EXTERNAL EVALUATION REPORT

EMERGENCY PUBLIC HEALTH ASSISTANCE; STRENGTHENING NON-COMMUNICABLE DISEASES AND MENTAL HEALTH CONTROL AND PREVENTION PROGRAMME (D2-05)

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Abbreviations and Acronyms

CDC	-	Centres for Disease Control
CIDI	-	Composite International Diagnosis Interview
COSIT	-	Centre of Statistical Information Technology
CVD	-	Cardio Vascular Diseases
DOH	-	Directorate of Health
FCTC	-	Framework Convention on Tobacco Control
GOI	-	Government of Iraq
IFHS	-	Iraq Family Health Survey
ITF	-	Iraq Trust Funds
MDG	-	Millennium Development Goals
MH	-	Mental Health
MoH	-	Ministry of Health
NDS	-	National Development Strategy
NCD	-	Non-Communicable Diseases
NGOs	-	Non-Governmental Organization
PHC	-	Primary Health Care
PHCU	-	Primary Health Care Unit
SOT	-	Sector Outcome Team
SOC	-	Stars Orbit Consultants
UNEG	-	United Nations Evaluation Group
UNDG	-	United Nations Development Group
UNICEF	-	United Nations Children Emergency Fund
USAID	-	United States Agency for International Development
WHO	-	World health Organization

Executive Summery

The main goal of the Strengthening Non-Communicable diseases (NCD) and Mental Health (MNH) Prevention and Control program is to improve the prevention and control activities of Non-Communicable Diseases and Mental Health services with special emphasis on community based initiatives in Iraq. The developmental goals for the project are to contribute to the reduction of mortality and morbidity due to Non-Communicable Diseases which constitute the main causes of death among adult population and morbidity due to mental health disorders of the crisis affected population in Iraq.

The immediate objectives of the project are outlined under the section Project under evaluation objectives (2.c) below.

The total project budge approved by UNDG Iraq Trust Fund Steering Committee was USD 11, 000,000. Funds were received into WHO on the 21st September 2004 – the official start date of the project. All funds were earmarked from the Japanese government. This budget was allocated to cover the cost of the following component activities:

- Supplies and Equipment: USD 3,270,000
- Contracts: USD 3,270,000
- Training: USD 890,000
- Personnel: USD 475,600
- Miscellaneous: USD 630,000
- Agency Support Costs: USD 622,641

The original project duration was from September 2004 to 31 December 2005. However, four extensions were approved; the last one covered the period July-December 2008. The project has been operationally closed by 31 December 2008.

WHO's major implementation partner was the Ministry of Health. All WHO programmes are implemented by MoH staff with the active participation of WHO national staff in Iraq who are considered experts in their specified technical areas. Other ministries are those of Education, Higher Education, Environment, Human rights, Finance and Planning. In addition a number of organizations were involved in the implementation of this programme including international NGOs e.g. Christian Blind Mission (CBM). Moreover, a number of private contractors were hired for the rehabilitation and construction of mental health facilities including the Imar Company, Al Bayena Company, Al Baqee and Areedo, Rasheed Alwah Company, Mohammed Salman, Khudier Abbas and Al-Nawars.

The Iraqi population as a whole has benefited from various public health activities of this project through support in the following areas: rheumatic fever control; improved surveillance of cancer, cardiovascular disease and diabetes; screening of hypertension and diabetes; rehabilitation of existing psychiatric units; construction of new psychiatric units; surveys in areas of non-communicable diseases risk factors, mental health and substance abuse; prevention and control of blindness; provision of essential medical supplies and equipment and violence and injury surveillance.

The implementation phase of the project has witnessed a complex and volatile security situation. The 2005-2007 time periods was referred to as the 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 migration of the 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 of movement have also affected the implementation of this project resulting in prolonged and extended implementation period.

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 spite of the significant, but unavoidable delay in implementation, all planned project activities were fully completed or initiated.

In the area of non-communicable diseases, prevention and control, a national survey on NCD risk factors was conducted for the first time in Iraq through which base line data were established, a standardized framework for surveillance of cardiovascular diseases, diabetes and cancer was established, a pilot project for screening for hypertension and diabetes was introduced in (41) PHC centers, the cancer registry was strengthened, a multi-sectoral committee was established for promotion of healthy lifestyles and primary prevention of NCDs, services for rheumatic heart disease, as well as for control and prevention of blindness were introduced/strengthened.

In the area of mental health, situation analysis of mental health needs was assessed; the functioning of existing mental health facilities was strengthened; training to improve the quality of mental health care within primary heath care centers carried out; services for the prevention and management of common mental disorders provided; mental health services in the schools established. In addition, situation analysis about substance abuse was undertaken and a system for flow of data was established.

However, sustainability of all these achievements remains much dependent on the continued commitment of the MoH and its staff at all levels, allocation of necessary running costs, continued supervision and monitoring as well as continued efforts to develop the technical capacity of staff at all levels.

- The precarious security situation that prevailed all through the project implementation phase and the counter measures taken to address security concerns, have had adverse consequences on project development and implementation including restriction of movement of international staff and national teams, disruption of training activities, conduct of studies and research and procurement, delivery of supplies and equipment.

  However, the STEP wise surveillance survey was conducted in early 2006 where the country has foreseen the maximum escalation of sectarian violence

- This was compounded by rapid turn-over of MoH staff at all levels, conflict between various departments, lengthy bureaucratic procedures within the government and the UN and overlap between the work of the government ,NGOS and WHO.

- National staff interviewed during the field evaluation reported that difficulties were encountered during the NCD survey and screening for NCDs because some people did not accept to provide blood samples for testing .However, this did not affect the results because the response rate was generally high.

A) Recommendations for WHO and MoH:

1. All project components were implemented over five year interval instead of the original period (September 2004 – 31 December 2005).

   Under emergency situations there is always a tendency to blame delays and deficiencies on the security situation. Although the adverse effects of the unstable security situation cannot be denied or under-estimated, nevertheless WHO and MoH should maintain their longstanding cooperation in order to identify and address other contributing factors that hinder implementation, in order to develop plans to overcome these obstacles in the future.

2. The approach adopted in the development of the NCD prevention and control strategy and prevention and control of mental disorders is appropriate, feasible, practical and cost-effective. However, optimal results can be obtained through this approach by expanding its scope country-wide and ensuring its future sustainability by maintaining high level of political commitment, allocation of the necessary financial resources and further development of human resources at management and service delivery levels in order to promote national ownership of the system and strengthen multi-sectoral partnerships.

