iraq's most pressing medical and administrative needs. These needs were addressed in part through the repair of existing MoH facilities, including medical labs and PHCCs, as well as the construction of new facilities such as training halls. These activities provided the necessary infrastructure for the provision of important medical and administrative health services that were either lacking or in poor condition prior to the project. Furthermore, new supplies provided to these facilities enabled them to provide the services for which they were intended.

Previously identified healthcare issues were further addressed through training programs which were designed to improve the capacity of MoH and PHCC staff regarding medical, administrative, and technical issues. Training sessions covered the following topics:

- Access to Quality Healthcare: quality control, strengthening PHC, essential medicines, nursing, health research and information system use
- Social Determinants of Health: food safety, health education, nutrition, promotion of healthy life styles, environmental health policy and risk analysis
- Prevention and Control of NCD: sessions related to cardiovascular diseases, diabetes, cancer, thalassemia, respiratory conditions, mental health, and substance abuse
- Prevention and Control of CD: session on HIV/STDs, disease surveillance and control, vector control, malaria, lashmaniasis, polio eradication, and immunization and disease development
- Mother and Child Health

- Human Resource Development: human recourse development, policy, planning and management, family medicine
- Health Policy Planning and Sustainable Development: national health policy and planning, CBI, and health research systems
- Health Education: provided PHCC staff and schoolteachers with knowledge and teaching techniques regarding disease prevention and healthy living
- Diagnosis and treatment of common childhood illnesses under the IMCI activity
- Training of trainers

Additionally, a set of standardized training manuals was developed by the MoH to facilitate future training sessions. SOC evaluation indicated that; these manuals were reviewed by a panel of 26 experts to ensure their practical and cultural relevance.

A number of activities also focused on facilitating the transition from a hospital-centred system to PHC based healthcare, as recommended by the "Joint Needs Assessment", from an administrative perspective. These included a pilot project establishing a referral system in three PHCCs, a pilot project introducing FPM into the same three districts, and the installation of the HIS to support communication between DoH and MoH offices. All of these activities were identified by the MoH and PHCC staff as important components of improving the Iraq healthcare system..

Interviews with PHCC staff and patients in Mosul indicated that, while the referral system was helpful in theory, there were times when violence prevented movement between the PHCC and the hospital, thus making referrals impractical. Similarly, violence in Diyala forced the DoH to change offices, thus cutting them off from the HIS equipment that was installed in their original location; this indicated that a stable location of operation is need for a DoH to make use of the HIS.

Violence throughout Iraq facilitated similar problems for the implementation of all activities through limiting the movement of MoH and WHO personal and the ability of patients to access care.

Other aspects of the SPHCS project were designed to address immediate healthcare needs in Iraq. These included support to the MoH regarding the control and treatment of a number of diseases, which were determined to be significant health threats, through provision of supplies and the development of a more efficient vaccine distribution plan. Health education campaigns also served this purpose by providing the public with information about behaviours that prevent the spread of disease.

Additionally, badly needed supplies and medicines were provided to hospitals struggling to cope with the escalating violence that occurred during 2005. This activity was the result of a direct request made by the MoH to the WHO for assistance.

Also, the BHSP that was developed will provide a national plan for addressing the most significant of Iraq's healthcare needs.

Several activities were undertaken which were designed to provide the MoH and WHO with an improved understanding of Iraq's healthcare needs. These included:

- Conducting of the country's first IFHS, which gathered data on the health issues facing different regions across Iraq
- Development of a BHSP, which was based on a review of the health status of the Iraqi population and was designed to address major health problems while taking into consideration the capacity of the PHC system

- Assessment of health hazards in schools and the knowledge of teachers regarding health issues through the AOSHC activity

These activities are intended to guide future projects and policies, providing information leading to increased effectiveness and relevance.

Finally, CBI was used to both assess the needs of selected communities and develop programs to specifically address those needs. This resulted in actions that were relevant to the lives of the people within each locality, as confirmed by interviews with local beneficiaries in each area where the activity was fully implemented.

4.3 Effectiveness

In accordance with the terms of reference, the analysis of the project's efficiency and effectiveness should include the following:

- How project results contribute to improved PHC access and converge, i.e. improved immunization coverage, improved services utilization, improved ANC and safe deliveries.

Interviews with MoH, PHCC, and DoH personnel, as well as patients indicated significant increases in the accessibility and quality of healthcare available in PHCCs. All visited PHCCs also reported significant increases in the number of people using the centres, with some PHCCs reporting a 100-200% increase in use. Reasons cited for this include:

- Increased space in PHCC facilities
- Improved access to medical supplies and new medical equipment
- Improved care resulting from training provided to medical staff
- Provision of new services (e.g. maternity wards, obstetrics, dental care, electrocardiography, and radiology)

The effectiveness of rehabilitated/new facilities as well new supplies and equipment was limited in some areas by a lack of maintenance of facilities and equipment, as well as inadequate replacement of supplies. Also, some PHCCs reported that new medical technology went unused. This may be the result of a lack of training regarding this equipment.

An increase in the quality of healthcare was also noted as a result of administrative reform. According to the evaluation interviews, the pilot program introducing a referral system facilitating the transfer of patients between PHCCs and hospitals proved to be highly effective. The exception to this was the PHCC in Mosul, where patients were prevented from travelling between the PHCC and hospital as a result of the security situation. The pilot program introducing FPM also proved to be effective in its target areas. It had a particularly significant effect on the PHCCs' ability to provide services in radiology, vaccine distribution, ECG, maternity care, and paediatrics. However, the PHCC in Mosel indicated that their effectiveness was limited by a lack of equipment and staff.

According to interviews, effectiveness of both systems was initially impeded by a lack of understanding by the public regarding their correct use. In both cases, this was rectified by community outreach programs explaining the new developments.

According to interviews with healthcare professionals and beneficiaries, the Public Health Activities facilitated more effective and widespread vaccine distribution. These interviews also noted that number of people infected with malaria, tuberculosis, leshmaniasis, nosocomial infections, and measles decreased in areas where the Public Health Activities disease prevention programs took place, by this project and other similar projects. The rehabilitation of medical labs, which was overseen by this activity, was effective to the point that labs, which were destroyed or under-equipped, are now operational; however, some of these labs reported that they are undersupplied. It was indicated that this problem might have been caused in part do to poor documentation regarding the distribution of equipment and rehabilitation of buildings.

The IFHS was effectively conducted and the survey information made available to DoH and MoH policymakers. Similarly, the survey conducted by the MoH under AOSHC, successfully assessed the health risks facing Iraqi schools and provided that information to the MoE.

Interviews with medical personnel and beneficiaries of the IMCI activity indicated that the areas affected by this activity saw reduced occurrences of common childhood diseases. Improvements regarding the number of cases of measles & malaria, treatment of children with acute diarrhoea, and habits contributing to malnutrition were specifically noted, thus indicating that this activity had a role in reducing these diseases. Interviews also indicated that the activity improved vaccine distribution and increased the number of people using PHCCs. However, these interviews also suggested that better follow up by the DoH and MoH would have increased the effectiveness.

"CBI", also proved to be highly effective. Within the areas that the CBI activity was fully implemented, it established a working relationship between the MoH, DoH, CSOs, and local community leaders. This relationship facilitated the identification of pressing local needs and developed projects that addressed them.

This resulted in projects which provided the local people with better access to healthcare, removed or mitigated the effects of health hazards, and improved economic potential. The noted changes in people's health related behaviour, increased PHCC use, and the elimination of health hazards (such as unsafe drinking water) indicate that the project was effective at improving the health of the people in its target areas. Interviews revealed that the people in these areas increased their participation in the healthcare system and in maintaining their personal health. Some CBI projects also included education programs about vaccines and vaccine distribution programs, which increased access and acceptance of vaccines.

Health Sector Reform activities contributed to the initiation of the health sector reform that will be implemented by the MoH. Reform efforts included the formulation of policies that are expected to have a direct impact on successful transformation from tertiary to primary healthcare, especially in the areas of healthcare financing, human resource development, and strengthening district health systems. It also contributed to the review and update of public health legislation and regulations and the improvement of health governance, especially in the area of health information system (HIS). It is worth mentioning that as a result of WHO health sector reform initiative, MoH is now in the process of developing a plan to meet the Iraqi sector special needs and in line with the national health policies.

Additionally, the effectiveness of the trainers that were trained as a result of the SPHCS project was maximised through the development of standardized training manuals, and the construction and supply of 19 training centres. These centres were built in all 19 governorates at strategic locations so as to optimise their accessibility to healthcare staff throughout Iraq.

In addition to these successful activities, there were several components of SPHCS which have yet to be fully implemented. These are as follows:

- HIS: While equipment for the HIS has been distributed, the system has not been activated; thus, at this point its effectiveness is limited to the use of email communication between offices.
- BHSP: Assessment of the health issues facing the Iraqi population was conducted with the purpose of supporting the development of the BHSP so as to make it as effective as possible; however, it will not be implemented until the execution of SPHCS Phase II.

4.4 Partnerships

In accordance with the terms of reference the analysis of the project's partnerships should address the following questions:

- Who are the partners in this project? How were they selected? Has the project forged new partnerships/strengthened existing partnerships, and if so, how?
- What factors hindered or fostered effective partnership development?
- To what extent has the project contributed to capacity development of the involved partners?

The implementation of all activities was the result of the cooperation between the WHO, MoH, and DoH in each governorate. Cooperation among these parties enabled SPHCS to draw on the expertise and political influence of the participant organizations, which aided in the implementation of activities at the local, regional, and national levels. This cooperation has increased the capacity of the MoH and DoH in providing accessible and effective healthcare in the following ways:

- Improved PHCC and medical lab facilities (public health labs in Baghdad, Erbil, and Mosul, the Central Blood Bank, and the National Drug Quality Control Labs in Baghdad and Erbil)
- The distribution of medical supplies and new medical equipment
- Training sessions for MoH and DoH personnel
- Training of trainers to facilitate continuing capacity development for MoH and DoH personnel
- The construction and supply of 19 training centres across Iraq facilitate effective access to training opportunities for all MoH departments and DoH personnel
- Improved communication between MoH and DoH offices through the installation of the HIS
- The implementation of the FPM pilot program through DoH and MoH cooperation
- The establishment of a pilot referral system which provided a model for DoH replication in other areas and for a developing MoH national referral system
- The development of a BHSP

The roles of these additional partners included other UN agencies, other ministries, parliamentarians, civil society, and community leaders (for more information on the roles of these partners see annex E).

These additional partners were particularly prominent in the following activities:

- Rehabilitation/Construction of Health Facilities
- Capacity Development of PHCCs

These activities were implemented through the cooperation of the WHO, MoH, DoH in each governorate, and community leaders. The Ministry of Higher Education, MoE, MoEnv, Ministry of Municipalities, MoA, and Ministry of Planning also contributed to their success.

- Action Oriented School Health Curriculum (AOSHC)

The key partners in this project were the WHO, MoH, and MoE. Financial and technical support for the implementation of the project was provided by the WHO to the MoH, which surveyed schools with the help of the MoE. It was noted by the interviewed MoH staff that they had expected the MoE to be more cooperative in responding to identified health hazards in school facilities.

- Iraq Family Health Survey (IFHS)

The successful implementation of the IFHS was the result of cooperation between the WHO and the IFHS Steering Committee, which consisted of representatives from the MoPDC, MoH, MoHK, KRSO, and COSIT. Cooperation between these partners resulted in the development, distribution, and analysis of the survey, which drew on expertise from professionals within each organization.

- Integrated Management of Childhood Illness (IMCI)

WHO representatives, MoH, DoH in the target governorates, and PHCC directors and staff all contributed to the success of the distribution of vaccines and the spread of awareness regarding illness in young children. This partnership allowed for the development of IMCI on a national level by the MoH, its implementation at the local level through the DoH and PHCCs.

- Community Based Initiative (CBI)

CBI activities had successfully facilitated partnerships between the MoH, DoH, local communities and CSOs, as well as other ministries[10]. The capacity to work effectively within the target areas of all stakeholders that took leadership within this project was strengthened through providing a precedent of shared resources. Interviews indicated that individuals within all stakeholder groups had the desire to continue these partnerships. Some MoH representatives discussed replicating the model in other areas. As was demonstrated in Sulaimaniya, high turnover rates of personnel within key entities, such as the DoH and MoH, can prevent the development of these partnerships.

Political instability resulting in high turnover rates within the MoH was identified in interviews as the most significant obstacle to the building of effective partnerships. Cooperation between partners was also disrupted by the security situation, which prevented freedom of movement and interrupted communication.

4.5 Sustainability

In accordance with the terms of reference the analysis of the project's sustainability should address the following questions:

- What is the current status of the project components? Are functions and facilities still maintained?
- Who is responsible for the management and oversight of project facilities after closure of the project?
- What is the current status of the service provision in the selected facilities? Has the service provision been effected (negatively or positively) after the end of the project cycle and, if so, why?
- Has the project resulted in knowledge transfer from those who were trained in different competencies and, if so, how?
- How did the project address the issues of insecurity during the implementation phase? Was any risk mitigation undertaken? If so, how?

SOC evaluators found that all rehabilitated PHCC facilities and newly constructed training halls are operational. Additionally, infrastructure developed under other activities, such as the reestablishment of the public health labs in Baghdad and Erbil, the installation of equipment for the HIS, school repairs and new roads that were constructed as a result of CBI, also continue to provide services in their areas. Furthermore, projects implementing new programs, such as the pilot referrals system and FPM programs, and the IMCI, continue to operate within their target areas.

The MoH is responsible for the maintenance and re-supply of all facilities and programs that are directly related to the provision of healthcare. Interviews with PHCC and medical lab staff indicated that while some facilities have been consistently maintained, others have been hampered by a lack of supplies and/or poor maintenance of facilities or equipment. The increase in demand for PHCC medical services was cited as one reason for the lack of supplies; however, others cited negligence on the part of the MoH. It is possible that the high turnover rates of MoH officials are partially responsible for this.

[10] See annex D for stakeholders and partners for each target area

Responsible parties for maintenance of infrastructure not directly related to healthcare, such as new roads and bridges, school repairs, and agricultural programs established under the CBI activity, include the MoE, MoA, MoL, and city governments.

In addition to new/rehabilitated infrastructure, SPHCS training sessions established a new knowledge base regarding medical, technical, and administrative techniques, thus allowing MoH and DoH personnel to continue to provide the new services and manage the new programs established by the project after its completion. Additionally, some training sessions focused on the development of teaching techniques. This included the creation of training manuals covering key health and administrative issues. The manuals will serve as a lasting resource for training PHC staff. Additionally, training was provided to MoH staff regarding the use of the manuals as teaching tools. This created a lasting resource for the effective dissemination of the manuals' information. Activities educating the public about health issues, such as disease prevention, basic sanitation, and infant care also created a new knowledge base beyond healthcare providers. Future training was further assured by the establishment of 19 training halls which provide continued education for at least 5,000 professionals.

In addition to the expansion of healthcare infrastructure, SPHCS activities also facilitated the spread of information, which will continue to guide MoH and other ministries' decisions. These included:

- The conduction of the IFHS and publication of the gathered information
- Health inspections of schools

While these activities have provided useful information regarding the current situation in Iraq, they will need to be repeated at regular intervals in order to ensure that this information remains accurate.

Finally, the success of the pilot referral system and FPM will serve as the basis for national MoH policy. Interviews with MoH officials also indicate that Health Sector Reform activity is influencing the development of national polices and ministry-wide reforms, which, when enacted, will have lasting effects on the Iraqi healthcare system.

SPHCS did not include a detailed risk assessment or explicit risk mitigation strategies. However, training and networking which were focused on mid-level MoH staff was intended to minimize the impact of high turnover rates in the higher levels of the MoH. Furthermore, the project avoided the most insecure areas thus reducing the likelihood of the destruction of new infrastructure.

Lessons Learned and Good Practices

Good Practices:

- Interviews and site visits indicated that the restoration of PHCCs and medical labs addressed an important need of the Iraqi healthcare system, facilitating an increase in the capacity of the MoH and in PHCC use.

- Evaluation interviews with MoH and PHCC personnel indicated that the training sessions regarding administrative techniques, new medical practices, and the proper operation of medical and communications technology was highly beneficial. Most PHCC staff indicated

  that the training sessions significantly improved PHCC capacity to provide quality healthcare. This opinion was confirmed by interviews with patients, who expressed appreciation for the enhancement in the quality and new services offered by PHCCs.

- The training of trainers, development of training manuals, and construction of training centres was widely recognized, according to evaluation interviews, as an essential component for ongoing increasing in the capacity of the MoH. Through the establishment of this knowledge base and the necessary supporting infrastructure, the MoH will be able to continue to expand their own capacity to provide quality care.

- Both the CBI and Public Health Activities included public education campaigns regarding health issues such as basic hygiene, disease prevention, and infant care. Interviews with MoH and PHCC personnel in these areas indicated that these campaigns led to a noticeable change in the behaviour of people in the areas in which they took place. According to SOC evaluation teams; the distribution of pamphlets that were disseminated for this purpose also has contributed to the observed change in behaviour.