3. Commendable efforts were exerted through the fellowship programme, training, workshops, meetings and conferences both in-country, inter-country and abroad.

   However, plans should be developed to ensure that core teams of train-the-trainers are established in every governorate and district to transfer knowledge and skills to those who were not trained. This should be complemented by refresher training courses, on-the-job training and ongoing monitoring and supervision of staff performance at the management and service delivery level to ensure that the investment made through this project is not wasted or compromised.

4. Cardiovascular diseases, diabetes and hypertension are leading causes of morbidity and mortality both in developed and developing countries .Management of these diseases requires good knowledge of and full compliance with the recommended management protocols, selection of the appropriate treatment regimen for each individual case, continuous supply of the life-saving medicines and regular monitoring of treatment outcomes. To achieve best results, MOH should consider a gradual paradigm shift from control of blood sugar and pressure levels to risk-based treatment decisions, of patients with diabetes and/or hypertension.

5. Patients with established coronary heart disease and cerebrovascular disease should be targeted for secondary prevention through counseling and provision of essential drugs. This would reduce recurrent heart attacks and strokes by 75%, improve cost-effectiveness of the programme and reduce morbidity and mortality.

6. Patients' self-reliance and ability to contribute to own health and management of NCDs should be strengthened through targeted programmes that improve patient competence and skills for the use of self monitoring instruments such as blood pressure and blood glucose testing. This would help to improve self-monitoring skills and reduce health staff work loads.

7. MoH should carry out in-depth technical evaluation of the NCD programme in close cooperation with WHO technical staff in order to assess completeness of individual patient records, technical competencies at the PHC level and their compliance with the

standard management protocols as well as to assess treatment outcomes of hypertension and diabetes in terms of complications and control status.

8. The emphasis on primary prevention of NCDs as well as early detection and management of emotional and behavioral disorders should be further developed within a multi-sectoral approach involving the health and education sectors, community organizations and mass-media. Not only that this helps to promote healthy lifestyle behavior, but it also helps to reduce the burden of these diseases ahead the need to meet the high cost of treating their complications and disabling effects.

9. Parents and school teachers are better placed to detect sudden decline in school performance and identify emotional or behavioural changes among school children because they spend longer times with them and can observe signs of deviation from normalcy. Social networks should be established to link with facilities and primary health care team members and school teachers should be trained up to competency level on the essential of mental health care. The training should focus on the recognition of commons mental disorders, psychological counseling and support using non-pharmacological interventions. With an

   appropriate referral system, psychiatrists should act as resource persons to guide the mental health programme and monitor rational prescribing of mental drugs that could increase the risk of drug abuse.

10. Integration of mental health care into primary health care services and schools remains the most cost-effective approach towards reducing expensive institutionalized care, because it facilitates social integration of affected persons and provides better opportunities for early intervention before psychological disorders develop to long-term mental illness.

    The initiatives undertaken through this project should therefore, be strengthened and expanded with special emphasis on targeting women, children and victims of violence, who are the most vulnerable groups in conflict situations.

11. There is traditionally a tendency on part of trained health professionals to assume roles, beyond their skills and competencies that should be reserved to fully qualified psychiatrists, MH training should focus on developing the capacity of health professionals at the PHC level on early detection of behavioural disorders and providing counseling support with minimal use of pharmacological treatment. This would avoid malpractice and misuse of mental drugs but it requires an effective referral system and feedback between the primary and secondary health care levels.

12. Because of the social stigma and fear of punitive measures, victims of substance abuse, hesitate to seek medical assistance. Iraq is situated in an area that is plagued by production and cross-border illicit trafficking of narcotics through neighbouring countries especially Turkey and Afghanistan.

    The long state of violence in the country might have also contributed to the spread of substance abuse.

    In the light of the above, it would be un-realistic to assume that the database on substance abuse reflects the actual prevalence in the country. More concerted effort should therefore, be exerted to conduct further situation analysis targeting high risk groups including ex-prisoners, detainees, former military personnel and physically impaired victims of violence.

13. Equipment should be provided to staff at the PHC level and staff trained on the use of information technology and computerization of data. Data management systems should be used for regular monitoring of non-communicable disease treatment outcomes and follow-up of patients. This can be done through phased implementation consistent with availability of funds and plans for human resource development. Data that is collected but not analyzed and shared stretches the capabilities of the already overburdened staff but remains of limited use for drawing conclusions and guiding policy -decisions.

14. Efforts should be exerted to decentralize decision-making processes and action-oriented activities within the framework of MoH approved policies and strategies. This will support the process of in institutional capacity building and reduce reliance on top management at central levels.

    Besides, it will help to overcome the difficulties of maintaining effective supervision and oversight of the programme. This is especially important if the current difficulties continue

    to impede effective communication and interaction between the MoH officials at the central level and the various governorates/districts.

15. Use of modern medical equipment at the PHC level requires adequate orientation of staff on the operation and regular calibration of the equipment .There should also be a system for carrying out regular preventive maintenance to ensure that the equipment remains functional and that services are not disrupted. For this purpose , all future procurements should be made through pre-qualified international suppliers, who meet the criteria of good manufacturing and who are able to provide after sale maintenance and repair services.

16. According to WHO country office basic indicators, the available provision of PHC facilities per 10,000 Population is 0.6. During interviews, MoH staff reported that the daily workloads of medical personnel can be as high as 150 consultations .Based on these statistics, the available provision of PHC facilities in the country needs to almost be doubled over a reasonable period of time, if comprehensive NCD and MH care are to be provided through these facilities. Iraq does not lack the resources to rehabilitate and expand its infrastructure of PHC facilities but rather needs the stability and the will to implement development plans that are responsive to the basic needs of the population, both in urban and rural areas.

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 health Care components (that were 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 country wide, 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 equipments, 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.

Of major concern to WHO and MoH Iraq was the increased incidence of morbidity, disability and mortality from non-communicable diseases such as cardiovascular diseases, diabetes mellitus and cancers, as well as the increased incidence of violence-related psychological and mental disorders.

2) Project Description

On top of the common risk factors, which contribute to the increased morbidity, disability and mortality from non-communicable diseases world-wide, the Iraqi population has been exposed to additional risks that renders the epidemiological situation rather fragile due to the negative impact of the prolonged violence and insecurity, increased poverty, poor access to power and water supply, lack of proper sewerage and drainage facilities, augmented possibilities for drug abuse, increased internal migration and increased incidence of stress-related mental disorders.

The project for strengthening non-communicable diseases and mental health control and prevention programme was launched by WHO to assist the MoH of Iraq develop policy, strategy, capacity and targeted interventions to address the burden of NCDs and MH.

The project was funded by the UNGD-ITF at USD11 millions, earmarked to be UN cluster: health and Nutrition.

The original duration of the project was September 2004 – 31 December 2005. However, the following extensions were approved:

i) Extension until February 2006
ii) Extension until June 2006

iii) Extension until 31 December 2007
iv) Extension until 31 December 2008

The main goal of the Strengthening Non-communicable Diseases (NCD) and Mental Health (MH) Prevention and Control project was to improve the prevention and control activities of Non-communicable Diseases and Mental Health services with special focus on integrating them within the Primary Health Care (PHC) system in Iraq. The developmental goals for the project were to contribute to the reduction of mortality and morbidity due to Non-communicable Diseases which constitute the main causes of death among adult population and morbidity and to reduce morbidity due to mental health disorders of the crisis affected population in Iraq.

Immediate objectives for NCDs were described as follows:

1. To assist MOH in carrying out needs assessment to obtain representative baseline data about major risk factors on NCDs and in establishing a surveillance system for NCDs including a well functioning cancer registry.
2. To support MOH in developing and in initiation the implementation of comprehensive multi-sectoral strategy for NCDs covering surveillance, prevention and management of common diseases.
3. To support MOH in establishing model projects for integrating health care of people with common NCDs into PHC.
4. To assist MOH in supporting the urgent needs of health facilities dealing with chronic diseases – cancer, CVD, and diabetes.

Immediate objectives of the Mental Health component of the project were:

1. Assess the mental health situation including substance abuse and analyze the local cultural context that determines mental health planning.
2. Upgrade mental services provided by the health facilities.
3. Improve types and quality of services through training to cover promotive and preventive services including school mental health and rehabilitation.
4. Initiate national substance abuse data collection system.

The project activities comprised of the following:

1. Establishing a standardized baseline data on common NCD risk factors and causes of injuries.
2. Strengthening the surveillance system for cardiovascular diseases, diabetes, and violence-related injuries.
3. Integration of hypertension and diabetes care into PHC services.
4. Strengthening the national cancer registry system.
5. Establishing a multi-sectoral committees and plan for the promotion of healthy lifestyles and primary prevention of NCDs.
6. Introduce health services for rheumatic heart disease.
7. Strengthening services for prevention and control of blindness with focus on primary eye care and establishing a baseline data on avoidable causes of blindness
8. Assessing mental health needs.
9. Strengthening the functioning of existing mental health facilities.
10. Conduct training to improve the quality of mental health care within PHC services.
11. Providing services for prevention and management of common mental disorders.
12. Establishing mental health services in schools.
13. Carrying out a situation analysis to assess substance abuse and establishing a system for flow of data.
14. Construction of new and rehabilitation of existing mental health units in selected hospitals.

3) Evaluation purpose and scope:

- This evaluation is part of the UNDG-ITF projects evaluations where specific criteria were applied to select some projects for evaluation purposes. This independent evaluation comes at the end of the implementation cycle of the project and aims to assess the overall contribution of the project towards strengthening the prevention and control of NCDs and Mental Health programmes in Iraq while distilling lessons and good practices to feed into future programming. The evaluation provides recommendations to enhance operational and programmatic effectiveness of similar initiatives in comparable situations. In addition, the evaluation assesses how WHO has contributed towards an enhanced partnership with MOH and NGOs in addressing critical issues affecting NCDs and Mental Health Programmes in Iraq.

- The evaluation findings will be disseminated to all stakeholders at different levels including decision makers both within the government of Iraq and the UN 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 Health Care system (PHC), with a focus on community outreach and community involvement.

- The evaluation findings will serve as an advocacy tool to demonstrate the results and feasibility of NCDs and MH programme integration in PHC which is currently adopted by GOI as cornerstone for the health care system in Iraq. The project will also provide donors with a comprehensive assessment of the outputs and utilization of their investment in these programmatic areas. In addition, the 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.

- Last but not least, the evaluation will also contribute to the next WHO country Cooperation Strategy (2010-14) for Iraq that guides the partnership and joint programming between WHO and GOI.

- This evaluation followed the project geographical coverage and was of national scope. However, for specific interventions and as guided by the project document, more focus was given to the facilities and districts where integration of NCDs and MH into PHC was piloted. The project targeted activities implemented across all selected PHC facilities at the target 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.

- Technically, the evaluation covered all key components as per project design including:

  - A national survey on the major NCDs risk factors
  - Public Awareness activities including workshops and education materials
  - Policy support to NCD control including the formulation of multi-sectoral committees and review of legislations
  - Training activities including fellowships in areas of mental health and NCDs
  - Provision of supplies and equipments in selected PHCs facilities for NCDs and other facilities within the control and prevention of blindness.
  - Development of manuals and guidelines in the different technical areas.
  - Support to data collection and surveillance.

- Cancer registry strengthening.
- Mental Health assessment survey.
- Institutional support to mental health departments
- Integration of NCD/mental health in PHC
- Provision of Mental health drugs and supplies.

4) Evaluation Methodology:

The evaluation addressed the Organization for Economic Cooperation and Development – Development Assistance Committee (OECD-DAC) evaluation criteria including relevance, effectiveness, efficiency, and sustainability. In addition, the evaluation also looked at the contribution of the project towards partnership building within UN, GOI and civil society. Specifically, the evaluation was guided by the following key objectives:

1) To assess and showcase the achieved progress and results against stipulated project objectives and outputs for improved Mental Health and NCDs Control Programmes in Iraq;
2) To assess the efficiency and effectiveness of the interventions included in the project.
3) To assess the relevance of project components in strengthening the integration of NCDs and Mental Health in the primary healthcare in Iraq vis-à-vis needs in the catchments areas of the selected districts.
4) To understand the extent to which this project has contributed to forgoing 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 results from similar initiatives in comparable situations.

A) Evaluation Methodology:

The evaluation process comprised of the following:

Desk review

The evaluation team reviewed 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 also reviewed relevant national strategies to see the links between the project objectives and national priorities.

Data collection and analysis

In consultation with WHO and MOH, the evaluation team identified all stakeholders to be included in the evaluation exercise. Once stakeholders were identified, the evaluation team devised participatory approaches for collecting first hand information. These included interviews, focus group discussions, observations, end-user feedback survey through questionnaires, etc.