- CBI activities proved to be successful in facilitating communication between community leaders, MoH, DoH, and other ministries. Evaluation Site visits & interviews indicated that this cooperation resulted in the identification of the most urgent needs of each community in which CBI activities took place. It also facilitated the development of programs which addressed these needs in a variety of ways, including educational programs, infrastructure development, and changes in PHCC operations. In this way, CBI was able to address many of the issues that contribute to health problems which fall beyond the scope of the healthcare provided by the MoH, such as poverty and damaged sanitation systems,

- Interviews indicated that changes in the healthcare system, such as the establishment of the referral system and the introduction of FPM, created confusion among patients. Districts that included public outreach activities which distributed information regarding these changes were able to significantly reduce this confusion.

- Regarding IMCI activity, the evaluation indicated that it successfully increased MoH capacity to diagnose and treat the most common diseases that contribute to the mortality of children under 5 years of age. SOC interviews with staff associated with this activity indicated that this focus on disease prevention, as well as education and vaccination campaigns, proved to be highly effective in combating childhood diseases.

Lessons Learned:

- Despite the unstable security situation in Iraq during the project implementation period, and the remote nature of managing, implementing and monitoring the project activities inside Iraq from WHO – Iraq, based in Amman, Jordan. It is the opinion of SOC evaluation team that the project met its objectives and goals.

- The staff of Al Salam PHCC in the Karkh District of Baghdad indicated that they initially encountered difficulties in coordinating with the area's hospital to process the patient referrals that were facilitated by the pilot program initiated by Referral System activity.

  This issue was resolved by the establishment of an office within the PHCC and the hospital which was dedicated to the processing of referrals. This indicates that the establishment of offices specify for processing referrals can be significantly beneficial.

- A referral system is only effective in areas where the security situation allows patients to travel between health facilities. This was demonstrated by patients who were unable to access healthcare as a result of travel restrictions stemming from the security situation in Mosul.

- The use of the HIS requires a stable security situation which allows for connected offices to remain in the same location.

- Staff of many rehabilitated facilities indicated that they were not receiving proper maintenance or adequate replenishing of medical supplies. This indicates a need for a more effective system to ensure the smooth operation of health services.

- A lack of understanding among the local population regarding new systems, such as the referral system and FPM, limited their use in some areas, thus reiterating the importance of community education campaigns.

Conclusions & Recommendations

Evaluation Conclusions

Despite being disrupted and delayed by the violent security situation and high turnover rates within the MoH, SPHCS Phase 1 was successfully implemented in all of 19 target districts. Through the rehabilitation and re-supply of 129 PHCCs, as well as several national and regional health labs, SPHCS was able to establish 19 functional PHC districts, one in each governorate with two in Baghdad. With the construction of these new facilities, the project was able to increase the quality and accessibility of healthcare for more than 19 million Iraqis. In addition to this improvement of the Iraqi healthcare infrastructure, SPHCS facilitated the installation of HIS equipment and software, which, when fully connected, will facilitate improved communication between each governorate DoH and the MoH.

The expansion of the MoH capacity through the restoration and re-supply of MoH facilities was reinforced and expanded through the training of MoH and DoH staff. Training sessions covered a wide range of medical, administrative and technical topics and took place across Iraq and in more than 16 countries. Some 4,004 people received training as a result of the project, thus surpassing the goal 2,000 trained professionals by more than 200%. These training sessions were widely viewed as one of the most important aspects of the SPHCS project, with MoH and DoH staff consistently requesting further opportunities for training. These requests were provide for in part through the training of trainers, the development of standardised training manuals, and the construction of 19 training centres. These centres were fully equipped with 1,216 training resources and strategically placed across Iraq so as to maximise their accessibility to MoH staff. These centres will provide -

approximately 5,000 MoH and DoH personnel with access to specialized education, thus enabling the MoH to continue to expand the capacity of their staff.

SOC evaluation confirmed that, under SPHCS, the WHO provided technical and logistical support to the MoH in order to control malaria, leishmaniasis, tuberculosis, and nasocomial infections. It also supported the development of more effective MoH vaccine management, the implementation of the Expanded Program on Immunization (EPI), and improving the surveillance systems to counteract public health threats. The evaluation results regarding these diseases in these areas indicated a decline in the number of reported instances, a phenomenon which may have been contributed to by SPHCS activities.

The capacity of the MoH and the transition from a centralised to a PHC based healthcare system was further facilitated through implementation of administrative reforms. These included:

- The implementation of pilot programs introducing a PHC model of operation and a referral system facilitating the transfer of patients between hospitals and PHCC in three PHCCs.
- The development of IMCI, which resulted in the training of PHCC staff in the effective diagnosis and treatment of the diseases that contribute most to the morality of Iraqi children under five years of age.
- The development of a national nursing and midwifery strategy.

In addition to these changes, the project facilitated the development of multiple policies, which, while not yet in effect, will significantly move the MoH towards nationally operating using a PHC model. These included the development of a BHSP (to be implemented under SPHCS Phase II), which will provide a vision for services provided on a national level under a PHC model.

It also includes a policy, which is under review, to establish a nationwide referral system modelled on the success of the pilot program. A policy regarding financing options for Iraq's health sector was also developed and is under review.

Finally, it's the opinion of SOC evaluation team that the project included activities which provided the MoH and other Iraqi ministries with new information regarding health issues faced by the Iraqi people. This included the first Iraq Family Health Survey, which gathered information on the health of 9,345 families and 14,675 women of reproductive age. It also included AOSHC activity, which assessed the knowledge of teachers regarding health issues and examined Iraqi schools for health hazards. Information from both surveys was made available to the relevant ministries.

The effects of these activities were assessed to be overwhelmingly positive. MoH and DoH staff reported widespread increases in PHCC use and patients indicated that they experienced a significant increase in the quality of the care provided by these facilities. However, in order for the rehabilitated and newly constructed facilities to continue to provide quality care, it is essential that they be properly maintained and re-supplied. Site visits and interviews with staff at many PHCCs and medical labs indicated that in many cases the MoH was not providing adequate maintenance or supplies to these facilities. Additionally, the effectiveness of the referral system was discovered to be limited to areas where the security situation allows for travel between health facilities.

Community participation in decision-making was facilitated through the successful implementation of CBI activities in eight districts. These activities successfully facilitated cooperation between officials from the MoH, DoH, other ministries, as well as local leaders, religious leaders, and NGOs in identifying and addressing the major problems facing their communities.

This resulted in a wide range of projects which addressed issues that were related directly and indirectly to community health. They also contributed to increased PHCC use.

SOC evaluation team indicated that the national ownership of the SPHCS project was further facilitated through the relationship between the WHO and the MoH. Throughout the project, the implementation of activities was taken on by the MoH and other relevant ministries. The WHO served a supporting role, providing financial and technical assistance while the MoH was responsible for the implementation of activities and their maintenance after completion.

Recommendations for WHO

- **Provide the MoH with more technical support regarding the rehabilitation and supply of PHCC facilities.**

Evaluation field visits & interviews indicated that rehabilitation of medical labs and PHCCs significantly improved the quality of medical care in their areas. However, these included only 7% of the nation's PHCCs, leaving many other facilities that could similarly benefit from this sort of assistance.

- **Provide follow up training session and implement new sessions on Primary Health Care topics.**

The training sessions proved to be one of the most effective components of the SPHCS project. Many of the participants in these sessions indicated that further training would be greatly beneficial to themselves and their colleagues.

- **Support the MoH in extending the implementation of FPM and the referral system.**

Both the FPM and referral system pilot programs were highly effective at increasing the quality of healthcare services in the target PHCCs and the efficiency of those facilities. This success could be replicated in other districts.

- **Support the MoH in providing capacity building for new staff related to FPM and referral systems.**

The expansion of the FPM and the referral system to other areas will require that the staff in these areas be trained in operating within these new systems.

- **Follow up with the MoH to ensure the activation of the HIS and overcome technical difficulties.**

While the necessary equipments for the HIS has been installed, the system is not yet operational. Support may be required to facilitate the operation of this system.

- **Support further CBI activities.**

The CBI activities implemented under SPHCS proved to be highly effective at facilitating community participation in the healthcare system, as well as cooperation between different ministries, community leaders, and NGOs. It not only resulted in improved PHCC use, but also facilitated a number of projects that addressed issues which contribute to health problems but lie outside the scope of the healthcare system (e.g. poverty, damaged septic systems, and damaged school facilities). Thus, this activity should be repeated in other regions.

- **Support the MoH in establishing a system for conducing IFHSs at regular intervals.**

In order to remain relevant the information collected by the IFHS must be periodically updated. This will require policy designating a schedule for future IFHS as well as resources for the survey.

Recommendations for the MoH

- **Continue maintenance and re-supply of PHCC and laboratory buildings and equipment.**

Evaluation Site visits and interviews with the staff of many facilities indicated they were not receiving adequate supplies or maintenance. Without this support the rehabilitated facilities will not be able to maintain the same level of quality care.

- **Provide more support for the rehabilitation and supply of PHCCS so as to facilitate the transition from a hospital-based to a PHC based system. Also provide staff with the necessary training to enable them to use and newly distributed equipment.**

The transition from a centralised healthcare system to one based on a PHC model will require that PHCCs are able to provide quality healthcare. This will require additional support to PHCCs that are not yet able to provide this due to damaged infrastructure and/or a lack of supplies. Staff who are unfamiliar with new equipment will require instruction in its use.

- **Facilitate more training sessions for health staff to facilitate better knowledge and capacity building. When selecting participants take care to ensure gender balance.**

The training sessions that took place during SPHCS Phase I proved to one of the most effective components of SPHCS project. Many of the participants in these session indicated that further training would be greatly beneficial to themselves and colleagues.

- **The FPM and referral system activities should be expanded to other governorates.**

Both the FPM and referral system pilot programs were highly effective at increasing the quality of healthcare in the target PHCCs and the efficiency of those facilities. This success could be replicated in other districts.

- **Work to build a closer relationship with the MoE so as to increase the impact of the AOSHC.**

SOC evaluation of the AOSHC activity indicated that while it was successful in assessing schools from a health perspective, a lack of cooperation from the MoE prevented this information from facilitating healthier schools. An awareness campaign regarding the importance of addressing these issues, and/or the development of closer ties with the MoE could help address this issue.

- **Solve the problem that has prevented the operation of the HIS.**

When operational, the HIS will be able to facilitate more effective information sharing between the DoHs and the MoH, thus improving the ability of these entities to mange the healthcare system.

- **Expand CBI activities to other areas.**

CBI activities implemented under SPHCS proved to be highly effective at facilitating community participation in the healthcare systems, as well as cooperation between different ministries, community leaders, and NGOs. It not only resulted in improved PHCC use, but also facilitated a number of projects that addressed problems which contribute to health problems but lie outside the scope of the healthcare system (e.g. poverty, damaged septic systems, damage and school facilities). Thus, this activity should be repeated in other regions.

- **Establish a system for conducing IFHSs at regular intervals.**

In order to remain relevant the information collected by the IFHS must be periodically updated. This will require policy designating a schedule for future IFHS as well as resources for the survey.

Recommendation for Donors

- **Maintain the support to WHO in carrying capacity building on new Primary Healthcare topics.**

The activities implemented by SPHCS Phase I proved to be highly effective at improving the quality of healthcare in the target areas and in improving PHCC uses. They also contributed significantly to the capacity of the MoH to provide healthcare and develop more effective care in the future. Many of these activities have the potential to be replicated in other areas, which will require continued support.

Annex A: Terms of References

Evaluation Terms of Reference
"Strengthening Primary Healthcare System in Iraq-Phase I"

1. Introduction and Context

WHO has been working in Iraq since 1960, leading the UN Health and Nutrition Sector Outcome Team since 2004. WHO is addressing the eight Primary Healthcare components (that was agreed during Al Mata declaration in 1978) which are: 1) Prevention and control of communicable and non communicable diseases; 2) Promotion of food supply and proper nutrition 3) Education concerning the prevailing health problems and methods of preventing and control 4) Maternal and Child Health including family Planning 5) Immunization against the major vaccine preventable diseases 6) Adequate supply of safe water and basic sanitation 7) appropriate treatment of common diseases and injuries and 8) Provision of essential drugs. WHO has been implementing projects countrywide, covering the whole population and area specific in accordance to the needs that were identified by the Government of Iraq.

The years of conflict and sanctions that were imposed on Iraq for 13 years have exerted a negative effect on access, provision and quality of essential services and the country has witnessed deterioration in healthcare system. Health indicators, particularly in South and Center of Iraq, for instance, dropped to levels comparable to those observed in least developing countries. The Joint Needs Assessment (2003) reported significant damage to health infrastructure, malfunctioning or antiquated equipment, shortage of drugs and a lack of trained medical professionals. The Ministry of Health was assessed to be in need for substantial technical, policy and capacity development support to rebuild the system. These challenges were aggravated with continuous population growth and demographic change, the effects of prolonged violence and the overall deterioration of public infrastructure, such as water and sanitation.

The project being evaluated was a response to identified priorities and the recommendations of the UN/WB-Iraq Joint Needs Assessment and along with the global movement to shift into Primary Healthcare which was adopted by the Iraqi MoH. The 'Strengthening Primary Healthcare System Phase I' project (SPHCS) was aimed to facilitate the transition of the Iraqi healthcare delivery system from curative and hospital bases, into a decentralized Primary Healthcare (PHC) based system, with a focus on community outreach and community involvement.

With that context, this project aimed at achieving the following objectives: 1) Building the capacity of MOH at central, governorate and district levels for the planning, implementation and monitoring of a decentralized PHC system at district level, hospitals and referral system and PHC model training centers 2) Supporting the MOH to develop a sustainable PHC system in the country 3) Upgrading the healthcare delivery system in 19-model district linked to Emergency Obstetric Care - EOC (proposal submitted by UNFPA earlier) and 4) Delivering a basic health package from the model PHC districts. Moreover, WHO and the MoH agreed to focus on decentralized Primary Healthcare System in 19 districts throughout the country (one per governorate and two in Baghdad) for improved healthcare delivery system through upgraded health facilities in terms of physical structure, needed equipments and supplies, capacity development of the health workers, and introducing new health concepts with a focus on community participation.

The SPHCS project was implemented during the period of July 2004-July 2008 at a national level, in a total of 19 districts. It was funded from UNDG-ITF with a total budget of USD 37, 363,515 million. The targeted districts include: Tilkeif, Dakok, Beiji, Khalis, Heet, Mahmoudia, Madaen, Swera, Amarah, Zubair, Suk Al Shyouk, Alurmaitha, Diwania, Manathera, Hindia, Al Musaiab, Akra, Shaklawa, Shamshama.

The project was implemented through the MoH, in collaboration with the following ministries: Higher Education, Education, Agriculture, Environment, Municipalities, Planning, Finance, Human Rights, in addition to the Parliamentarians, Civil Society and Private Contracts. Other UN sister agencies have also complimented WHO work such as UNICEF and UNFPA, as well as the World Bank and USAID. Finally, some activities were implemented along with the NGOs such as MERLINE.

Moreover, collaboration, coordination and information sharing with other UN agencies working with the Health and Nutrition Sector such as UNOPS, WFP, UNIDO, UNDP and others in addition to intra-sector collaboration and coordination were always ensured through the UN Health and Nutrition Sector Outcome Team forum and other UN Sector Outcome Teams in addition to the Peer Review Coordination forum.

It is worth mentioning that SPHCS project implementation witnessed a complex and volatile security situation. The 2005-2007 time period was referred to as most insecure period with very high incidences of violence. The fragile situation resulted in massive turnover in the government in general and in particular the MOH staff at all levels, this situation was complicated with attacks against health professionals and the migration of skilled health professionals. The absence of an appointed Minister of Health for some period, friction among the different departments within the ministry, lack of MoH operational running cost, security situation on the ground not allowing for freedom movement has also affected the implementation of this project.

Finally, building on the achievements of SPHCS phase I and in order to continue WHO support to the MoH, SPHCS phase II was developed and designed to contribute to upstream national policy level and at downstream health service delivery level.

2. Purpose of the Evaluation

This evaluation will complement the earlier independent review of selected UNDG ITF project evaluations conducted by the Scanteamand published in January 2009[11].The Scanteamreview also included this particular project[12].

This independent evaluation comes at the end of the implementation cycle of Phase I of the Strengthening PHC System project and aims to assess the overall contribution of the project towards strengthening primary healthcare system in Iraq while distilling lessons and good practices to feed into a second phase of the project (SPHCS Phase II) which is already underway. The evaluation will provide recommendations to enhance operational and programmatic effectiveness of similar initiatives in comparable situations. In addition, the evaluation will assess how WHO has contributed towards a strengthened partnership with MOH in addressing critical issue of healthcare system for the people of Iraq.