Field visits to target districts

Field visits were paid to all project sites and meetings held with all partner institutions including primary health centers where NCDs and MH control is integrated. To the extent possible, beneficiary populations in all districts were 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 were held;
- Field visits to the DOHs, where questionnaire, focus group discussion, interviews and site observations were 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 were used to gather the needed information;
- Focus group discussions were held with the beneficiaries from the upgraded services; Questionnaires were used for beneficiaries from the different capacity building activities.

Three questionnaires were used; one detailed questionnaire for stakeholders at management level (in English and Arabic) and two questionnaires in Arabic, one for medical personnel at PHC centers and another for beneficiaries.

Evaluation Guidelines
In preparation of the Stars Orbit Consultants "SOC" evaluation report due consideration was given to the UNEG evaluation guidelines and the UNDG-ITF guidelines on Development Effectiveness and Operational Effectiveness.

B) Pre- Evaluation Meetings:

Prior to the start of SOC's evaluation, two days workshop 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 D2-05 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. Attendance of this meeting in Annex B

This meeting took place in ElBatra Hall, Land Mark Hotel, Amman on 8 & 9 February 2010, this meeting was attended by more than 27 participants from MoH, UNDG, WHO, UNICEF & FAO.

The main objectives of this meeting were:

- Lunch the evaluation convention.
- Insure the support of the related ministries and their 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

C) Evaluation Field Activities:

A detailed evaluation methodology, approach and programme of work were agreed upon between WHO and the evaluation team before the start of the evaluation. The evaluation team met in Amman for orientation, briefing and initial interviews with WHO staff in Amman followed by similar discussions/briefings by WHO staff based in Baghdad and the national counterparts.

As the evaluation team started field work, staff of WHO, Iraq Office extended every possible assistance to facilitate the mission of the team, be it through in-depth interviews or by providing supporting documents on the progress of the various components of the project.

SOC mobilized 12 staff to carry out the field work. The activities of the evaluation field team covered 8 governorates (Erbil, Sylimania, Duhuk, Mosel, Kirkuk, Baghdad, Babel and Basra. 22 facilities were

inspected. 44 official interviews were made with government staff and 5 interviews were made with UN international and national staff. In addition a total number of 120 project beneficiaries were interviewed to obtain their views and perceptions and on-how the project addressed their needs and aspirations.

The evaluation team made every possible effort to bridge information gaps and obtain copies of official documents exchanged between WHO on one hand and Ministry of Health on the other as well as to obtain copies of all printed material including technical guidelines, manuals, field surveys and assessments, registers and health education publications.

D) Limitations:

The activities of the project are multi-faceted and were implemented over a five years period. During this period there were a lot of developments on the ground and high turnover of staff within the UN, various government departments and NGOs, which rendered it more difficult to obtain first hand information from the multiple partners, who were directly involved in project design and implementation as well as in checking on the status of equipment and access to documents. The feedback obtained during field evaluation was in some instances brief or incomplete and some officials did not appear to be adequately informed about the developments outside their governorate.

However, in spite of the above constraints, the comprehensive reports prepared by WHO and the subsequent field work, helped the Evaluation Team to assess the progress achieved towards attaining the stipulated project activities.

5) Evaluation findings:

A) Achievements and results:

The progress towards achievement of the stipulated project results was as follows:

Non-Communicable Diseases

Outcome #1: Standardized baseline data on common NCD risk factors and causes of injuries established; a surveillance system for cardiovascular diseases, overweight and obesity, diabetes, cancer; injuries and violence established; integration of hypertension and diabetes management into primary health care established;

Outputs #1:

1.1 Survey on Risk Factors of Chronic Non-Communicable Diseases: This survey was conducted in early 2006 as an integrated effort between Ministry of Health and Ministry of Planning and Development Cooperation/Central Organization for Statistics and Information Technology (COSIT) in collaboration with WHO. The WHO standard STEP wise approach was used to build up baseline data on the prevalence of risk factors for Non-communicable diseases which was conducted in Iraq for the first time using the resources of this programme.

2 The survey was conducted in 17 governorates including Kurdistan region (except Erbil). More than 400 field workers from the directorates of health along with members of COSIT in the governorates participated in data collection.

The survey design was that of a cross-sectional study, whereby a multi-stage clusters sampling design with stratification was used. The response rate was very high (above 94 %), thanks to the efforts of dedicated MoH and DoHs staff, community leaders ,civil society organizations and WHO national focal points .

Distribution of Study Population by Gender

Gender	Number	Percentage
Female	2,557	56.8%
Male	1,946	43.2%
Total	**4,503**	**100%**

The report of the survey which was published in 2007, presents the main results in regard to the contributory risk factors. Results showed that 40.4% of those included in the survey had high blood pressure, 10.4% had hyperglycemia, and 37.5% had hypercholesterolemia. Also, 66.9% were overweight, 21.98% were smokers, 90.1% had low fruit and vegetable consumption and 56.7% had low physical activity. The prevalence of high blood pressure and hyperglycemia was higher among males whereas obesity was higher among females.

2.1 Surveillance system for cardiovascular diseases, cancer, and diabetes: The collection of NCD baseline data through the Chronic Non-communicable Disease Risk Factors Survey was one of the first steps in this process. Through the survey process, most NCD focal points in the centre and governorates received training on NCD surveillance.
A standardized framework for the surveillance of cardiovascular diseases, cancer and diabetes was established with technical support by WHO in 2007.

2.2 Integration of Hypertension and Diabetes Care into PHC: Through this programme, an official implementation of screening of hypertension and diabetes has taken place in 41 PHC centres in the governorates, of centre and south in October 2008 and at the DoHs of Kurdistan region in November 2008.
Local competency based training workshops were implemented by the NCD focal points in the DoHs for the physicians and the other assigned health workers, laboratory and administrative staff working in the selected screening PHC. The training included clinical aspects of the work in addition to discussion of the job description of the work team. It also included field implementation and assessment. PHC staffs on the surrounding areas were trained. Local laboratory sites were selected and laboratory supervisors were assigned to train and supervise the screening PHC labs. Central workshops were also carried out at the Central Public Health Lab for laboratory supervisors to discuss supervisory tools.

During the preparatory phase in May 2008, the screening program was piloted in a selected PHC centerin Baghdad (Resafa) where 43 medical and health support staff from the selected PHC (20 males and 23 females) have attended a training workshop which was followed by a ten days practical screening implementation and data collection training.

Moreover, before the implementation of the screening project, 3-5 workshops were conducted in each governorate to train all staff members of the involved PHCs on the new guidelines and instructions.

National guidelines for the management of hypertension and diabetes were developed, published and distributed in 2008 to PHC physicians all over Iraq and physicians

working at public clinics. The guidelines were prepared by a National Steering Committee comprised of NCD managers, national experts and specialists as well as WHO technical

advisors. The guidelines were based on WHO recommended criteria and cut-off points for screening, diagnosis and treatment outcomes.

The project expanded in 2009 to 25% of main PHC at directorates of health with the financial support of the Ministry of health and DoHs. Follow-up and monitoring is carried out through central and local supervision and meeting with focal points as well as the selected PHC staff. Reports are submitted to higher authorities according to whom interventions are made. However, MoH staff interviewed confirmed that although data is being collected and reported on regular basis, it is not being locally analyzed because the urgently needed equipment for computerization of data is not readily available and further training on use of IT is needed. The reported data are analyzed at central level at the NCD section /MoH and submitted to higher authorities. Accordingly, interventions are made. Feedback is also made and the results are discussed on central workshops with NCD focal points and DoHs representatives to evaluate the process of implementation based on which modifications are made.

In the area of integration with secondary care level, arrangements are made to train the PHC physicians and the health paramedical personnel at the hospitals within the catchments areas under supervision of specialist at the cardiovascular and the diabetes clinics and ophthalmology departments.

2.3 Injury surveillance: This project made significant steps towards the establishment of an injury surveillance system at the national level in Iraq. Under WHO support, one (3 days) workshop was conducted in each of the governorates of Baghdad/Resafa, Erbil, Basra and Kerbala in 2008, in addition to central workshop at MOH/HQ to central supervisors. The above was preceded by a workshop to discuss the national strategy on the prevention of violence and injuries which was conducted in Amman in December 2007 for representatives from Ministry of Health, Ministry of Higher Education, Ministry of Labor and social Affairs, Ministry of Interior, Ministry of Human rights, Ministry of Education and Ministry of Awqaf and religious affairs. The above capacity building activities were followed by the establishment of 4 sentinel sites that ensure regional representation of the country and expected to generate valid information on the causes and prevalence of domestic injuries in Iraq.

Global status report on road safety:

- Iraq has joined the workshop on road safety. The main objective was to prepare A Global Status Report on Road Safety. The participating countries were requested to complete the report based on the available national data.
- The related ministries are identified to respond to the report and a national committee of the representatives of these ministries is established. Accordingly, the report questionnaire and guidelines are distributed to the respondents.
- A consensus meeting for the committee members was held by the end of April in order to discuss and finalize the report t. The final report was published and distributed by the WHO containing the data on Iraq.

Cancer Registry:

Outcome #2: The national cancer registry system strengthened

Output #2:

2.1 Cancer Registry System: The cancer registry system was strengthened through the conduction of 2 central workshops conducted in 2008 to cancer registry focal points in all DOHs on improvement of the cancer registry system which were attended by 33 concerned physicians (28 males and 5 females), 11 of whom were from DoHs other than Baghdad.

WHO also supported the training of 4 Iraqi doctors on Cancer Registry in Amman, Jordan in February-March 2007. In addition to 4 workshops inside Iraq for physicians from Basra, Najaf and Mosul on data collection and analysis to strengthen population based cancer registry piloted there. Moreover, WHO has provided support to print, publish and distribute a manual on the prevalence of all Iraq/MoH's hospital-registered cancer cases as per cancer registry unit records up till 2004.

Initial plan for strengthening the national cancer registry system was drafted in 2007. It is worth noting that six MoH physicians and nurses attended a training course on palliative care for cancer patients in 2005.

WHO/Iraq started a close collaboration with Ministry of Women and conducted various awareness and advocacy meetings and workshops on breast cancer utilizing funds from other projects.

Outcome #3: A multi-sectoral committee and plan for the promotion of healthy lifestyles and primary prevention of NCDs established.

Output #3:

3.1 Multi-sectoral Committees: Several meetings were held over the course of this programme by the NCD Multi-Sectoral Task Force Steering Committee and executive working teams. Participants from the following agencies were involved: Ministry of Health. Other line ministries such as the Ministry of Higher Education and Scientific Research, Ministry of Labor and Social Affairs, Ministry of Education, Ministry of Interior, Ministry of Agriculture, Ministry of Human Rights, Ministry of Youth and Sports and other government offices not affiliated to ministries.

National multi-sectoral committees were established in the following areas:

- Central national committee for surveillance of NCD risk factors.
- High committee for tobacco control.
- National committee for blindness prevention.
- Network for prevention of violence and accidents.
- Committee for prevention of road traffic accidents.
- Committee for promoting physical activity.
- In 2007, a national committee was established to publish national guidelines for chronic NCDs.

In 2006, a national symposium was held on the integration of NCD control activities within primary health care services with the participation of 20 specialists in internal medicine, community medicine, laboratory and technical affairs and higher education participating. The objectives were to discuss the problem of NCDs in Iraq, the training

schedules required for the PHC physicians, the levels of care required for NCD patients, and the guidelines for referrals.

In addition to the inter-sectoral collaboration with other departments at the ministry of health and partnership with other related ministries, institutions and organizations, several activities are integrated with other programs e.g. school health, maternal and child health, nutrition.

Tobacco control:
- Iraqi government ratified the Tobacco free convention, and declared by the UN to be a member of the Convention.
- Tobacco free medical college project continues at Al Nahrain medical college. Several workshops were held with the teaching staff and other personnel, and follow-up meetings started at the college.
- Global health professional survey (GHPS) and Global youth tobacco survey (GYTS) and Global school personnel survey (GSPS) were implemented and published in collaboration with the WHO and CDC.

Obesity control: - Control of overweight/obesity among adults is added as integral part of Screening and care for hypertension and diabetes project.
- A project on prevention and control of overweight/obesity is started at health promoting schools in collaboration with School Health section and Nutrition Research institute at the Directorate of Public health, the related directorates of the ME, and with the specialized Diabetes and Endocrine centers.

Promotion of physical activity:
- A Multisectoral committee is established.
- National physical activity, diet and health action plan frame is prepared
- Several national training activities were held for school personnel.