The evaluation findings will be disseminated to all stakeholders and at different levels including decision makers both within the Government of Iraq and the MOH to support future policy development especially in the area of Health Sector Reform Process –the process is ongoing and aims at facilitating *the transition of the Iraq health delivery system from curative and hospital based into a decentralized Primary Healthcare System (PHC), with a focus on community outreach and community involvement.*

The evaluation findings will serve as an advocacy tool to demonstrate the impact and feasibility of PHC approach which is currently adopted by GOI as cornerstone for the healthcare system in Iraq. The project will also provide donors within a comprehensive assessment of the impact and utilization of their investment in these programmatic areas

WHO is considering the evaluation of this project as a first step in the process of evaluating independently other WHO projects, some of which were funded by UNDG-ITF and implemented during the period of 2004 until present. Such evaluation will support WHO own capacity for programming, project management and accountability towards donors, GOI and the target population. The lessons from the evaluation and the evaluative evidence will also feed into the upcoming UNDG ITF lessons learned process as well as the proposed UNDG ITF project evaluations.

[11] 'Stocktaking Review of the International Reconstruction Fund Facility for Iraq' (IRRFI), 2009

[12] The Scanteam review concludes that the project is on track to meet its objectives, and has made a contribution to strengthening the Iraqi healthcare system; the outcome of the project is undermined by implementation delays resulting from management challenges between the MoH and WHO and the security situation in the country. Overall the review appreciated the project in terms of efficiency, effectiveness, relevance and national ownership

Last but not least, the evaluation will also contribute to the next WHO Country Cooperation Strategy (2010-14) for Iraq.

3. Evaluation Objectives

The evaluation will address the OECD-DAC evaluation criteria including relevance, effectiveness, efficiency, impact and sustainability. In addition, the evaluation will also look at the contribution of the project towards partnership building within UN, GoI and civil society. Specifically, the evaluation will be guided by the following key objectives:

1. To assess and showcase the achieved progress and results against stipulated project objectives and outputs for a strengthened primary healthcare model in Iraq;
2. To assess the efficiency and effectiveness of the 19 model PHC districts;
3. To assess the relevance of project components in strengthening the primary healthcare delivery in Iraq vis-à-vis needs in the catchment areas of the 19 PHC model districts;
4. To understand the extent to which this project has contributed to forging partnership with MOH at different levels, the Government of Iraq, Civil Society and UN/donors;
5. To appreciate the management arrangements in place by the GoI and/ or the beneficiary communities towards the sustainability of various project-initiated services and benefits;
6. To generate lessons on good practices based on assessment from the aforementioned evaluation objectives and to provide recommendations to GoI and WHO on how to maximize the impact from similar initiatives in comparable situations

4. Scope of the evaluation

This evaluation builds on the independent review of SPHCS Phase I project undertaken by the ScanTeam with a focus on the Southern region. The rational for focusing on the South was due to the fact that other parts of the country were affected by military activity and humanitarian crises. However, this current evaluation will include activities implemented across all 19 model PHC districts, focusing on both direct and indirect project beneficiaries and implementing partners including MoH officials at central, governorate and district levels, community representatives, contractors and WHO staff. A detailed list of project stakeholders is provided in Annex 1.

Technically, the evaluation will cover all key components as per project design including:

- Rehabilitation/construction of health facilities
- Capacity development of MOH officials
- Family physician model
- Referral system
- Health Information System
- Public Health activities
- Emergency response
- School health (or Health Education)
- Health Sector Reform
- Iraq Family Health Survey
- Basic Health Service Package
- Primary Healthcare Manuals
- Integrated Management of Childhood Illness
- Community Involvement and decision making process under Community Based Initiative Approach.

5. Key Evaluation Questions

Achievements and results

- How the project components have contributed to the realization of underlying project objectives, as perceived by the beneficiaries?

- Has the project been able to achieve the stipulated project results?
- How the project contributed to strengthening the PHC model in the selected governorates?
- What has been the contribution of this project towards national priorities?

Efficiency and effectiveness

- The extent to which the project activities were implemented in a cost-effective way vis-à-vis the Iraqi context
- How project results contribute to improved PHC access and coverage i.e. improved immunization coverage, improved services utilization, improved ANC and safe deliveries.

Relevance

- Has the project been responsive to the overall issue of primary healthcare in Iraq and how?
- Were the project strategies tailored to the current Iraqi context and in line with the national policies and strategic plans?

Partnerships

- Who are the partners in this project? How they are selected? Has the project forged new partnerships/ strengthened existing partnerships and how?
- What factors hindered or fostered effective partnership development?
- To what extent has the project contributed to capacity development of the involved partners?

Sustainability

- What is current status of the project components? Are functions and facilities still maintained? Who is responsible for the management and oversight of project facilities after its closure?
- What is current status of services provision in the selected facilities? Has the service provision been affected (negatively or positively) after the end of the project cycle and why?
- Has the project resulted in knowledge transfer from those who were trained and capacitated in different competencies and how?
- How the project did address the issues of insecurity during the implementation phase? Were there any risk mitigation undertaken? If yes, how?

Lessons learned and good practices

- What are the good practices that have resulted from this project? How and why some these practices can be labeled as a 'good practice'? Substantiate with evidence.
- What are the key lessons learned from the project implementation? What recommendations could be replicated in similar projects implemented in comparable situations?
- Is the project replicable in other governorates? Are there any specific recommendations to be considered when designing similar projects in the future?

6. Evaluation Methodology

A detailed evaluation methodology, approach and programme of work will be agreed upon between WHO and the evaluation team before the start of the evaluation. The evaluation team will meet in Amman for orientation, briefing and initial interviews with WHO staff in Amman followed by similar discussions/ briefings by WHO staff based in Baghdad. An inception report will be prepared by the Team Leader outlining the evaluation framework, key challenges if any and implementation arrangements including a detailed work plan.

Desk review

The evaluation team will review the project document, progress reports, external reviews and evaluations with focus on UNDG ITF and other documentary materials generated during project implementation to extract information, identify key trends and issues, develop key questions and criteria for analysis, and compile relevant data during the preparatory phase of the evaluation. The team will also review relevant national strategies to see the links between the project objectives and national priorities.

Data collection and analysis
In consultation with WHO, the evaluation team will identify all stakeholders to be included in the evaluation exercise. Once stakeholders are identified, the evaluation team will devise participatory approaches for collecting first hand information. These will include interviews, focus group discussions, observations, end-user feedback survey through questionnaires, etc.

Field visits to target districts
Field visits will be conducted to all 19 districts and meetings will be held with all partner institutions including primary health centers. To the extent possible, beneficiary populations in all districts will be engaged in the evaluation process to get their feedback and reflection on project benefits.

- Field visits for MoH – central level staff, where focus group discussion will be held;
- Field visits to the DoHs, where questionnaire, focus group discussion, interviews and site observations will be used to gather the needed information.;
- Field visits to the district levels/ at the facility level where questionnaire, focus group discussion, interviews and site observations will be used to gather the needed information;
- Focus group discussions will be held with the community leaders and Sheikhs and the beneficiaries from the upgraded services;
- Questionnaires will be used for beneficiaries from the different capacity building activities.

7. Expected Deliverables

The expected outputs from the evaluation exercise are:

- Output and possible outcomes Evaluation Report agreeable to the UN Evaluation Groups (UNEG) standards and requirements is produced;
- Presentation of the final report to WHO team.

The evaluation report will contain but not limited to:

- A detailed assessment of project achievements – what went well and why? What went wrong and why?
- Relevance of the project design in addressing underlying problems
- Sustainability of the project
- Assessment of project's effectiveness in addressing the key problems associated with quality primary healthcare service delivery
- Efficiency of the project components/ approaches in delivering quality healthcare services (resource usage)
- Overview of partnerships developed and coordination mechanisms in support of project implementation
- Lessons learned
- Recommendations on future projects development and implementation:
    - Defining good management/ implementation practices, opportunities and challenges.
    - Other appropriate recommendations on implementation arrangements.

It should include a description of:

- how gender issues were implemented as a cross-cutting theme in programming, and if the project gave sufficient attention to promote gender equality and gender-sensitivity;
- whether the project paid attention to effects on marginalized, vulnerable and hard-to-reach groups;
- whether the project was informed by human rights treaties and instruments;
- to what extent the project identified the relevant human rights claims and obligations;
- how gaps were identified in the capacity of rights-holders to claim their rights, and of duty-bearers to fulfill their obligations, including an analysis of gender and marginalized and

- vulnerable groups, and how the design and implementation of the project addressed these gaps;
- how the project monitored and viewed results within this rights framework.

The evaluation report outline should be structured along the following lines:

- Executive summary
- Introduction
- Description of evaluation methodology with challenges
- An analysis of situation in line with evaluation objectives and key evaluation questions
- Findings and Conclusions
- Recommendations
- Lessons learned
- Annexes

The evaluation report should not exceed 30 pages in total (excluding annexes). First draft of the report should be submitted to WHO-Iraq Office within 2 weeks of completion of in-country evaluation process.

8. Management Arrangements

The Evaluation will be undertaken by independent evaluator/s (individual consultant/s or organization) that is in line with the UNEG Norms and Standards and in accordance with the parameters included in the terms of reference.

The evaluation will be undertaken in close consultation with MOH and efforts will be made to allow the GoI partner/s to drive the evaluation process in line with UNEG Norms and Standards.

Role of WHO:

- Provide project background information and any other relevant data required by the evaluation team
- Ensure that all stakeholders are informed about the evaluation process
- Oversee the process in accordance with the agreed terms of reference and the UNEG Norms and Standards, and ensure that the process remains neutral, impartial and independent
- Approve the evaluation final report and disseminate evaluation findings
- Facilitate the field work for the evaluation team and contact with the MoH/DoH and other relevant partners and stakeholder
- Provide management response to evaluation findings and recommendations

Role of National Counterparts

In line with Paris Declaration, the national counterparts will be encouraged to participate in the evaluation process right from planning to sourcing information to the dissemination of evaluation findings and contribution to management response. This would enhance national ownership of the process and promote the spirit of mutual accountability.

Role of Evaluation Team/ Evaluator/s

The Evaluation Team is responsible for:

- Undertaking the evaluation in consultation with WHO and in full accordance with the terms of reference;
- Complying with UNEG Norms and Standards as well as UNEG Ethical Guidelines;
- Bringing any critical issues to the attention of the Evaluation Manager (appointed by WHO) that could possible jeopardize the independence of the evaluation process or impede the evaluation process;
- Adhering to the work plan, to be mutually agreed with WHO, as commissioner for this evaluation; and

- Ensuring that the deliverables are delivered on time, following highest professional standards.

The evaluation team will report to the Evaluation Task Manager while providing regular progress updates on the overall process to WHO Senior Management and the Evaluation Steering Committee.

MoH-WHO Task Force:

WHO-MoH team will be formed to provide oversight and overall guidance to the evaluation process. The team will comprise of a coordinator nominated by the MoH to coordinate this process within the ministry at central, governorate and district levels as well as a focal point from WHO.

The team will oversee that the evaluation process is in line with the ToRs, UNEG Norms and Standards and implemented in a participatory, neutral and impartial manner.

9. Indicative Work Plan

Phase	Key Activities	Time Frame*	Responsibility
Preparatory phase	Agreement on methodology and detail work plan		Evaluation Team
	Participate at the initial stakeholder meeting to launch the evaluation process		WHO (Lead) Evaluation Team
Field work/ Data Collection	Review of documents, reports, supporting materials		Evaluation Team
	Meetings with MoH, Baghdad		
	Finalize questionnaires for primary data collections		
	Meetings with district health officials		
	Visit project facilities		
	Meeting with secondary beneficiaries (community leaders, sheikhs and project beneficiaries)		
Data Analysis	Undertake data analysis of the qualitative and quantitative data acquired from the field work and data collection processes		Evaluation Team
Reporting preparation	Preparation of the draft evaluation report		Evaluation Team
	Presentation on draft findings/ report to WHO and Ministry of Health		
	Finalization of the Report based on feedback from peers, MOH and WHO		
	Submission of Evaluation report to WHO		
Dissemination			WHO

Annex B: Source of Information

Annex B I: Key Official WHO documents

Project Documents

- *UNDG-ITF D2-03-SPHC project document*
- *UNDG-ITF- D2-25 Project document for SPHCS-Phase II*

Project Progress Reports

- *UNDG-ITF final six monthly progress report (July 2004-July 2008)*
- *UNDG-ITF eighth progress report (January-July 2008)*
- *UNDG-ITF seventh six monthly progress report (July-December 2007)*
- *UNDG-ITF fifth six monthly progress report (January-June 2007)*
- *UNDG-ITF forth six monthly progress report (January- June 2006)*
- *UNDG-ITF third six monthly progress report (July-December 2005)*
- *UNDG-ITF second six monthly progress report (Jan-June 2005)*
- *UNDG-ITF first six monthly progress report (July-December 2004)*

External Review Reports

- *Interim report of the external auditor to the sixtieth WHO Health Assembly: Audit of the WHO for financial report 2006-2007.*
- *'Stocktaking Review of the International Reconstruction Fund Facility for Iraq' (IRRFI) - January 2009.*

Strategic Programme Documents

- *UN Assistance Strategy 2008-10*
- *WHO Country Cooperation Strategy*

Normative Guidance

- *UNEG Norms for Evaluation*
- *UNEG Standards for Evaluation*
- *UNEG Ethical Guidelines*
- UNDG RBM Harmonized Terminology

Annex B II: Key MoH and DoH Documents

Baghdad:

Letter Number	Letter Date	Department
18322	12 Nov.2007	MoH
7907	9 May 2007	MoH
4469	18 Jun. 2009	MoH
8356	16 May 2007	MoH
5099	30 Dec. 2007	DoH - Rusafa
18322	12 Nov.2007	MoH
5405	17 Feb.2008	DoH - Rusafa
502	13 Feb.2008	DoH - Rusafa
5554	6 Feb.2008	MoH

4021	3 Feb.2008	DoH - Rusafa
152	19Jan.2010	DoH - Karkh
182		DoH - Karkh
7416	22 Feb.2006	MoH
7415	22 Feb.2006	MoH
12832	19 Mar.2006	MoH
57976	13 Oct.2009	DoH - Karkh
3551	26 Jan.2006	MoH
4624	3 Apr.2008	MoH
4487	4 Feb.2007	MoH
8536	23 Mar. 2005	MoH
53111	14 Sep.2009	MoH
7431	28 Oct. 2007	DoH - Karkh
1115	26 Sep.2007	DoH - Karkh
29114	19 Sep. 2007	DoH - Karkh
23	25 Jan.2007	DoH – Al Kadhmiya district
20076	8 Jul.2007	DoH – Al Mahmodya district
20077	8 Jul.2007	DoH - Al Mahmodya district
20078	8 Jul.2007	DoH - Al Mahmodya district
20079	8 Jul.2007	DoH - Al Mahmodya district
29698	30 Sep.2007	DoH – Al Salam PHCC
1131	19 Sep.2007	DoH - Al Salam PHCC
1231	4 Oct.2008	DoH- Karkh
1986	6 Oct.2008	DoH – Al Salam PHCC
6753	23 Sep.2008	DoH – Al Kadhmiya district
15867	6 Oct.2008	DoH – Al Kadhmiya district
7239	28 Sep. 2008	Al Yarmok Hospital
1983	6 Oct.2008	DoH – Al Salam PHCC
69159	21 Sep.2008	DoH – Al Kadhmiya district
6753	23 Sep.2008	DoH – Al Kadhmiya district
81513	12 Nov.2008	DoH- Karkh
20226	5 Oct.2008	Local Council -Al Kadhmiya
81513	12 Nov. 2008	DoH- Karkh
8194	19 Nov. 2008	DoH – Al Kadhmiya district
6594	18 Nov. 2008	DoH- Karkh
81513	12 Nov. 2008	DoH – Al Kadhmiya district
1650	24 Dec.2008	DoH – Al Salam PHCC
20265	4 May 2008	MoH
6618	19 May 2008	DoH- Karkh
1156	23 Sep.2007	DoH – Al Salam PHCC
1167	24 Sep.2007	DoH – Al Salam PHCC
1173	24 Sep.2007	DoH – Al Salam PHCC
32326	6 Nov. 2007	DoH- Karkh

29114	19 Sep.2007	DoH – Al Salam PHCC
1156	23 Sep. 2007	DoH – Al Salam PHCC
902	27 Jan. 2009	DoH – Al Salam PHCC
9119	7 Feb.2008	MoH
1431	10 Feb.2009	DoH- Karkh

Babel:

Letter Number	Letter Date	Department
2530	16 Nov.2009	DoH – Al Musaib District
022193	26 Sep.2005	DoH – Al Musaib District
218265	23 May 2005	DoH
40043	3 Oct.2005	DoH
6708	15 Mar.2006	DoH
7608	15 Mar.2006	DoH
40044	27 Oct. 2005	DoH
7602	8 Mar.2006	DoH
7603	8 Mar. 2006	DoH
6602	8 Mar. 2006	DoH
7602	8 Mar. 2006	DoH

Diyala:

Letter Number	Letter Date	Department
12547	23 Jun.2008	DoH- Al Khalis District
5983	17 Sep.2006	DoH- Al Mansoriya District
316	30 Jul.2006	DoH- Al Mansoriya District
40514	27 Oct.2005	DoH- Al Khalis District
HIS	7 Feb.2008	DoH

Erbil, Duhuk & Sulaymania:

Letter Number	Letter Date	Department
156	25 Mar.2007	DoH – Aqra District
985	25 Mar.2007	DoH – Aqra District
1366	17 Feb.2008	DoH- Duhuk
31249	17 Jul. 2007	Kurdistan MoH
616	14 Nov. 2005	Kurdistan MoH
281	10 Apr. 2005	DoH- Sulaymania

Kirkuk:

Letter Number	Letter Date	Department
23988	21 Dec.2009	DoH
66986	24 Nov.2009	DoH
20554	29 Oct. 2009	DoH

Mosel:

Letter Number	Letter Date	Department
512	16 Feb.2006	DoH
737	25 Jul.2005	DoH
378	17 May 2005	DoH- Telkaif District
737	25 Jul. 2005	DoH- Telkaif District
478	17 May 2005	DoH- Telkaif District
20265	4 May 2008	MoH

Basra:

Letter Number	Letter Date	Department
20265	4 May 2008	MoH

Karbala:

Letter Number	Letter Date	Department
5480	23 Jul.2007	DoH

Najaf:

Letter Number	Letter Date	Department
495	11 Oct. 2005	DoH- Al Manathra District
6951	10 Oct. 2006	DoH
32	18 Jan.2006	DoH- Al Manathra District

Salah Al -Din:

Letter Number	Letter Date	Department
9289	2 Oct. 2007	DoH
17158	6 Dec. 2009	DoH
67264	25 Nov. 2009	DoH
390	14 Mar.2007	DoH
4818	30 Jul.2006	DoH
4285	29 Jun. 2006	DoH
8536	20 Mar. 2005	DoH
4398	13 Jul. 2005	DoH
7991	18 Oct. 2005	DoH
8025	19 Oct. 2005	DoH
5810	14 Feb. 2006	DoH
7083	21 Feb. 2006	DoH
7416	22 Feb. 2006	DoH
9289	30 Sep.2007	DoH
417	28 Feb. 2007	DoH

Missan:

Letter Number	Letter Date	Department
3512	14 Dec. 2009	DoH
195	10 Nov.2009	DoH

Thi Qar:

Letter Number	Letter Date	Department
24	25 Apr. 2004	DoH – Al Shatra District
2080	27 Apr.2005	DoH– Al Shatra District
460	12 Jul. 2007	DoH– Al Shatra District
2082	27 Jul.2005	DoH– Al Shatra District
1109	8 Apr. 2009	DoH
1466	27 Apr. 2008	DoH– Al Shatra District
2106	3 Jul. 2006	DoH– Al Shatra District
8607	23 Mar. 2008	DoH
1723	22 Apr. 2009	DoH – Al Jibayesh District
99	20 Apr. 2005	DoH– Al Shatra District
955	18 Apr.2005	DoH
915	9 Apr. 2008	DoH
3421	29 Nov. 2005	DoH– Al Shatra District
2084	27 Jul.2005	DoH– Al Shatra District

Annex B III: Desk Study Documents

- HCG, Selected Health Information on Iraq, March 2003
- International Conference on Primary Healthcare, Alma-Ata, USSR, 6-12 September 1978, Declaration of Alma-Ata, (1978)
- Iraqi Strategic Review Board, National Development Strategy 2005-2007, June 30 2005
- UNDG ITF, Seventh Six-month 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): Report of the Administrative Agent of the UNDG ITF for the Period 1
- July to 31 December 2007, 01 May 2008UNDG ITF, D2-03: Strengthening Primary Healthcare
- System in Iraq; Sixth Six Monthly Report for Project, 1 January 2007 to 30 June 2007, (report undated)
- UNDG ITF, D2-03 Project Fiche, March 2008
- UNDG ITF, Progress in Health and Nutrition Cluster, January- June 2007 (report undated)
- UNDG ITF, D2-03: Strengthening Primary Healthcare System in Iraq; Fourth Six Monthly Report
- for Project, 1 January 2006 to 30 June 2006, undated
- UNDG ITF, D2-03: Strengthening Primary Healthcare System in Iraq; Second Six Monthly Report / for Project, 1 July 2005 to 31 December 2005, undated
- UNDG ITF, D2-03: Strengthening Primary Healthcare System in Iraq; Second Six Monthly Report / for Project, 1 January 2005 to 30 June 2005, undated
- UNDG ITF, D2-03: Strengthening Primary Healthcare System in Iraq; Form for Submission to UNDG Iraqi Trust Fund Steering Committee, April 27 2004

- UNDG and World Bank, United Nations/World Bank Iraq Needs Assessment, October 2003

- World Health Organization Eastern Mediterranean Regional Office Community Based Initiatives Unit, Guidelines for Introduction of BDN in a New Area, undated

Annex B IV: Preliminary Interviews

Preliminary interviews took place with the following organizations

- WHO Amman Office
- WHO Iraq
- MoH

Annex B V: Indepth Interviews

1. Rehabilitation/Construction of Health Facilities
2. Capacity Development of PHCCs

Governorates	Location / Job description	Names
Duhuk	DoH / Planning Department's Director	Dr. Suror Sadik Bahaa
	DoH Director / Oqra	Dr. Fadhil Balandi
	DoH Manager / Oqra	Mr. Ahmed Shoshe
	PHCCs Department's Director / Bardarash	Dr. Masuood Abdul Kareem
	PHCCs Department's Director / Oqra	Dr. Issa Raheem
	Oqra PHCC Director	Dr. Waleed Rasheed
	Oqra PHCC / Pharmacologist	Dr. Nazar Mohammed Asaad
	Beneficiaries from the targeted community	
Erbil	DoH / Planning Department's Director	Dr. Muaad Abdula
	DoH / Planning Department	Dr. Asoo Hamed
	DoH / Treatment Department's Director	Dr. Abdul Star Aziz
	DoH / Statistics Department	Mr. Sedan Rasol
	Shaklawa Hospital's Director	Dr. Saed Dakhel Saed
	Shaklawa Hospital / Medical Assistant	Mr. Muhsen Jameel
	Shaklawa Hospital / Lab. Manger	Dr. Sarkoot Anwar
	Shaklawa Hospital / Lab. Assistant	Mr. Sabah Habib
	Liaison Officer / DoH - WHO Beneficiaries from the targeted community	Dr. Lana Bahram
Sulaimaniya	DoH Director	Dr. Rekot Hama Rasheed
	DoH Director Assistant	Dr. Jaafer Haider
	DoH / Media Department's Manager	Mr. Bestoon Fatah Aziz
	Treatment Department's Manager	Dr. Najim Al Din Hassan
	Engineers' Manager / DoH	Eng. Haiman Khalid
	Dokan PHCC Director	Dr. Ara Moamer Esmael
	Emergency Room/ Medical Assisstant / Dokan PHCC	Mr. Shaheen Abdul Wahab
	Medical Lab. / Dokan PHCC	Mr. Shawkat Abdula
	Medical Lab. / Dokan PHCC	Ms. Bahar Ahmed
	Beneficiaries from the targeted community	

Mosul	DoH Director	Dr. Abdul Rezaq Atiya
	Telkaif District's Director	Dr. Bassam
	Beneficiaries from the targeted community	
Kirkuk	DoH / Deputy Director	Dr. Hussain Omar Rasol
	Daquq District's Director	Dr. Sabah Amen Ali
	PHCCs Department's Director	Mr. Tariq Khudher Mohamed
	Primary Healthcare Department's Director	Dr. Jabar Hassan Jalab
	Lilan PHCC Director	Dr. Hussain Finjan
	Taza PHCC Director	Dr. Nasar Jabar
	Beyanlo PHCC Director	Mr. Hasan Hussain
	AIDS unit Director / DoH	Dr. Samar Khilil Ali
	Malaria Department / DoH	Mr. Natiq Faeq
	Beneficiaries from the targeted community	
Salahaldin	PHCCs Department's Director	Dr. Sahar Kamel
	Beji District's Director	Dr. Zedan Khalaf
	Beji District's Previous Director	Dr. Muzhair Hasan
	Biji PHCC	Dr. Jamal
	Al Tawheed PHCC	Dr. Hamed Mayah
	Beneficiaries from the targeted community	
Diyala	Al Khalis District's Director	Dr. Liwa
	Al Khalis PHCC	PHCC staff
	Al Mansoriya PHCC Director	Dr. Qaus Kamil
	Al Mansoriya PHCC / Dentist	Dr. Mohamed Ahmed
	Beneficiaries from the targeted community	
Baghdad	Al Madaen District's Director	Dr. Mustafa Fadhil Abdul Hussain
	Al Madaen District	Dr. Ali Abdul Hadi
	Al Madaen District	Dr. Farida Ibrahim Khalil
	Al Madaen District	Dr. Ahmed
	DoH / Rusafa	Dr. Israa Muhea Al Deen
	DoH / Rusafa	Dr. Aws Talal
	DoH / Rusafa	Dr. Raheem
	Al Jeser PHCC	PHCC staff
	Vaccination department / Al Naftiya PHCC	Hussain Salim
	Vaccination department / Al Naftiya PHCC	Farah Qasim
	Vaccination department / Al Naftiya PHCC	Mukhlis Hadi
	Vaccination department / Al Naftiya PHCC	Samir Flaih
	Vaccination department / Al Naftiya PHCC	Qasim Ali
	Al Salam PHCC Director	Dr. Abdul Ghani Saadon Humdi
	Al Salam PHCC	PHCC staff
	Beneficiaries from the targeted community	
Babel	Al Musaab District's Director	Dr. Abdul Kareem Ali Hassan
	Al Musaab District's Director Assistant	Dr. Atta Mohammed Naef
	Pharmacologist	Dr. Waseam Mohammed Qanbar
	Beneficiaries from the targeted community	
Karbala	Al Hindiya District's Director	Dr. Maysoon Abdul Wahab
	Al Hindiya District / Responsible for Educational Hall	Safana Najim Nasir

	Beneficiaries from the targeted community	
Najaf	PHCCs Director in Najaf	Dr. Saad Humud Al Lami
	Al Manathra District's Director	Dr. Jabar Naema
	Al Manathra District / resident doctor	Dr. Hussain Abdula Hussain
	Beneficiaries from the targeted community	
Diwania	Al Diwania District's Director	Dr. Batool Ali Al Atiya
	Beneficiaries from the targeted community	
Wassit	Al Razi PHCC / Al Sweara District	PHCC staff
	Beneficiaries from the targeted community	
Missan	Al Yarmok PHCC / Missan Teachers collage	PHCC staff
	Missan PHCCs Department's Director	Dr. Mithaq Shamkhi Jaber
	Prevention Department's Director	Dr. Intesar Jumaa Hussain
	Beneficiaries from the targeted community	
Thi Qar	Missan PHCCs Department's Director	Dr. Fadhil Hassan
	Suq Al Shukh District's Director	Dr. Osama Juad Kadhum
	Al Hawra PHCC Director	Dr. Sameera Mahdi
	Al Hawra PHCC	Dr. Mazin Abdul Zahra
	Beneficiaries from the targeted community	
Mothanna	Mothanna PHCCs Department's Director	Dr. Fadhil Aziz
	Al Rumaitha District's Director	Dr. Hassan Abd Ali
	Al Najmi PHCC Director	Dr. Haider Farhan
	Al Rumaitha District's Store Director	Mr. Hassan Hamza
	Medical Assistant	Mr. Fadheil Auda
	Al Rumaitha District / employee	Mr. Amjad Abdul Hamza
	Beneficiaries from the targeted community	
Basra	Public Health Department's Director	Dr. Hussain Tuama Mohammed
	Al Zubair District's Director	Dr. Masar Abdul Al Jaleel
	Al Zubair District's Director Assistant	Dr. Ghareeb Al Asadi
	Al Batin PHCC Manager	Mr. Hussain Ali
	Al Shifaa PHCC Manager	Mr. Mohammed Zaid
	Al Batin PHCC	PHCC staff
	Al Shifaa PHCC Beneficiaries from the targeted community	PHCC staff

3. Professional Training:

Governorates	Location / Job description	Names
Duhuk	DoH / Planning Department's Director	Dr. Suror Sadik Bahaa
	DoH Director / Oqra	Dr. Fadhil Balandi
	PHCCs Department's Director / Bardarash	Dr. Masuood Abdul Kareem
	WHO Representative	Dr. Kawa Mohammed Amen
	Beneficiaries from the targeted community	
Erbil	DoH / Planning Department's Director	Dr. Muaad Abdula
	Shaklawa District's Director	Dr. Faris Yousif

	Shaklawa Training Centre	Mr. Aziz Audo
	Shaklawa Training Centre	Mr. Faraan Ahmed Hassan
	WHO Representative	Dr. Yaseen Ahmed
	Beneficiaries from the targeted community	
Sulaimaniya	DoH Director	Dr. Rekot Hama Rasheed
	Chief pharmacists Kurdistan, Sulaymania	Dr. Saeed Qasim Hassan
	Training Centre Director	Mr. Hassan Mahmoud
	Training Centre / Director Assistant	Mr. Bukhtyar Ahmed
	WHO Representative	Dr. Nawroz Outhman Saeed
	Beneficiaries from the targeted community	
Mosul	Telkaif District's Director	Dr. Bassam
	Beneficiaries from the targeted community	
Kirkuk	DoH / Deputy Director	Dr. Hussain Omar Rasol
	Technical Department's Director	Dr. Shaswar Mohamed
	Civil Engineer	Eng. Moloud Abdula Sulaiman
	Manpower Department's Director	Mr. Waraya Hakeem
	Statistic Department	Mr. Abdul Al Latif Abdulkarim
	Beneficiaries from the targeted community	
Salahaldin	PHCCs Department's Director	Dr. Sahar Kamel
	Health System Department's Director	Dr. Ban Ahmed
	Beneficiaries from the targeted community	
Diyala	Administrative Assistant / DoH	Dr. Mohamed Abdul Rahman
	Al Khalis PHCC / Medical Assistant	Mr. Amer Hashim hameed
	Beneficiaries from the targeted community	
Baghdad	DoH / Rusafa	Dr. Israa Muhea Al Deen
	Beneficiaries from the targeted community	
Babel	Engineering Department / DoH	Eng. Fatin Abadi Zamil
	Beneficiaries from the targeted community	
Karbala	Accounts Department's Director	Ms. Sabiha Abdul Rasool
	Beneficiaries from the targeted community	
Najaf	Al Najaf District / Maternal Care Department	Dr. Khalida Mahdi Hadi
	Beneficiaries from the targeted community	
Diwania	Al Diwania District's Director	Dr. Batool Ali Al Atiya
	Beneficiaries from the targeted community	
Wassit	PHCCs Department's Director	Dr. Sundus Abdul Hussain
	Al Sweara District	Dr. Raad Abdul Hadi
	Medical Assistant	Mr. Ibrahem Mohsen
	Beneficiaries from the targeted community	
Missan	Missan District's Director	Dr. Hussain Raheem
	Missan PHCCs Department's Director	Dr. Mithaq Shamkhi Jaber
	Prevention Department's Director	Dr. Intesar Jumaa Hussain

	Accounts Department's Director	Mr. Khalaf Mohamed
	Beneficiaries from the targeted community	
Thi Qar	Missan PHCCs Department's Director	Dr. Fadhil Hassan
	Suq Al Shukh District's Director	Dr. Osama Juad Kadhum
	Legal Department Director / DoH	Mr. Khayoon Fadhil
	Beneficiaries from the targeted community	
Mothanna	Mothanna PHCCs Department's Director	Dr. Fadhil Aziz
	Orthopaedic surgery	Dr. Amjad Auda
	Radiology specialist	Dr. Afaf Abdul Zahra
	Engineer	Eng. Ali Naem
	Building Department's Director	Eng. Zainab Mohamed
	DoH / IT Assistant	Mr. Abdul Al Latif Lisa
	Medical Tests Specialist	Mr. Amjad Mousa
	Engineering Department / Technician Beneficiaries from the targeted community	Mr. Muslim Shuhaib
Basra	Public Health Department's Director	Dr. Hussain Tuama Mohammed
	DoH	Dr. Nazhat Najim
	DoH	Dr. Amani
	DoH	Mr. Faris Najim Aboud
	DoH	Ms. Lamia Abdul Aziz
	DoH	Mr. Hussain Jalil
	DoH Beneficiaries from the targeted community	Ms. Jalal Katia