3.2 Capacity Building:
In August and September 2008, a total of 40 competency- based training workshops were conducted by NCD focal points in 19 DoHs for 890 PHC staff (562 males and 328 females). Workshops included clinical aspects as well as field implementation and assessments. PHC staff included physicians, other assigned health workers.

WHO supported 19 national training activities/workshops in 2007 to enhance the capacities of concerned staff in 19 DHOs on the integration of NCD into primary health care. The main focus of these workshops was the early detection of hypertension, diabetes and breast Cancer.

In 2006, twenty fellows were trained in the UK. The training fellowship which was a clinical course had the following learning objectives:

- to update candidates on best clinical practices to control and manage NCDs within primary health care services;
- to explore modern methods to manage chronic disease in clinics outside hospitals;
- to learn best practices of identifying risk factors which may lead to chronic diseases;
- to learn best practices of the prescription and management of medicine and,
- to develop a framework for monitoring and evaluation suitable to Iraq.

Output #4: Health services for rheumatic fever and rheumatic heart disease introduced and implemented; - 100% achieve.

Output #4:

4.1 Rheumatic Fever control: the control of rheumatic fever and rheumatic heart disease was strengthened through a series of training activities throughout the course of the

programme. Local training activities were conducted at the governorate level in 2008 to strengthen rheumatic fever control. 13 workshops were held in 13 DOHs attended by 172 medical and health support staff including nurses and Paramedicals (112 males and 60 females).

In 2007, 8 workshops were attended by PHC physicians and nurses in more than 60 PHC centres covering different aspects of rheumatic fever/rheumatic heart disease prevention and control. These included clinical aspects, evidence-based management protocol and interpersonal communication skills.

Output #5: Services for control and prevention of blindness strengthened with a focus on primary eye care.

5.1 Procurement of Essential Diagnostic Equipment: As part of improvement of primary eye care, a total of 22 Community vision centres have been established all over Iraq to provide eye care by ophthalmologists and refractionists. The centres were equipped with basic diagnostic equipment and supplies by WHO. The ophthalmologists and refractionists working at these PHC centres were engaged in practical training at the hospitals under supervision of specialists. In addition, other equipment was supplied to specialist eye hospitals, microscopes, light-direct ophthalmoscopes, indirect ophthalmoscopes and binoculars. WHO has also supported a workshop in Amman to some selected Ophthalmologists on the treatment of Diabetic Retinopathy by Laser in October 2005.

5.2 Capacity Building in Eye Care: Ophthalmologists and opticians working at community vision centres that were fully equipped by WHO procurements have been trained under the supervision of specialists.

Training on primary eye care was conducted in Baghdad, Ninewa and Basra in2006/ 2007. Training workshops continued to cover other 13 DoHs in 2008.During 2008, four training workshops were conducted for school teachers concerning the early detection of visual impairment in children in Baghdad (Kerkh), and Baghdad (Resafa). The workshops were attended by 66 primary school teachers (37 males and 29 females).

However, there is an obvious need for further training of teachers if the program is to be expanded to all schools .Besides, school children with vision impairments should be provided with eye-glasses. During interviews, it was reported that few spectacle

production workshops were developed sponsored by organizations like UNICEF or the governorate's resource. There is still need for further workshops to cover the needs.

Rapid Assessment for Avoidable Blindness (RAAB): the primary objective of this assessment was to establish a baseline data on the causes of blindness and visual impairment in Iraq in order to fulfill an obligation towards the "Vision 2020 Initiative". This assessment was conducted in the districts of Sulaymania and Basra as a starting point by the end of 2008.

Preliminary report is prepared and submitted to higher authority and to WHO. Efforts are made to improve cataract surgery coverage based on the results. Plans are made to extend RAAB to other areas of Iraq to give an estimate on the prevalence of blindness and visual impairment in Iraq.

Mental Health:

Outcome #1: Situation analysis of mental health needs assessed; the functioning of existing mental health facilities strengthened; training to improve the quality of mental health care within primary health care implemented; services for the prevention and management of common disorders provided; mental health services in schools established.

Output #1:

1.1 Research work on MH: Fifteen research projects were undertaken in 2006 to examine the magnitude of mental health problems in specific population groups and the impact of the mental disorders in terms of quality of life of ill persons (See annex C). These projects were the result of the training on research methodology in MH and are listed below:

1) Prevalence of post traumatic stress disorders in primary school children in Baghdad;
2) Quality of life of outpatients with schizophrenia from rural and urban areas in Iraq;
3) Prevalence of psychiatric morbidity among plastic surgery patients with mutilated ears;
4) Prevalence of depression during pregnancy;
5) Prevalence of post traumatic stress disorders in adolescents in secondary school;
6) Prevalence of post traumatic stress disorder among psychiatric outpatients in the Al-Fayhaa Hospital in Basra;
7) Comparison of the quality of life between outpatients with schizophrenia and a sample from Baghdad's general population;
8) Mental health symptoms following the wars and repression in Mosul;
9) Prevalence of alcoholism among male emergency room attendants in two general hospitals in Baghdad;
10) Resettlement prospects for inpatients at the Al-Rashad Mental Hospital;
11) Prevalence of psychiatric morbidity among patients with dermatological diseases at the dermatological clinic;
12) Prevalence of anxiety and depressive disorders in primary care centres;
13) Rate and correlates of depression in diabetic patients in Baghdad;
14) Knowledge of PHC physicians in Baghdad about psychiatric medications;
15) Psychiatric morbidity among working children in Dahuk City.

It was concluded that there is a high need for mental care in Iraq with a special emphasis on children who exhibited high morbidity rates from ill mental health.

1.2 Iraq Mental Health Survey (IMHS): The Iraq Mental Health Survey (IMHS) was undertaken jointly by the Ministry of health (MoH) and Ministry of Planning and Development Cooperation (MoPDC) the Ministry of Health/Kurdistan region in Iraq (MoHK) and the Kurdistan Regional Statistics Office in Iraq (KRSO).

IMHS was the first nationwide mental health epidemiological survey in Iraq. IMHS was conducted in 2006/2007 along with the Iraq Family Health Survey (IFHS).
IMHS was conducted by assessing a random sample of 4,332 adults aged 18 years and older representing the Iraqi household population. The response rate reached 95.2%. The methodology of IMHS was the same as the World Mental Health Survey. Data was collected by using two survey instruments, a Self Reported Questionnaire (SRQ) and the Composite International diagnostic Interview (CIDI).