4. Family Physician Model (FPM):

Governorates	Location / Job description	Names
Mosul	Al Qudus PHCC Director	Dr. Mohamed Mahmoud Dawood
	Al Qudus PHCC Beneficiaries from the targeted community	PHCC Staff
Baghdad	Al Salam PHCC Director	Dr. Abdul Al Ghani Saadon
	DoH / Al Karkh	Dr. Sahar Al Jashaami
	Al Salam PHCC	PHCC staff
	Al Salam PHCC / Nurse	Mr. Qahtan Madhlum
	Al Salam PHCC / Nurse Beneficiaries from the targeted community	Mr. Murtadha Ayad
Basra	Azi Al Din Salim PHCC / Deputy Director	Dr. Hanady Lazim
	Azi Al Din Salim PHCC / Doctor GP	Dr. Yaurob Nasir
	Family Medicine Office	Ms. Wafa Abdula
	Azi Al Din Salim PHCC / Family physician	Dr. Ayda Adel
	Azi Al Din Salim PHCC / Staff	Mr. Hassan Mohammed
	Al Razi PHCC / Family physician	Dr. Hind Elya
	Beneficiaries from the targeted community	

5. Referral System:

Governorates	Location / Job description	Names
Mosul	Al Qudus PHCC Director	Dr. Mohamed Mahmoud Dawood
	Al Qudus PHCC	PHCC Staff
	Beneficiaries from the targeted community	
Baghdad	Al Salam PHCC Director	Dr. Abdul Al Ghani Saadon
	DoH / Al Karkh	Dr. Sahar Al Jashaami
	Al Salam PHCC	PHCC staff
	Al Salam PHCC / Nurse	Mr. Qahtan Madhlum
	Al Salam PHCC / Nurse	Mr. Murtadha Ayad
	Beneficiaries from the targeted community	
Basra	Azi Al Din Salim PHCC / Deputy Director	Dr. Hanady Lazim
	Public Health Department's Director	Dr. Hussain Tuama Mohammed
	Azi Al Din Salim PHCC / Doctor GP	Dr. Yaurob Nasir
	Azi Al Din Salim PHCC / Family physician	Dr. Ayda Adel
	Azi Al Din Salim PHCC / Staff	Mr. Hassan Mohammed
	Al Zubair District's Director	Dr. Masar Abdul Jalil
	Beneficiaries from the targeted community	

6. Health Information System

Governorates	Location / Job description	Names
Duhuk	DoH / Planning Department's Director	Dr. Suror Sadik Bahaa
	IT Department / DoH	Eng. Adel Shamoel
Erbil	DoH / Planning Department	Dr. Asoo Hamed
	IT Department / DoH	Mr. Diyal Bilal
	Software Engineer	Mr. Sidan Rasoul
	Statistics Department	Mr. Saman Issa
	WHO Representative	Dr. Yaseen Ahmed
Sulaimaniya	DoH / Media Department's Manager	Mr. Bestoon Fatah Aziz
	IT Department / DoH	Mr. Banaz Omar
	WHO Representative	Dr. Nawrooz Outhman
Mosul	DoH Director	Dr. Abdul Rezaq Atiya
	Telkaif District's Director	Dr. Bassam
Kirkuk	DoH / Deputy Director	Dr. Hussain Omar Rasol
Salahaldin	IT Department / DoH	Eng. Rafid Hussain
	IT Department / DoH	Eng. Omar Amer Hazaa
Diyala	IT Department / DoH	Eng. Zainab Dhiya
	IT Department / DoH	Eng. Nobugh Subhi
	IT Department / DoH	Eng. Mohamed Khalaf
	IT Department / DoH	Eng. Omar Ahmed
	IT Department / DoH	Eng. Ahmed Fawzi Saadon
Baghdad	DoH / Rusafa	Dr. Israa Muhea Al Deen
	IT Department / MoH	Dr. Haider Ismael Tawela

Babel	IT Department / DoH	Eng. Hameed Al Deen Iqbal
Karbala	IT Department / DoH	Eng. Mustafa Mahdi
	IT Department / DoH	Eng. Ahmed Mamour
Najaf	IT Department / DoH	Mr. Ragheed Hamewed
	IT Department / DoH	Ms. Majida Abdul Jabar
Diwania	Al Diwania District's Director	Dr. Batool Ali Al Atiya
Wassit	PHCCs Department's Director	Dr. Sundus Abdul Hussain
Missan	Health Protection Department's Director	Dr. Intesar Jumaa Hasoun
	Missan District's Director	Dr. Hussain Raheem
	IT Department / DoH	Mr. Khalaf Mohammed
Thi Qar	DoH	Mr. Saad Abdul Razaq
	DoH / Statistics Department	Mr. Salih Hassan
	DoH / Statistics Department	Mr. Raad Mohammed
Mothanna	IT Department / DoH	IT staff
Basra	DoH Director	Mr. Abdula Abdul Bari
	IT Department / DoH	IT staff

7. Public Health Activities:

Governorates	Location / Job description	Names
Erbil	Kurdistan MoH / Health issues Department's Director	Dr. Jameel Ali
	Kurdistan MoH / Lab. Department's Director	Dr. Hussain Ismael
	Kurdistan MoH / Pharmacy Director	Dr. Shlair Saadoon
	Health Protection Department's Director	Dr. Sarhank Jalal
	Kurdistan MoH / Quality Control Department's Director Beneficiaries from the targeted community	Dr. Ramzi Outhman
Mosul	DoH Director	Dr. Abdul Rezaq Atiya
	Telkaif District's Director	Dr. Bassam
	Beneficiaries from the targeted community	
Baghdad	Central Medical Labs	Dr. Abdul Elah Mahmoud
	Central Medical Labs	Dr. Laith Majeed
	Central Medical Labs	Dr. Eman Abdula
	Central Medical Labs	Dr. Ali Hussain
	Beneficiaries from the targeted community	

8. Action Oriented School Health Curriculum (AOSHC)

Governorates	Location / Job description	Names

Baghdad	MoH	Dr. Bushra Jameel
	MoH	Dr. Alya

9. Health Sector Reform:

Governorates	Location / Job description	Names
Baghdad	MoH	Dr. Ahlam Saaed
	MoH	Dr. Baraa Hameed
	MoH	Dr. Nidhal Ebrahim

10. Iraq Family Health Survey (IFHS):

Governorates	Location / Job description	Names
Baghdad	MoH	Dr. Ahlam Saaed
	MoH	Dr. Hanan Hashim

11. Basic Health Service Package (BHSP):

Governorates	Location / Job description	Names
Baghdad	MoH	Dr. Suhad Nuaman

12. Basic Health Service Package (BHSP):

Governorates	Location / Job description	Names
Baghdad	MoH	Dr. Suhad Nuaman
	MoH	Dr. Rana Mahdi

13. Integrated Management of Childhood Illness (IMCI):

Governorates	Location / Job description	Names
Baghdad	MoH	Dr. Nidhal Ebrahim

14. Community Based Initiative (CBI):

Governorates	Location / Job description	Names
Sulaimaniya	DoH Director	Dr. Rikot Hama Rasheed
	DoH Director Assistant	Dr. Jaafar Haider
	CBI Project Manager	Dr. Akram Aziz
	Halabja Healthcare Department's Director	Mr. Fadhil Hassan
	Beneficiaries from the targeted community	
Baghdad	MoH	Dr. Enas Basim Khalil
	DoH / Rusafa	Dr. Raheem Mathkoor
	DoH / Rusafa	Dr. Israa Muhea Al Deen
	79 District / Al Sader City / Local Council member	Mr. Mahdi Kadhum
	Al Intisar Village / Al Rashidiya / Local Council member / Tribal Leader	Mr. Mohsen Edi
	MoH	Ms. Nidhal Mohammed
	MoH	Ms. Sawsan Fadhil
	Beneficiaries from the targeted community	
Babel	CBI Project Manager	Dr. Eman Faloji

	Beneficiaries from the targeted community	
Najaf	PHCC Director	Mr. Jameel Mohsein
	Beneficiaries from the targeted community	
Missan	Missan District's Director	Dr. Hussain Raheem
	Beneficiaries from the targeted community	
Thi Qar	PHCCs Department's Director / Al Shatra District / Al Sulaiman Village	Dr. Fadhil Hassan
	Health Control Department's Director	Dr. Abdul Ridha Obaid
	Al Sulaiman PHCC Director	Mr. Sabieh Kadhum
	Beneficiaries from the targeted community	
Mothanna	Mothanna PHCCs Department's Director	Dr. Fadhil Aziz
	Public Health Department's Director	Dr. Laith Shukur
	CBI Committee in the village / member	Mr. Hashim Abdul Khudhir
	PHCCs Department	Mr. Ali Juad
	DoH	Mr. Amer Red
	Beneficiaries from the targeted community	

15. Emergency Response:

Governorates	Location / Job description	Names
Baghdad	MoH / Operational Department	Dr. Mohameed Jasib
	MoH / Operational Department	Dr. Sabah Al Salihi
	Emergency Department	Dr. Shakir Kadhum
	Emergency Department	Dr. Harbiya Sufar
	MoH	Dr. Amer Abdul Sada
	MoH	Dr. Ahlam Saed

Annex C: PHCCs Visited

#	Governorate	PHCC Visited by SOC evaluator

1	Babel	Al Musayab / Al Musayab district
2	Baghdad	Al Madani PHCC / directorate of Health / Rosafa
		Al Jesser PHCC
		Al Nafti PHCC
		Al Salam PHCC/Al Tobchi
		PHCC/Sector 79/ Al Sader City
		PHCC/Entesar Village/ Al Rashdia City
	Diyala	Ba'aqwba PHCC/ Ba'aqwba district
	Erbil	Erbil PHCC/ Shaqlawa district
3	Basrah	Al Baten PHCC
		Al Shifaa PHCC
		Ez Al Deen Saleem PHCC
4	Diwania	Al Diwania PHCC/Diwania district
5	Duhuk	Al Aqrah PHCC
6	Sulaymania	Mahmood Sidree PHCC/ Dokan City
7	Kabalaa'	Al Hindiya PHCC/Karbalaa' City
8	Kirkuk	Daquq PHCC/ Kirkuk City
9	Missan	PHCC/Al Mualemen Collage/Missan University
10	Mosel	Tilkef PHCC/directorate of Health /Naynawa/Tilkef Sector
		AL Qudos PHCC/Masel City
11	Muthana	Al Najmi PHCC/Al Remetha district
		Thawrat Al Ishreen PHCC/Al Remetha district
12	Najaf	Al Manathers PHCC
13	Salah Al Din	Al Tawheed PHCC/Beji district
		Beji PHCC/Beji district
14	Thiqar	Suq Al Shoyokh and AL Hawraa' PHCC
		Al Razy PHCC/Al Gharaf sub district
15	Wassit	Al Razy PHCC/Al Sowaira district

Annex D: CBI: Outputs by Target Area

Targeted Areas	Projects	stakeholders
Al Rashidiay and Al Intesar Village,	• Training volunteers for the public health	• Community

Baghdad	programs • Training for the environment program • Training on beekeeping • Rehabilitation of schools • Street paving • Project providing potable water • Lessons in the study of the Qur'an • Distribution of chicken cages, fertilizers, and seeds • Irrigation projects • Literacy courses • Installation of Electric Generators • Income generation projects • Distribution of computers • Establishment of a new PHCC • Awareness programs on health issues	representatives • MoH • MoE • Municipalities • MoL • City council • MoA • Waqif Suni
Sector 79, Baghdad	• Distribution of computers • Building of new schools • Rehabilitation of existing schools • Establishing parks • Training of volunteers • Establishment of Hussainiya • Opening a computer training center • Distribution of food to the needy families • Beginning of construction on new sewage networks • 80 families registered by the MoL for living assistance and receiving cash allowances • Distribution of blankets and cash assistance of 50,000 ID to 200 needy families • 20 families given small business loans • Awareness programs on health issues	• Community representatives • MoH • MoE • Municipalities • MoL • MoEnv. • Waqif Shiah • CSOs
Babel	• Establishment of PHCC in a new location • Training of volunteers • Monthly stipends to widows and poor families provided by the Al Zahraa institution • Development of new job opportunities • Computer training sessions • Literacy courses • Street paving • Rehabilitation of the Al Tawra city market • Installation of facilities providing potable water • Establishment of a new sewer system • Establishment of a garbage removal service • Vaccination campaigns • Awareness programs on health issues • Improved electric grid	• Community representatives • MoH • MoE • Municipalities • MoA • MoEnv. • CSOs
Najaf	• Installation of facilities providing potable water • Development of a PHCC • Distribution of fertilizers and seeds	• Community representatives • MoH • MoE

	• Volunteer training • Irrigation projects • Street paving • Rehabilitation of schools and distribution of school supplies • Construction of a new primary school • Literacy courses • Bridge construction • Construction of regulators on the Al Hashimi River • Awareness programs on health issues • Distribution of cash assistance to widows and poor families • Distribution of agricultural tools, sewing machines, chicken cages, and computers	• Municipalities • MoA
Missan	• Installation of facilities providing potable water • Establishment of a new PHCC • Distribution of computers • Volunteer training sessions • Street paving • Literacy courses • Distribution of sewing machines • Installation of a 500 kW electric generator for village • Rehabilitation of two schools' septic systems • Awareness programs on health issues	• Community representatives • MoH • Municipalities • MoA
Thi Qar	• Rehabilitation of PHCC • Volunteer training sessions • Establishment of an agricultural research center • Rehabilitation of water purification and distribution system • Construction of a bridge over Al Badaa River • Street paving • Awareness programs on health issues • Distribution of sewing machines and wheelchairs • Construction of fencing and bathrooms for girls' school • Trash removal campaign • Distribution of water tanks	• Community representatives • MoH • Municipalities • MoA • MoEnv
Mothanna	• Construction of new schools • Establishment of a new PHCC • Installation of facilities providing potable	1. Community representatives 2. MoH

	water • Volunteer training sessions • Computer training sessions • Street paving • Distribution of sewing machines and computers	3. Municipalities 4. MoA 5. MoEnv 6. CSOs
Sulaimaniya	• Training of volunteers • Equipment Distribution	
Faluja, Anbar	Activity in this area was cancelled due to the security situation	

Annex E: Partnerships[13]

Partnerships with GoI Minsitries:

[13] Information taken from the "D2-03 Final Narative Report"

1. **The Ministry of Health** acted as the leading implementing ministry in this programme as well as the Health Financer and Provider of Health Services;

2. **The Ministry of Higher Education**: played a significant role in strengthening and enhancing health professionals' capacities in addition to the finance, administrative and logistical capacity of the health sector workers;

3**. Ministry of Education**: its main contribution focused on sending key messages to community and strengthen basic education in terms of improved quality of life, close coordination on the school health component of this programme was ensured during the implementation;

4. **Ministry of Environment**: supported health living conditions and prevented environment degradation. This programme included activities addressing 'Water and Healthcare Waste Management' to limit its adverse impact on the on the public health;

5. **Ministry of Municipalities**: its major contribution to this programme was promoting the Healthy Cities Initiative in three cities along with MoH and other line ministries;

6**. Ministry of Agriculture:** has contributed to many components of this programme, however, the significant contribution was while implementing the Community Based initiative in 9 localities;

7. Ministry of Planning: supported the MoH in strategizing and putting health on the political agenda;

8. **Ministry of Finance**: support the MoH in adequately financing health priority areas;

9. Ministry of Human Rights: sending key messages stating that access to health is a basic human right and it is the responsibility of everyone. The health system should provide the quality services but also the population is responsible for seeking care when sick and for not abusing the system when unneeded;

10. The Parliamentarians: supported the MoH in revising the health legislation and ratifying policies;

11. Civil Society: civil society and responsiveness to community need is the approach adopted during the implementation of this programme, hence, the invitation of community leaders and religious or women leaders to meeting in Amman ensures their inclusiveness in the decision making process and that they will have a greater effect when they go back to Iraq;

12. Private Contractors: are those who were contracted by MoH to do rehabilitative work of the health facilities in this programme.

It is worth noting that several areas where implemented in close coordination and cooperation with the International Community including UN agencies members of the Health and Nutrition Sector Outcome Team (SOT), and International NGOs, in addition to the World Bank.

WHO has worked and closely coordinated with UNICEF on the Primary Healthcare Programme

in order to avoid overlapping of activities and ensure complimentarity. The major activities that were coordinated under this programme with UNICEF were: **a.)** Integrated Management of Childhood Illness (IMCI), **b.)** Initiation of the Family Physician Practice **c.)** Expanded Programme of Immunization (EPI) and nationwide MMR immunization campaign. Collaboration with UNFPA for Emergency Obstetric Care has also been an important and consistent resource.

WHO also coordinated with the World Bank (WB) while implementing the Establishment of National Health Accounts programme and the Financing Options for Iraq's Health Sector programme.

During the first 24 months of programme implementation, WHO worked closely with USAID on Strengthening the PHC System.

MERLIN (INGO) was involved in the program and conducted a series of Trainings of Trainers (ToT) in the Communicable Disease Centre in Baghdad.

Collaboration, coordination and information sharing with other UN agencies working with the Health and Nutrition Sector such as (UNOPS, WFP, UNIDO, UNDP and others) in addition to other sectors were ensured through the Health and Nutrition Sector Outcome Team forum and other Sector Outcome Team in addition to the Peer Review Coordination forum.