The survey found that the lifetime prevalence of any mental health disorder was 16.5% among the Iraqi population while only 2.2% of those affected received any medical treatment.
IMHS also found that women have a higher prevalence of anxiety and behavioral disorders than men; men have higher rates of substance abuse than women; and the prevalence of mental health disorders vary between those living in urban and rural areas and across different regions in Iraq.

1.3 National Mental health Council: The National Mental Health Council was established in 2004 to guide the development of mental health and substance abuse programmes in Iraq. Members included representatives from the following ministries: Ministry of Health (MoH), Ministry of Higher education (MoHE), Ministry of Labour and Social Affairs (MoLSA), Ministry of Justice (MoJ), Ministry of Human Rights (MoHR), Ministry of Interior (MoI) and Ministry of Education (MoE).

The council's key areas of focus are policy development, reconstruction of mental health infrastructure, human resource development, community education and research.

The council's accomplishments included the approval of the Mental Health Act in 2005. This legislation focuses on access to mental health care including:

1) Access to the least restrictive care;
2) Rights of mental health service consumers, family members, and other care givers;
3) Competency, capacity, and guardianship issues for people with mental illness;
4) Voluntary and involuntary treatment; law enforcement and other judicial system issues for people with mental illness;
5) Mechanisms to oversee involuntary admission and treatment practices; and
6) Mechanisms to implement the provisions of mental health legislation.

The mental health legislation was achieved in collaboration with the Ministry of Justice and was reviewed by most psychiatrists in the country.

1.4 Mental Health Care Manuals: Two major projects were undertaken to develop manuals regarding mental health care. The first was, to develop several manuals on psychological first aid for community level workers and schools through the primary health care system.

The focus of these manuals was to emphasize the normalcy of reactions and to increase the coping capacity of children and adults. They are available in English and Arabic.

The second project was, to prepare a manual on the provision of mental health care by physicians
1) stigmatization of patients and staff;
2) screening;
3) Treatment of patients with both physical and mental illnesses;
4) Shared infrastructure leading to improved cost-efficiency;
5) Potential of universal coverage and mental health care; and
6) Use of community resources to partly offset the limited availability of mental health personnel.

1.5 Provision of Essential Drugs for Mental Health Conditions: Around USD 1 million worth of essential mental health drugs were purchased by WHO to the Ministry of

Health. These drugs were distributed by Ministry of Health to its facilities for the treatment of depression, stress and neurological conditions.

1.6 Rehabilitation/Construction of Psychiatric Facilities: Iraq Ministry of Health along with support from the WHO initiated a long term capacity project to rehabilitate and construct psychiatric facilities at the national level. They are designed to be sensitive to the special requirements of psychiatric care and the unique cultural and social aspects of the Iraqi society and include separate wards for men and women.

WHO supported the renovation of seven mental health units in Mosul, Basra, Kebala, Babel, Diala, Baghadad (Russafa) and Baghdad (Karkh) at a cost of USD 117,850.75. In addition, six mental health units were newly constructed in Kirkuk, Wassit, Nassirya, Najaf, Erbil, and Baghdad (Russafa with a cost of USD 2,829,067.42.

1.7 Community Mental health Initiatives: These initiatives began with the construction of mental health units which have been functioning out of hospitals in each governorate. Community outreach mental health activities have been established but are not functioning well. So far, it has been done by NGOs only.

1.8 Mental Health Capacity Building: In order to better serve the mental health needs of the Iraqi population, primary health care workers went through a number of trainings in the following areas from 2004 to 2006:

- Research methodology (20 psychiatrists in 2005);
- Psychiatry update (25 professionals in 2004 in Jordan)'
- Psychiatric training specifically for physicians (13 physicians in Bahrain in 2006);
- Psychiatric training specifically for nurses (40 nurses in Egypt in 2004; 20 nurses in Bahrain in 2006);
- National capacity building and mental health leadership (number of professionals visited Egypt, India and the UK in 2005);

- Substance abuse trainings (3 psychiatrists in India in 2005; 7 professionals in the UK in 2006);
- Improvement of psychiatric skills specifically for medical undergraduate education professors and teachers (10 psychiatrists in the UK in 2005).

1.9 Mental Health Education Campaign: A large scale mental health campaign was developed by Ministry of Health with the support of the WHO to increase awareness on mental health problems and initiate community based services to the general public.

With the active involvement of mental health and media professionals from Iraq, WHO/Iraq and Regional Office along with its professional medial personnel, prepared 5 posters on stigma, mental disorders, psychological first aid, Schizophrenia and depression along with five pamphlets on self-care in crisis situations, mental disorders, schizophrenia, depression and mental retardation.

1.10 School Mental Health Initiatives: The primary objectives of mental health initiatives implemented in the school system were as follows:

1) To raise awareness of school teachers regarding their roles in the emotional development of children;

2) To provide school teachers with a minimum knowledge to improve the process of early detection of emotional problems in children; and
3) To develop positive relationships between schools and primary health care centres.

In spite of these commendable efforts ,it was ascertained during interviews with MOH officials that the process of integrating mental health within PHC activities and schools is far from being complete and additional efforts need to be exerted in close cooperation with WHO in the areas of national capacity development of health personnel ,training of teachers and social mobilization . This is a very demanding programme that requires continuous development of the knowledge and skills of caregivers and development of effective mechanisms for interaction between health care facilities , schools, teaching institutions , community organizations and families as well as a proper referral and feedback system .

Substance Abuse

Outcome # 1: Situation analysis about substance abuse assessed and flow of data established:-

Output # 1:

1.1 Situation Analysis of Substance Abuse: A situation analysis about the prevalence of substance abuse was carried out through the Iraq Mental health Survey in 2006/2007. It was demonstrated that men have a higher prevalence of substance abuse than women. Overall, the data from this survey provided baseline data from which health care professionals can set targets for future substance abuse programmes.

It is worth noting that a team of 12 mental health professionals consisting of Psychiatrists, clinical Psychologists, social workers and nurses participated in a four-week training course in Cairo in 2006 to learn how to create a hotline service.

A "hotline" has been established as a well recognized method of reaching the drug using community.

Based on the above achievements it can be concluded that the Iraqi population as a whole has benefited from various public health control activities of this programme through support in the following areas: rheumatic fever control; improved screening of hypertension and diabetes; rehabilitation of existing psychiatric units; construction of new psychiatric units; surveys in areas of mental health and substance abuse; control of blindness; provision of essential medical supplies and equipment; violence and injury surveillance.