Annex F: Comparison Sheet between number of beneficiaries before and after rehabilitation of Shaqlawa Hospital in Erbil from DoH - Erbil:

احصائية عام 2009	احصائية عام 2004	الفقرات

(بعد التاهيل)	(قبل التاهيل)	
66641	58735	المرضى المراجعين للمستشفى
394	380	الولادات الطبيعية
176	2	الولادات القيصرية
7464	2732	الدخول للمستشفى
1758	254	العمليات الجراحية
8829	3898	الاشعة المصروفة
4029	0	السونار
62	0	الايكو
79274	22390	الفحوصات المختبرية
3	1	صالات الولادة
20 سرير	4 اسرة	الطوارى
11	2	غرف الاستشاريات
8+ انتظار المراجعين	2	غرف المختبر
اشعة و سونار	1	غرف الاشعة

Annex G: Field evaluation Guidelines & Questionnaires

Activity No. 1 and 2

Sustainable functioning 19 model PHC system (rehabilitation part) in one district at each of the 18 governorates (Baghdad 2 centers). The work generally included: maintenance or replacing replacement of existing service system (i.e. electrical and sanitation systems), improving the finishing works (i.e painting, tiling, plastering, cement rendering, roofing and others), repairing or replacing windows and doors and providing generators where requested. In addition to that a total of 19 training halls were constructed and fully equipped with approximately 1,216 teaching resources (such as TVs, data shows, cassette recorders, digital cameras…etc),

Sustainable functioning 19 model PHC system (refurnished and operational part), medical equipments, supplies, drugs, kits, informatics equipment and furniture.

Stakeholders for this activity:

- WHO representative.
- MoH
- DoH at the governorate level
- Benefited PHC directors, staff and Doctors.
- Patient and beneficiaries.
- Community leaders and sheikhs.
- Rehabilitation contractor
- Supply contractors

Field evaluation guidelines:

1. Visit the training hall within your governorate and report on the hall capacity, equipments, maintenance plan, current condition and sustainability of its operation and intended purpose (19 training halls were constructed and fully equipped with approximately 1,216 teaching resources (such as TVs, data shows, cassette recorders, digital cameras…etc).
2. Benefited PHC to be visited! This is a PRIORITY
3. What is his/her opinion of the project idea in general?
4. Was the rehabilitation and supply of equipment implemented according to plan? (per PHC)
5. Was it finished the way they were expecting?
6. What were they expecting? Ask them about this in detail!! Even if they said yes with the previous question. Was their answer (expectations) according to the proposal?
7. Assess the cooperation among the rehabilitation contractors and supply contractors with DoH in the governorate and PHC director.
8. Did the rehabilitation face any problems during the implementation period?
9. What was the level of cooperation between WHO representatives and DoH
10. Did the rehabilitation achieve its goals?
11. How is the design of the intervention relevant to the context?
12. How do the proposed interventions have a potential for replication for other PHCs?
13. How the needs, purpose and overall objectives were properly defined before the rehabilitation started?
14. How the risks and assumptions were correctly defined? (security and logistics)

15. How well has the rehabilitation been adapted during implementation?
16. How could the intervention have been done better, more cheaply or more quickly?
17. How has the cost of inputs relative to outputs indicated that value for money has been achieved in undertaking the projects?
18. To what extend this newly rehabilitated facilities participated in addressing the disease burden, which many Iraqis are facing and the lack of access to essential health care services.
19. Did all 129 benefited PHCCs complete the rehabilitation and operational?
20. What was the role of DoH/PHC in this project? What was the contribution of other ministries in the implementation of this project? Ministries that contributed to the implementation of this project:
    a. The Ministry of Higher Education.
    b. Ministry of Education
    c. Ministry of Environment
    d. Ministry of Municipalities
    e. Ministry of Agriculture
    f. Ministry of Planning
21. In general how was the health situation of the surrounding communities before implementation of the project? (Accessibility to PHC, distance to the nearest PHC, number of patients in the community, type of medical cases, pregnant women care, child care, major diseases care...)
22. How did the medical situation of the surrounding communities improved after the implementation of the project? (Accessibility to PHC, distance to the nearest PHC, number of patients in the community, type of medical cases, pregnant women care, child care, major diseases care...)
23. Are doctors and medical staff using the new devices?
24. Did the new medical devices support the PHC staff and doctors for better diagnosis for diseases?
25. During the visit to the PHCs make sure to check if the rehabilitation process had been completed as planned, which may include:
    a. Replacement of existing service system (i.e. electrical and sanitation systems).
    b. Improving the finishing works (i.e painting, tiling, plastering, cement rendering, roofing and others).
    c. Repairing or replacing windows and doors and providing generators where requested.
26. Bill of Quantity Check (per visited PHC in your governorate)
    a. Check details of BoQ
    b. Check items/equipment against the contract specifications; make sure the items are exactly the same as on the Bill of Shipping
    c. Check if each one of these details has been carried out.
    d. Check if these details has been completed 100%
    e. Report if any diversity / changes / not completed.
    f. Make sure to check the numbers of the medical and non medical equipments supplied under this project and the dates of delivery to the PHCs and make sure that the total number is the same as agreed by WHO.
    g. Double CHECK details of the equipments (medical devices and computers…) and its current condition.(take pictures)
    h. Check workmanship and finish. Are there any damages? Are all the parts there? (i.e. drawers, shelves, etc)

i. Make sure that the Specifications are EXACTLY the same as on the Bill of Quantity from WHO
j. Check the condition of the goods. Is it clean? Damaged? Anything missing? Is it working (TEST it).
k. MOST IMPORTANTLY: is it being used for the intended purpose?
l. Is the PHC staff and patients using the medical devices and happy with them?
m. If there are any comments, WRITE these down. i.e. are the medical devices appropriate? Should it have been different? Bigger / smaller? Other specifications? Was it needed?

27. When visiting the office of the rehabilitation contractors or supply contractors, you must check implementation plan, delivery notes for equipments and other supply related documents.
28. What was the role of DoH in this project?
29. Assess the capacities and capability of the contractors team.
30. Were there any structural defects during handover? What were the damages, if any?
31. Examine the warranty period.
32. Was there any maintenance system for the project (the rehabilitated building, supplied equipments) in the PHCs to be applied AND in place, once the project was handed over to the related government department?
    a. Is the maintenance system functional?
    b. If not, why not, and what are the problems?
    c. Can these be solved? How, and how quickly?
    d. Who is responsible for providing the maintenance? IP, WHO, DoH, other?
33. Was the project implemented according to plan? Everything finished on time?

If not, why not? Was WHO informed on time?

34. Were there any delays?
    a. What were the reasons for the delays?
    b. Who was the reason for the delay? (IP, WHO, government, security, beneficiaries' .etc)
    c. How did the IP deal with this delay in terms of solving it and provide solutions?
35. What could be done to make the rehabilitation more effective when implementing similar activities in the future?
36. How are objectives in line with needs, priorities and partner government policies?
37. How have the conditions of the intended beneficiaries group changed since the beginning of the development intervention?
38. Are all planned beneficiaries using or benefiting from the projects' results?
39. Success stories and lessons learned according to direct and indirect beneficiaries (please state the person interviewed name, age, gender and occupation)
40. Quotes of direct and indirect beneficiaries (please state the person interviewed name, age, gender and occupation)
41. Assess the output from this intervention.
42. To what extent, this activity participated in improving the health sector services.
43. To what extend this activity participated in building the PHC staff capacity and in which area

Activity No. 3

2,000 trained health cadres at all levels (the gender distribution is very important). In-service and pre-service skills and knowledge. The training curriculum is to be designed and implemented. The aim is to train 2,000 various categories of health personnel. (Physicians, nurses, health facility

managers, administrators, etc...). The capacity building activities were conducted at two levels; inside the country and abroad. Whilst most training activities were conducted in Iraq, the abroad activities were conducted in three forms 1) workshops & trainings 2) fellowships and 3) international

conferences and meetings. These activities were conducted in different countries to exchange experiences, knowledge and lessons learnt. The major countries that hosted the Iraqi participants in the region were Jordan, Egypt, Syria, Lebanon, Oman, Bahrain, Tunis Saudi Arabia, UAE and Morocco other countries included UK, Italy, Sweden, Holland, Thailand and Switzerland. All these activities were in line with the ministry priorities. The training covers the following areas:

a. Access to Quality Health Care, access to quality control lab, strengthening PHC, essential medicines, nursing, health research system, health information system.
b. Social Determinants of Health, food safety, health education, nutrition, promotion of health lifestyle including oral health, environmental health policies and risk analysis, health research.
c. Prevention and Control of NCD, prevention & control of cardiovascular diseases, diabetes, cancer, Thalasemia, and respiratory conditions, mental health and substance abuse.
d. Prevention and Control of CD, HIV/STD, disease surveillance and control, Vector Control, Malaria, leshamnia and schimotasiss, polio eradication, Immunization & development of disease.
e. Mother and Child Health, IMCI.
f. Human Resource Development, human resources policy, planning & management, family medicine.
g. Health Policy Planning and Sustainable Development, national health policy and planning, CBI, health research system.

Stakeholders for this activity:

- WHO representative.
- MoH
- DoH at the governorate level

Field evaluation guidelines:

1. What is his/her opinion of the training program?
2. What were they expecting? Ask them about this in detail!! Even if they said yes with the previous question. Was their answer (expectations) according to the proposal?
3. Did the training achieve its goals?
4. How is the design of the training relevant to the context?
5. How does the proposed training have a potential for replication and sustainability?
6. Do you believe that the subjects need more training and follow up training sessions?
7. How were the needs, purpose and overall objectives properly defined?
8. How could the training have been done better?
9. How do the projects build on existing skills, knowledge and coping strategies?
10. Were the training session and capacity building of 2000 staff affected and enhanced the health services in the PHC (meet with staff participated in the training under this project, ask them where they were trained and on what subject and if the training was successful and useful)
11. What were the criteria used to select the participants in the training sessions?

12. Assess the training took place in Communicable Disease Centre in Baghdad.(the centre is rehabilitated and fully equipped)
13. Assess the workshop held in Amman June 2007; PHC Training Manuals have been initially reviewed by 26 MoH experts and WHO Iraq technical staff
14. Are the information and education materials received during the training practical and useful in your day to day operations?
15. What was the quality of training materials such as manuals, articles, texts, library materials, videos, etc?
16. Was the learning procedure in participatory way?
17. What was the period of the training sessions? Was it enough or you recommended that you should have more time?
18. How did the health care staff receive the training?
19. Did you get enough benefit from this training?
20. In your opinion what are the subjects that weren't covered by the training session and you believe it's important for you and other health care staff to be considered for training in the future
21. Were the results of the training sessions been implemented in PHCs?
22. Assess the output from this intervention.
23. To what extent, this activity participated in developing the health sector services.
24. To what extend this activity participated in building the PHC staff capacity and in which area

Activity No. 4

Family physician and nurse practitioner model initiated. The Family Medicine Practice project aims to improve the quality of health services in the PHCCs through the introduction of family medicine approach including a mechanism to refer complicated cases to secondary and tertiary levels of care. This project was piloted in three PHCCs, located in the North, South and Center of Iraq as per the below details.

a. North: Al Qudus PHCC in Al Aysar District-Mousel (Mosul), serving around 3,678 families
b. South: Ez Al Deen Saleem PHCC-Basra, serving 4,927 families;
c. Center: Al Salam PHCC in Karkh District-Baghdad, serving 6,400 families

Stakeholders for this activity:

- WHO representative.
- MoH
- DoH at the three benefited governorates
- Benefited PHC
- Patient beneficiaries.

Field evaluation guidelines:

1. The model was developed in close cooperation and coordination with MoH senior officials and has been approved. What was the level of cooperation, support and involvement of MoH during the project implementation?
2. What is his/her opinion of the Family physician and nurse practitioner model initiate?
3. Who is in charge of implementing the Family Medicine Practice at the PHC level
4. Please describe in details the progress in establishing, planning and implementing the Family Medicine Practice.

5. Is the Family Medicine Practice properly functional (in the three governorates)
6. What are the challenges facing the Family Medicine Practice? (in the three governorates)
7. Was it implemented the way they were expecting?
8. What were they expecting? Ask them about this in detail!! Even if they said yes with the previous question. Was their answer (expectations) according to the proposal?

9. Did the Family Medicine Practice face any problems during the implementation period?
10. Did the Family Medicine Practice achieve its goals?
11. How is the design of the intervention relevant to the context?
12. How do the proposed interventions have a potential for replication in other governorates?
13. How were the needs, purpose and overall objectives properly defined?
14. How well has the Family Medicine Practice been adapted during implementation?
15. How could the intervention have been done better, more cheaply or more quickly?
16. What is your opinion on the Family Medicine Practice project? (This project was piloted in three PHCCs, located in the North, South and Center of Iraq as per the below details:
    a. North: Al Qudus PHCC in Al Aysar District-Mousel (Mosul), serving around 3,678 families
    b. South: Ez Al Deen Saleem PHCC-Basra, serving 4,927 families;
    c. Center: Al Salam PHCC in Karkh District-Baghdad, serving 6,400 families
17. Immediate output on the behavior of beneficiaries, a.i. whether the number of beneficiaries had increased due to upgrading the skills of the health staff
18. Future expected improvement on the behavior of the health services seekers.
19. What are positive and negative effects?
20. Did the positive effects more than negative?
21. Are all planned beneficiaries using or benefiting from the Family Medicine Practice results?
22. How do the beneficiaries perceive the Family Medicine Practice benefits?
23. How is the timing of the intervention relevant from the point of view of the beneficiaries?
24. Success stories and lessons learned according to direct and indirect beneficiaries (please state the person interviewed name, age, gender and occupation)
25. Quotes of direct and indirect beneficiaries (please state the person interviewed name, age, gender and occupation)
26. Assess the output from this intervention.
27. To what extent, this activity participated in developing the health sector services.
28. To what extend this activity participated in building the PHC staff capacity and in which area (in the three governorates)

Activity No. 5

Establishing a functional referral system in the 19 model PHC districts throughout Iraq. A referral system is a continuum of health care moving from the initial contact at the PHCC to the provision of treatment at the hospital and a referral back to the initial contact. WHO provided the MoH with technical support at national and local levels in establishing an effective referral system that minimizes duplication of services and inefficient use of resources? A draft policy for the 'Referral System' was prepared by the MoH and reviewed by WHO. By the time of completion of the project, this policy has not yet been implemented however; a pilot of the policy of the Referral System was conducted in the three PHCCs centers where the Family Health Practice project was piloted. The PHC system was further supported by support in form of new equipment. This included procuring and delivering 19 four wheel drive ambulances, 38 four wheel drive pick-up trucks and 300 motorcycles to be used for outreach activities. These items covered the needs of approximately 9 million Iraqis and contributed to health quality improvement.

a. North: Al Qudus PHCC in Al Aysar District-Mousel (Mosul), serving around 3,678 families
b. South: Ez Al Deen Saleem PHCC-Basra, serving 4,927 families;
c. Central Al Salam PHCC in Karkh District-Baghdad, serving 6,400 families

Stakeholders for this activity:

- WHO representative.
- MoH
- DoH at the three benefited governorates
- Benefited PHC
- Patient beneficiaries.

Field evaluation guidelines:

This evaluation will be implemented at the MoH level and at the three benefited governorates level only.

1. Functional referral system was developed in close cooperation and coordination with MoH senior officials and has been approved. What was the level of cooperation, support and involvement of MoH during the referral system development and implementation?
2. What is his/her opinion of the project?
3. Who is in charge of implementing the functional referral system (at DoH level and PHC level)
4. Please describe in details the progress in establishing the functional referral system.
5. Is the functional referral system properly functional (per PHC)
6. What are the challenges facing the functional referral system
7. Did the project succeed in making people in these districts to use the PHC instead of the hospital?
8. Is the referral system operational (we need figures and statistics of referral cases before and after the implementation of this project)
9. Did the PHCs supported by 19 four wheel drive ambulances, 38 four wheel drive pickup trucks and 300 motorcycles to be used for outreach activities under the referral system from hospitals to PHCs?
10. Was it implemented the way they were expecting?
11. What were they expecting? Ask them about this in detail!! Even if they said yes with the previous question. Was their answer (expectations) according to the proposal?
12. Did the project face any problems during the implementation period?
13. Did the project achieve its goals?
14. How is the design of the intervention relevant to the context?
15. How do the proposed interventions have a potential for replication in other governorates?
16. How were the needs, purpose and overall objectives properly defined?
17. How the risks and assumptions were correctly defined?
18. How well has the project been adapted during implementation?
19. How could the intervention have been done better, more cheaply or more quickly?
20. The opinion of community leaders in the targeted area regarding the project.
21. Immediate output on the behavior of beneficiaries.
22. Future expected output on the behavior of beneficiaries.
23. Assess the sustainability of the referral system.
24. How are all planned beneficiaries using or benefiting from the projects' results?

25. How do the beneficiaries perceive the projects' benefits?
26. How is the timing of the intervention relevant from the point of view of the beneficiaries?
27. Success stories and lessons learned according to direct and indirect beneficiaries (please state the person interviewed name, age, gender and occupation)
28. Quotes of direct and indirect beneficiaries (please state the person interviewed name, age, gender and occupation)

29. To what extent, this activity participated in improving the health sector services.
30. To what extend this activity participated in building the PHC staff capacity and in which area

Activity No. 6

Health Care Information System (HIS), another component that was addressed under this project was the development of a Health Information System. The HIS project provides a framework to organize information, manage documents and enable efficient coordination with users (physicians, PHC management, NCD and Mental Health workers) who can access their needs in a familiar and interactive way. Currently the19 model DoHs are connected together with the Ministry of Health in Baghdad via VSAT as a part of the HIS. This project was split into three components:

a. Information technology infrastructure that included procurement of data network infrastructure and HIS equipment. These equipments were procured, delivered to the end user and installed. It is worth mentioning that 19 engineers underwent oversees training to support this system.
b. Software applications involved data base management software for health records, health statistics, surveillance and mapping. This software was installed and capacity building activities were conducted to train 21 statisticians on the usage of the software applications. In line with this component MoH, with the support of WHO, developed 'patients' files' in the 19 model districts that included information on all the families in the catchments area.
c. The Telecommunication and connectivity the network connectivity between MoH Baghdad and DoHs has been installed, and there is a data flow from DoH to MoH Baghdad a vise versa.

Software applications developed under this project and are currently functional includes:

- Communicable diseases.
- Mother Child health
- Family Medicine.

Stakeholders for this activity:

- WHO representative.
- MoH in Baghdad.
- DoH at the governorate level
- HIS operational staff at MoH and DoH level

Field evaluation guidelines:

1. Health Care Information System (HIS) was developed in close cooperation and coordination with MoH senior officials and has been approved. What was the level of cooperation, support and involvement of MoH during the project implementation?

2. What is his/her opinion of the project?
3. Was it implemented the way they were expecting? (government level)
4. What were they expecting? Ask them about this in detail!! Even if they said yes with the previous question. Was their answer (expectations) according to the proposal?
5. Did the project face any problems during the implementation period? (government level)
6. Did the project achieve its goals?
7. How do the proposed interventions have a potential for sustainability?

8. How were the needs, purpose and overall objectives properly defined?
9. Describe the level of cooperation and coordination among DoH at the governorate level and PHCs in the governorate.
10. Are all DoH in the governorates connected to MoH in Baghdad via VSAT as a part of the Health Information System HIS?
11. Is the HIS functioning properly in your governorate (hardware and software)?
12. How is responsible for operating/maintaining the HIS and VSAT hardware and software
13. How is the general and functional condition of the VSAT system in each governorate?
14. Describe VSAT operation staff (hardware and software) training plan and follow up training plan to insure their capability for operating this system
15. What are the benefits of implementing this system to the heath care system in Iraq?
16. In your opinion, what are the lessons learned.
17. Describe the role of MoH / DoH during the implementation of the project. (Planning, implementation and after implementation)
18. To what extent have the agreed objectives been achieved?
19. Assess the output from this intervention.
20. To what extent, this activity participated in improving the health sector services.
21. To what extend this activity participated in building the PHC staff capacity and in which area

Activity No. 7

Public Health Activities, Control of public health threats and the implementation of a systematic surveillance system were partially supported under this programme. Technical and logistical support was provided to prevent and control Malaria and Lesishmaniasis, tuberculosis, Nasocomial Infections, and to implement vaccine management and the Expanded Programme on Immunization (EPI). Moreover, some of the health care provision facilities were assessed and supported either partially or fully, in order to meet the demands. This work involved strengthening public health labs in (Baghdad, Erbil, and Mosul), the central blood bank, National Drug Quality Control Lab, food safety services and enhancing surveillance systems to counteract any public health threats. This entailed training staff, rehabilitation of buildings and/or equipment provision.

Stakeholders for this activity:

- WHO representative.
- MoH
- public health labs in (Baghdad, Erbil, and Mosul)
- the central blood bank
- National Drug Quality Control Lab

Field evaluation guidelines:

1. Assess in general the technical and logistical support provided to prevent and control Malaria and Lesishmaniasis, tuberculosis, Nasocomial Infections, and to implement vaccine management?
2. Did the activities under Public Health Activities achieve its goals?
3. Was it implemented the way they were expecting?
4. What are the strength and weaknesses of the Public Health Activities?
5. In your opinion, what are the lessons learned.
6. In your opinion what are the positive outputs of the Public Health Activities on the short term and long term?
7. Do the positive effects outweigh the negative ones?

8. To what extent have the agreed objectives been achieved?
9. When assessing each activity as a separate module, assess the efficiency in implementing the activity in cross-check with the designed and planed module.
10. How has the intervention affected the wellbeing of different groups of stakeholders?
11. Assess the outputs from this intervention.
12. To what extent, this activity participated in improving the health sector services.
13. To what extend this activity participated in building the PHC staff capacity and in which area

Activity No. 8

School Health, the Action Oriented School Health Curriculum (AOSHC) was adopted in Iraq in 1996 by the health education department, WHO is providing technical and financial support to MoH and MoE and working to strengthening the school health service

Stakeholders for this activity:

- WHO representative.
- MoH

Field evaluation guidelines:

1. Who is in charge of implementing the Action Oriented School Health Curriculum (AOSHC) prgramme (Central level)
2. Please describe in details the progress in designing, planning and implementing the Action Oriented School Health Curriculum (AOSHC)
3. Is the Action Oriented School Health Curriculum (AOSHC) is properly functional
4. What are the challenges facing the Action Oriented School Health Curriculum (AOSHC)
5. What is his/her opinion of the activity?
6. Did the Action Oriented School Health Curriculum (AOSHC) achieve its goals?
7. Did the school students health improved as a result of implementing such programme?
8. Describe the level of cooperation and coordination among MoH and MoE to strengthening the school students health service
9. In your opinion, what are the lessons learned.
10. In your opinion what are the positive effects of this activity on the short term and long term?
11. To what extent have the agreed objectives been achieved?
12. When assessing each activity as a separate module, assess the efficiency in implementing the activity in cross-check with the designed and planed module.
13. How has the intervention affected the wellbeing of different groups of stakeholders?

14. To what extent, this activity participated in improving the health sector services.
15. To what extend this activity participated in building the PHC staff capacity and in which area

Activity No.9

Health Sector Reform, Health Governance, this project has also contributed to the initiation of the health sector reform. Reform efforts included the formulation of policies that have a direct impact on successful transformation from tertiary to primary health care, especially in the areas of health care financing, human resource development, and strengthening district health systems. It also contributed to the review and update of public health legislation and regulations and the improvement of health governance, especially in the area of health information system (HIS). Below are the established policies under this programme.

a. Establishment of National Health Accounts;
b. Financing Options for Iraq's Health Sector;
c. Nursing and Midwifery Strategy for Iraq;
d. Integrated Management of Childhood Illness (IMCI) plan of action

Stakeholders for this activity:

1. WHO representative.
2. MoH

Field evaluation guidelines:

14. Did the below policies were developed and established under this programme?
    e. Establishment of National Health Accounts;
    f. Financing Options for Iraq's Health Sector;
    g. Nursing and Midwifery Strategy for Iraq;
15. Assess the need for these policies
16. In your opinion what are the positive and negative effects of these policies on the short term and long term?
17. To what extent have the agreed objectives been achieved?
18. When assessing each activity as a separate module, assess the efficiency in implementing the activity in cross-check with the designed and planed module.
19. How has the intervention affected the wellbeing of different groups of stakeholders?
20. Assess the outputs from this intervention.
21. To what extent, this activity participated in improving the health sector services.
22. To what extend this activity participated in building the PHC staff capacity and in which area
23. Are there any other heath issues that need to be put into policy?

Activity No. 10

Iraq Family Health Survey (IFHS), the IFHS is the first comprehensive Family Health Survey to be conducted in Iraq. The survey took place in 2006/2007 under the authority of the MoH in partnership with the MoPDC/ the Central Organization for Statistics and Information Technology (COSIT), the MOH/Kurdistan Region (MoHK) and the Kurdistan Regional Statistic Office. Technical support was provided by the WHO. The principle objective is to provide policy, decision makers and researchers with a reliable, useful and relevant database for the development of health and population policy. A group of national and international experts-demographers, epidemiologists and health professionals from implementing ministries and agencies designed the survey. IFHS was a

nationally representative survey of 9,345 households and 14,675 women of reproductive age and covers all governorates in Iraq. A Steering Committee was formed to oversee the management of the implementation. This committee comprised of representatives from each of the key partners and was headed by the Technical Deputy Minister of Health with representatives from the MoH, COSIT and the MoHK. IFHS required 112 survey teams, 224 interviewers (112 males and 112 females) 100 supervisors (21 central, 20 local and 59 field supervisors), 23 central editors, 55 trained data entry personnel and data programme as well as specialists in census and survey processing systems. The results of this survey indicate that access to essential health services is a major problem for the conflict-affected communities. This has adversely affected public health programmes such as immunization, maternal and child health and nutrition.

Stakeholders for this activity:

3. WHO representative.
4. Members of IFHS Steering Committee

Field evaluation guidelines

31. What is his/her opinion of the Family Health Survey?
32. What were the survey major findings?
33. Did the MoH use and benefit from the results of this survey? Give examples and case studies as prove the MoH utilized the nationwide survey outputs in planning and decision making process
34. Did the survey face any problems during the planning period?
35. Did the survey achieve its goals?
36. Was it worthy to implement such survey? Did MoH use the data obtained from that survey?
37. How is the design of the survey relevant to the context?
38. How were the needs, purpose and overall objectives properly defined?
39. Did the steering committee and executive committee meet regularly?
40. Describe the level of cooperation between WHO and MoH in the Iraq Family Health Survey (IFHS).
41. To what extent, the results of this survey will participate in improving the health sector services.

Activity No 11

Basic Health Service Package Developed (BHSP), a Basic Health Service Package is defined as a minimum collection of essential health services that all population need to have a guaranteed access to. Essential services are health services that provide a maximum gain in health status on the national level, for the money spent. The elements of this package includes; 1) health education; 2) maternal and newborn health; 3) child health and immunization; 4) communicable disease treatment and control; 5) food safety; 6) environmental health; 7) school health; 8) non-communicable disease prevention and control; 9) emergency care; 10) nutrition; 11) essential medicine; 12) immunization: 13) diagnostic services: 14) mental health. The BHSP has been finalized and adopted by the MoH. This package will be implemented in selected districts during the implementation of SPHC System phase II. The process started with a review of the health status of the Iraqi population to determine major health problems and to identify health services essential for addressing these problems. The PHC network was also assessed in terms of its infrastructure and human resources so as to determine the scope and type of services it is capable of delivering. The package was developed by a core team of MoH specialists with expertise in all relevant areas. The

role of the consultants (EPOS Health Consultants) under the SPHCS project was merely facilitative and advisory. The collaborative process involved several months of assessment and planning and capitalized on existing studies and previously completed work:

a. A Planning Workshop was held in Amman in March 2008 with the purpose of defining the product, agreeing on a conceptual framework and brainstorming about the content of the BHSP.
b. An assessment of health status and infrastructure was conducted to identify the current health priorities in Iraq. The analysis was rapid and relied on secondary data sources since the focus was to feed into the package rather than conduct a thorough situational analysis.
c. The content of the package (as defined by the services to be delivered at the different levels of the PHC network) was drafted by the relevant MoH experts. A participatory process was used to deal with cross-cutting issues. Several rounds of email and phone exchanges were utilized to refine and reach consensus on the content.
d. The trade-off between what's affordable or doable and what's ideal was the biggest challenge that the team had to struggle with given the current implementation realities in Iraq.
e. With the technical assistance of the SPHCS consultants, equipment and essential drug lists for the agreed upon services to be included in the BHSP, were drafted.

Stakeholders for this activity:

- WHO representative.
- MoH

Field evaluation guidelines

1. What is his/her opinion of the BHSP?
2. Who is in charge of drafting this Package?
3. What are the efforts, plan that MoH implementing to achieve this?
4. How is the design of the BHSP relevant to the context?
5. How were the needs, purpose and overall objectives properly defined?
6. Describe the level of cooperation with MoH

Activity No. 12

Primary Health Care (PHC) Training Manuals, under this project, comprehensive, nationwide PHC Training Manuals were drafted. These manuals have been initially reviewed by 26 MoH experts and WHO Iraq technical staff during a workshop held in Amman June 2007 to ensure that they were scientifically correct, culturally sound, and factually consistent. The package of modules was finalized during a meeting held in Amman in December 2007 and Training of trainers completed consisting of 20 multidisciplinary staff working at sector and PHC level. The principle aim of these manuals is to enhance the PHC staff competencies in acquiring the skills of knowledge management these manuals are a guide for future national trainings using the updated and feasible accessible teaching and training methodologies to transmit health messages the manual consist of 10 prioritized training modules:

a. Reproductive Health,
b. Child Health and EPI,
c. Communicable Diseases,
d. Non Communicable Diseases,

e. School Health,
f. Oral Health.
g. Mental Health
h. Environmental Health
i. PHC Management guide
j. Nutrition and food safety.

Stakeholders for this activity:

- WHO Iraq technical staff.
- MoH experts drafting the Primary Health Care (PHC) Training Manuals.

Field evaluation guidelines:

1. What is his/her opinion of the training Manuals?
2. What were they expecting? Ask them about this in detail!!
3. Who is in charge of drafting and developing these manuals?
4. What are the efforts, plan that MoH putting to achieve this?
5. How is the design of the training manuals relevant to the context?
6. How does the proposed training manual have a potential for replication?
7. How were the needs, purpose and overall objectives properly defined?
8. How did the health care staff receive the training? (The package of modules was finalized during a meeting held in Amman in December 2007 and Training of trainers completed consisting of 20 multidisciplinary staff working at sector and PHC level)
9. What was the period of the training sessions? Was it enough or you should have more time?
10. What are the strength and weaknesses of the training Manuals?
11. In your opinion what are the subjects that weren't covered in training Manuals and you believe it's important for you and other health care staff to be considered in the future?
12. Describe the level of cooperation with MoH
13. Assess the need for these manuals and will it be useful at the PHC level nationwide once implemented and distributed

Activity 13

The Integrated Management of Childhood Illness (IMCI); IMCI was another new concept that has been integrated within the PHC programme. The aim of implementing IMCI programme is to reduce the under 5 (U5) child morbidity and mortality rate by combating the three main killing diseases: acute respiratory tract infections, acute diarrhoeal diseases and malnutrition by increasing detection rates and actions taken by the health care staff. This project component was piloted in 27 PHCCs in four different governorates: Baghdad (Karkh and Rassafa), Ninwa, Naseryia and Babel.

Stakeholders for this activity:

- WHO representative.
- Directors and doctors of 27 PHCCs in four different governorates: Baghdad (Karkh and Rassafa), Ninwa, Naseryia and Babel
- Director of health in Baghdad (Karkh and Rassafa), Ninwa, Naseryia and Babel
- Direct beneficiaries.
- Sheikhs and community leaders.

Field evaluation guidelines

1. What is his/her opinion of the IMCI?

2. What were they expecting? Ask them about this in detail!! Even if they said yes with the previous question. Was their answer (expectations) according to the proposal?
3. Did the IMCI achieve its goals?
4. How is the design of the Integrated Management of Childhood Illness (IMCI) relevant to the context?
5. How do the proposed interventions have a potential for replication?
6. WHO has worked and closely coordinated with UNICEF in this project, the major activities that were coordinated under this project with UNICEF were:

- Integrated Management of Childhood Illness (IMCI)
- Initiation of the Family Physician Practice
- Expanded project of Immunization (EPI) and nationwide MMR immunization campaign
- Did all above activities with UNICEF have been achieved?

7. Are IMCI activities under implementation in your PHC and achieving results?
8. To what extent have the agreed objectives been achieved?
9. How this intervention could participate in improving the health care system?
10. How has the intervention resulted in benefits going to unintended beneficiaries? Is there a coverage bias in terms of the intended beneficiaries? For example, religion, ethnicity or race been excluded?
11. Measure the outpus of this project and especially in enhancing the health care system
12. Gather lessons learned and success stories.
13. How are the successfully achieved activities sufficient to realize the agreed outputs?
14. What could be done to make the intervention more effective?
15. To what extend this activity participated in building the PHC staff capacity and in which area

Activity No. 14

Community participation in decision making and health service provision, community participation means the involvement of the community members in assessment, analysis, decision making, planning and programme implementation, as well as in all the activities from research and rescue to reconstruction. The Community Based Initiative (CBI) programme under this output focused on: enhancing access to basic quality health services that meet the needs of the population; CBI included 2 projects; 1.) Basic Development Needs (BDN); 2.) Healthy Cities, WHO implemented the CBI in 9 areas geographically distributed in North, South and the Centre and two cities (Falluja and Sader City). The implementation structure included the formalization of a National Committee consisting of 15 Government institutions in addition to Sunni and Shia Waqf. The implementation structure also included a national focal point within the MoH who acted as the project manager and worked closely with the national and local councils, directors of health in each governorate and cluster representatives who were elected by the community in the 9 localities. It is worth noting that all activities under this project were cost-shared with the Government and community resources. Awareness raising and sensitization of: policy makers, health professionals, and community leaders to introduce the concept of PHC.

Stakeholders for this activity:

- WHO representative.
- CBI National Committee (9 locations. i.e 9 committees)
- CBI national focal point within the MoH – project manager
- Local councils in the **9** governorates.
- Director of health in the **9** governorates.
- Direct beneficiaries.
- Sheikhs and community leaders.

Field evaluation guideline

1. What is his/her opinion of the project?
2. Did the project achieve its goals?
3. How is the design of the CBI relevant to the context?
4. How do the proposed interventions have a potential for replication?
5. How were the needs, purpose and overall objectives properly defined?
6. To what extent does the CBI contribute to capacity development and the strengthening of institutions?
7. Describe the activities of The Community Based Initiative (CBI) programme that had been implemented in 9 areas geographically distributed in North, South and the Centre and two cities (Falluja and Sader City). The implementation structure included the formalization of a National Committee consisting of 15 Government institutions in addition to Sunni and Shia Waqf.
8. Assess the immediate output on the behavior of beneficiaries.
9. Assess future output on the behavior of beneficiaries.
10. What are strength and weaknesses?
11. Are all planned beneficiaries using or benefiting from the CBI results?
12. How do the beneficiaries perceive the CBI benefits?
13. Success stories and lessons learned according to direct and indirect beneficiaries (please state the person interviewed name, age, gender and occupation)
14. Quotes of direct and indirect beneficiaries (please state the person interviewed name, age, gender and occupation)
15. In what awareness session did you participate in (date, location and session subject)
16. Did the awareness sessions contribute in raising awareness of community leaders to introduce the concept of PHC?
17. Were the awareness sessions clear and easy to understand by the beneficiaries?
18. Did the beneficiaries attend to these sessions regularly?
19. Were there discussions during the sessions?
20. How did the behaviour of beneficiaries changed as a result of the awareness sessions?
21. Did the beneficiaries apply the information from the sessions in their daily behaviour?
22. Assess the outputs from this intervention.
23. To what extent, this activity participated in improving the health sector services.
24. How are the successfully achieved activities sufficient to realize the agreed outputs?
25. What could be done to make the intervention more effective?
26. To what extend this activity participated in building the PHC staff capacity and in which area

Activity No. 15

Emergency Response; part of the WHO emergency response was supported under this programme. WHO supported MoH in the provision of medicine and medical supplies including life saving items, water quality control kits for water testing for environmental contamination and limited emergency medical oxygen supplies for the use of 57 hospitals during 2005 emergencies that served a total population of 9 million people.

Stakeholders for this activity:

- WHO representative.
- MoH

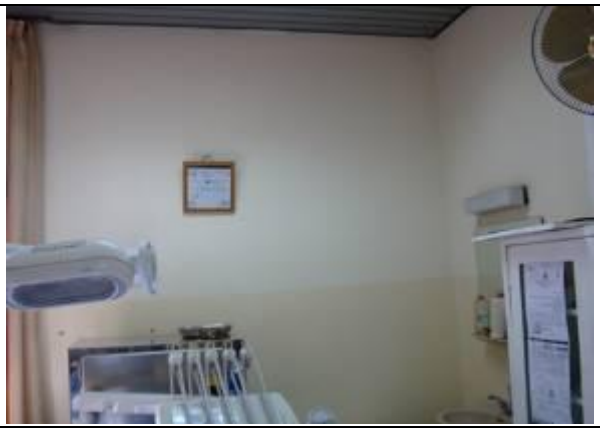
Field evaluation guidelines:

1. Did medicine and medical supplies (including life saving items, water quality control kits for water testing for environmental contamination and limited emergency medical oxygen supplies for the use of 57 hospitals during 2005 emergencies that served a total population of 9 million people) have been delivered to MoH?
2. Were all the 57 hospitals benefited from the Emergency Response activities as a respond to the response to the emergencies on ground
3. Assess the geographical distribution of the 57 benefited hospitals

4. What are the challenges facing the Emergency Response activities?
5. What is his/her opinion of the Emergency Response activities?
6. Did the Emergency Response activities achieve its goals?
7. Are all planned beneficiaries using or benefiting from the projects' results?
8. In your opinion what are the positive and negative outputs of implementing the Emergency Response?
9. To what extent have the agreed objectives been achieved?
10. Assess the output from this intervention.
11. To what extent, this activity participated in improving the health sector services in Iraq

Annex H: SPHCS Pictures

	
Baghdad / Rehabilitation & supplying of Al Nafti PHCC	Baghdad / Rehabilitation & supplying of Al Nafti PHCC
	
Baghdad / Al Nafti PHCC Ambulance	Baghdad / Al Nafti PHCC Ambulance
	
Baghdad / Rehabilitation & supplying of Al Jesser PHCC	Baghdad / Rehabilitation & supplying of Al Jesser PHCC

	
Baghdad / Rehabilitation & supplying of Al Jesser PHCC	Baghdad / Rehabilitation & supplying of Al Jesser PHCC
	
Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities	Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities
	
Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities	Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities

Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities

Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities

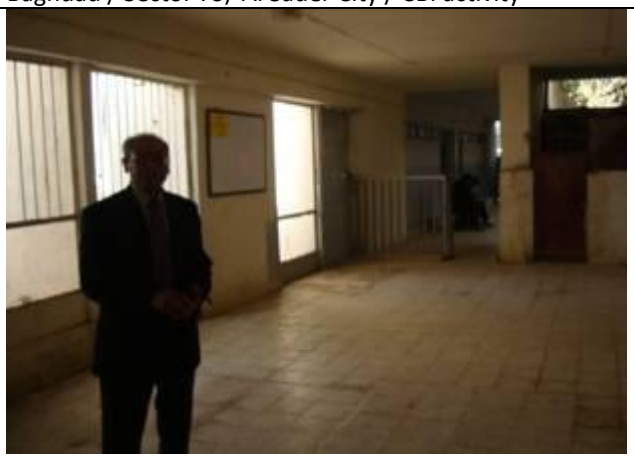
Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities

Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities

Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities

Baghdad / Al Salam PHCC/Al Tobchi / Family Physician Model & Referral system activities

	
Refferal cards	Refferal cards
	
Ambulance	SOC evaluator checking the Ambulance
	
Baghdad / Al Entesar Village / WTU / CBI activity	Baghdad / Al Entesar Village / WTU / CBI activity

	
Baghdad / Sector 79/ Al Sader City / CBI activity	Baghdad / Sector 79/ Al Sader City / CBI activity
	
Baghdad / Rehabiliattion of garden in Sector 79/ Al Sader City / CBI activity	Baghdad / Rehabilitation of School in Al Entesar village / CBI activity
	
Baghdad / Rehabilitation of School in Al Entesar village / CBI activity	Baghdad / Rehabilitation of school / Sector 79/ Al Sader City / CBI activity

	
Baghdad / Rehabilitation of school / Sector 79/ Al Sader City / CBI activity	Baghdad / Rehabilitation of school / Sector 79/ Al Sader City / CBI activity
	
Baghdad / Al Entesar village / small shops, small projects / CBI activity	Baghdad / Al Entesar village / building of new shops / CBI activity
	
Baghdad / Al Entesar village / Land where PHCC will be build / CBI activity	Baghdad / Al Entesar village / Land where PHCC will be build / CBI activity

	
Baghdad / Sector 79/ Al Sader City / school to be build during the next few months / Iran street/ CBI activity	Baghdad / Sector 79/ Al Sader City / generators / CBI activity
	
Baghdad / Sector 79/ Al Sader City / generators / CBI activity	Baghdad / Sector 79/ Al Sader City / generators / CBI activity
	
Babel / Rehabilitation & supplying of Al Musayab PHCC	Babel / Rehabilitation & supplying of Al Musayab PHCC

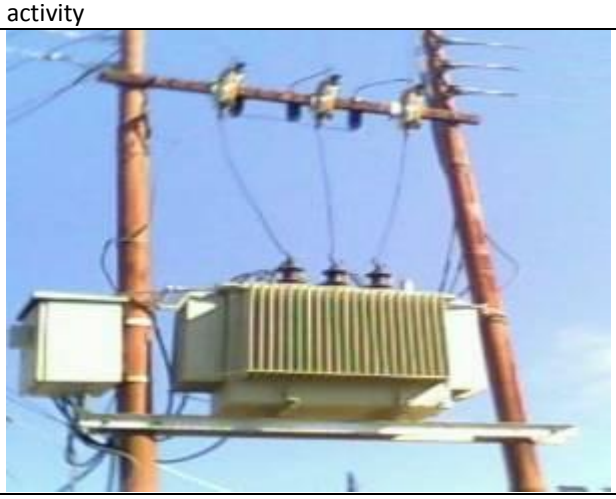
	
Babel / Rehabilitation & supplying of Al Musayab PHCC	Babel / Rehabilitation & supplying of Al Musayab PHCC
	
Babel / HIS activity	Babel / HIS activity
	
Basra / Rehabilitation & supplying of Al Baten PHCC	Basra / Rehabilitation & supplying of Al Baten PHCC

	
Basra / Rehabilitation & supplying of Al Baten PHCC	Basra / Rehabilitation & supplying of Al Baten PHCC / new computers
	
Basra / Rehabilitation & supplying of Al Shifaa PHCC	Basra / Rehabilitation & supplying of Al Shifaa PHCC
	
Basra / Rehabilitation & supplying of Al Shifaa PHCC	Basra / Rehabilitation & supplying of Al Shifaa PHCC / new dental chair

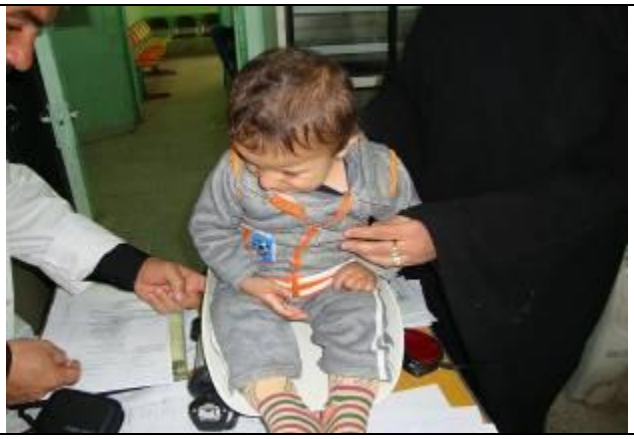
	
Basra / Training hall	Basra / Training hall
	
Basra / Ez Al Deen Saleem PHCC / Family Physician Model & Referral system activities	Basra / Ez Al Deen Saleem PHCC / Family Physician Model & Referral system activities
	
Diwania / Al Diwania PHCC	Diwania / Al Diwania PHCC

	
Diyala / Rehabilitation & supplying of Ba'aqwba PHCC	Diyala / Rehabilitation & supplying of Ba'aqwba PHCC
	
Diyala / Rehabilitation & supplying of Ba'aqwba PHCC	Diyala / Rehabilitation & supplying of Ba'aqwba PHCC
	
Karbalaa / Al Hindiya PHCC	Karbalaa / Al Hindiya PHCC
	
Karbalaa / Al Hindiya PHCC	Karbalaa / Training Hall

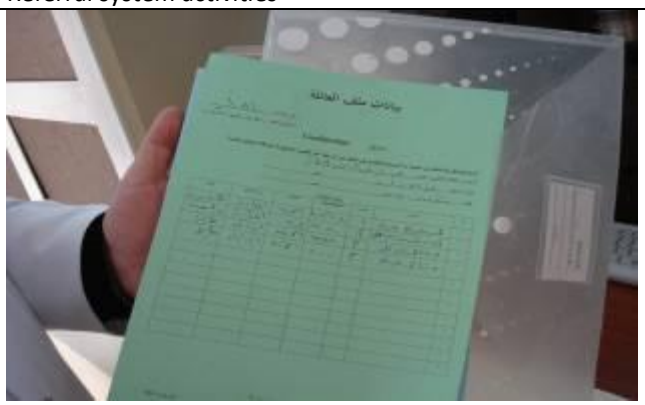
	
Najaf / Training Hall	Najaf / Training Hall
	
Missan / PHCC/Al Mualemen Collage	Missan / PHCC/Al Mualemen Collage
	
Missan / Training Hall	Missan / Training Hall

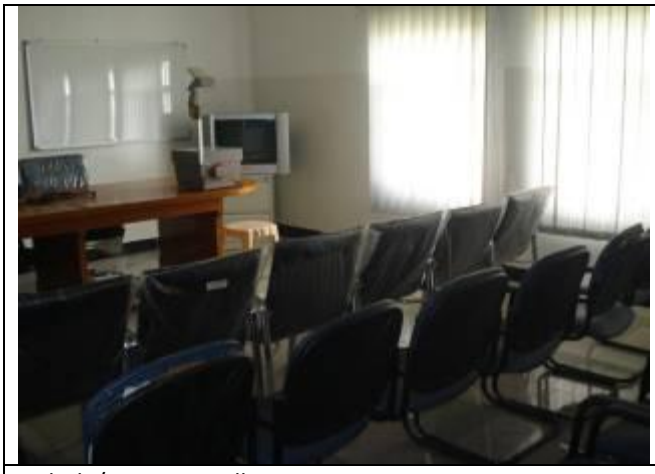
	
Missan / Al Mujbes village / Al Musharah district / CBI activity	Missan / Al Mujbes village / Al Musharah district / CBI activity
	
Missan / Al Mujbes village / Al Musharah district / CBI activity	Missan / Al Mujbes village / Al Musharah district / CBI activity
	
Muthanna / Al Najmi PHCC/Al Remetha district	Muthanna / Al Najmi PHCC/Al Remetha district

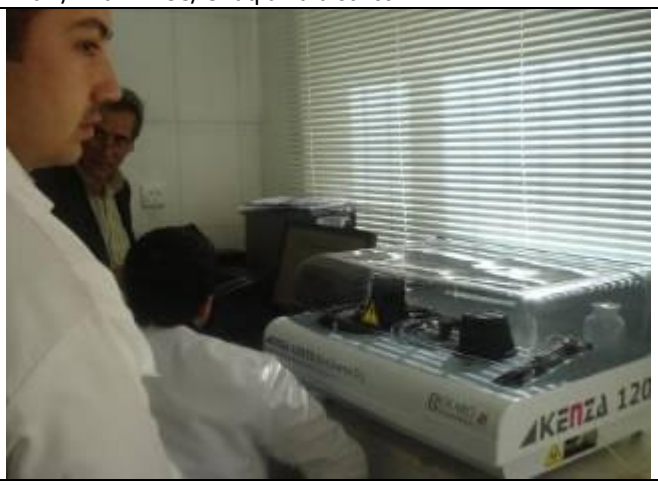
	
Salah Al Din / Al Tawheed PHCC	Salah Al Din / Al Tawheed PHCC
	
Salah Al Din / Training Hall	Salah Al Din / Training Hall
	
Salah Al din / HIS activity	Thi Qar / Al Razy PHCC / IMCI

	
Thi Qar / Al Razy PHCC / IMCI	Thi Qar / Al Razy PHCC / IMCI
	
Thi Qar / Al Salman village / CBI activity	Thi Qar / Al Salman village / CBI activity
	
Thi Qar / Al Salman village / CBI activity	Thi Qar / Al Salman village / CBI activity

	
Thi Qar / Al Salman PHCC / CBI activity	Thi Qar / Al Salman PHCC / CBI activity
	
Wassit / Al Razy PHCC/Al Sowaira district	Wassit / Al Razy PHCC/Al Sowaira district
	
Wassit / Al Razy PHCC/Al Sowaira district	Wassit / Al Razy PHCC/Al Sowaira district

	
Mosel / AL Qudos PHCC / / Family Physician Model & Referral system activities	Mosel / AL Qudos PHCC / / Family Physician Model & Referral system activities
	
Mosel / AL Qudos PHCC / / Family Physician Model & Referral system activities	Mosel / AL Qudos PHCC / / Family Physician Model & Referral system activities
	
Kirkuk / HIS	Duhuk / HIS

	
Duhuk / Training Hall	Duhuk / Training Hall
	
Duhuk / Al Aqrah PHCC	Duhuk / Al Aqrah PHCC
	
Duhuk / Al Aqrah PHCC	Duhuk / Al Aqrah PHCC

	
Erbil / Erbil PHCC/ Shaqlawa district	Erbil / Erbil PHCC/ Shaqlawa district
	
Erbil / Erbil PHCC/ Shaqlawa district	Erbil / Erbil PHCC/ Shaqlawa district
	
Sulaymania /Training Hall	Sulaymania /Training Hall

	
Sulaymania / Mahmood Sidree PHCC/ Dokan City	Sulaymania / Mahmood Sidree PHCC/ Dokan City

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