The health sector benefited from this programme through the training of approximately 6,224 health care professionals who attended meetings, workshops inside and outside Iraq; in addition to fellowships outside Iraq. The number involves 5,184 in the prevention and control of NCDs and 1,040 in the areas of mental health and substance abuse.

Number of fellowships outside Iraq in external training centres 2005-2007

Topic	2005	2006	2007	Total	Remarks
Mental Health	45	28	-	73	Fellowships took place in the UK, Jordan, Egypt, Bahrain, and Lyon (France)
Substance abuse	-	11	-	11	Fellowships took place in Egypt
Cancer registry	-	1	4	5	Fellowships took place in Jordan and Lyon.
Breast Cancer	-	22	-	22	Fellowships took place in Egypt
Integration of NCDs into PHC services	22	-	-	22	Fellowships took place in the UK
Tobacco cessation	1	-	-	1	Fellowship took place in Thailand
Total				**134**	

Number of workshops and meetings conducted inside and outside Iraq 2004-2005

Topic	2004	2005	2006	2007	2008	Total
Mental Health	2	4	-	-	-	**6**
NCD	-	24	10	21	43	**98**
Diabetic Retinopathy	-	1	-	-	-	**1**
Rheumatic Fever	-	-	-	-	14	**14**
Physical activity	-	1	-	-	-	**1**
Cancer Palliative care	-	-	-	-	-	**1**
Cancer Registry	-	-	-	2	2	**4**
Breast Cancer	-	1	-	1	6	**8**
Blindness and primary eye care	-	1	-	1	6	**8**
Tobacco control	-	8	-	1	-	**9**
Substance abuse	26	1	-	-	-	**27**
Injury surveillance	-	-	2	-	-	**2**
Human Rights	1	1	-	-	-	**2**
CIDI and IFHS	1	10	6	-	-	**17**
First Aid	1	-	-	-	-	**1**
Clinical Malnutrition	1	1	-	-	-	**2**
Landmine victim surveillance	-	-	1	-	-	**1**
IATA regulations on shipment of medical samples	-	-	-	-	1	**1**
Total						**203**

- There are five areas of action identified in the National Development Strategy for Iraq 2007-2010 which were addressed by this programme:

  1) Meeting urgent needs and improving services;
     - Addressing shortages in medicines and urgent supplies,
     - Strengthening disease surveillance systems,
     - Meeting the most urgent rehabilitation needs.

  2) Strengthening results-based management;

  3) Developing standards for rehabilitation and new construction;
     - Developing standards for rehabilitation and new construction.

  4) Training and capacity building;
     - Strengthening capacity in public health and related areas,
     - Training in clinical skills.

  5) Mobilizing resources;
     - Improving information on current status and needs.

  This program serves the country at two levels:

  1) The developmental level in terms of long term capacity building and policy formulation and;
  2) The humanitarian level which provides immediate access to vulnerable populations.

- The project will contribute to attainment of the priorities identified in the NDS and the Millennium Development Goals, in particular:
- Goal #1: poverty reduction through its relation to economic development since these diseases and their risk factors are highly prevalent among the poor and contribute to poverty. It is recommended to be incorporated into poverty reduction strategy.

  Goal #3: Promote gender equality and empower women, by providing training opportunities to women health personnel and equal access to NCD/MH services without discrimination.

  Goal #6: Combat Diseases, by increasing public awareness on NCDs and mental disorders and reducing morbidity from cardiovascular diseases, diabetes and cancer.

Building on the above, the Evaluation Team came to the conclusion that WHO and MOH had adopted a systematic approach to address the challenges of this demanding project through all phases of planning and implementation by meeting all pre-requisites for its success including:

- Agreement on the overall policies, strategies and approaches of the programme ahead implementation.
- Undertaking comprehensive surveys to obtain baseline data and assess needs.
- Preparation of technical guidelines and operation manuals to ensure staff compliance with standard norms and procedures.
- Embarking on an intensive training programme to develop national capacity.
- Provision of basic equipment and essential supplies.
- Conducting focused advocacy and public awareness campaigns.
- Development of a series of health educational material.

- Establishment of several multi-sectoral committees to promote public awareness and forge effective partnerships for health development.
- Review of standing legislations and approval of the Mental Health Act, 2005 .

However, it should be recognized that few health care systems in the world had taken the initiative to integrate NCDs and MH services within PHC activities. Adopting this approach in Iraq represents a pioneer experience in the Region. Full development of the programme is rather a long –term process that would take years of sustained political commitment and heavy investment before the impact of the project could be assessed.

B) Relevance:

- The project has been responsive to the overall issue of NCDs and mental health in Iraq,to a varying degrees.

  A more comprehensive response would require completion and generalization of the process of integration of NCD care within the activities of the remaining 75% of PHC facilities including capacity building of staff in every district and provision of the required equipment and supplies.

  In addition, mental health services need to be expanded and further strengthened, in particular, the school mental health programme.

  These endeavors need also to be backed up by multi-sectoral interventions through other ministries and related community sectors civil society and the mass-media.

- This programme relates to the following areas of the UN Assistance Strategy 2005-2007 for Iraq:

  - Assistance in the development of human capacity among health professionals;
  - Support to Iraq/MoH in the delivery of an integrated primary health care package;
  - Targeted technical and financial assistance for the control of communicable and non-communicable diseases including support for the continued improvement of MoH disease surveillance system;
  - Provision of technical assistance to the development of mental health and psycho-social support services at the primary health care level;
  - Support to health promotion/disease prevention programmes and activities for health service providers and the community with emphasis on vulnerable groups.

- In addition, the project strongly relates to the WHO Global strategy for the prevention and control of Non-communicable diseases (March 2000):
  - WHO Framework Convention on Tobacco Control
  - Global Strategy on Diet, Physical Activity and Health
  - Global Strategy for the Prevention and Control of Non-communicable Diseases

The UN convention against Illicit Traffic of Narcotics and Psychotropic substances is also of special relevance to the MH components of the project especially with regard to distribution and issue of mental drugs.

C) Efficiency and effectiveness:

There were significant delays in implementation of the project activities which was originally envisaged as one year starting September 2004. The coordination mechanisms within the various Governorate Departments proved that there was much to be desired for improving efficiency in implementing such a multi-faceted programme.

The project results will contribute to improved access and coverage to NCD, and MH services through various means including: the impact of public awareness programmes on prevention of risk factors; promoting primary prevention and lifestyle modifications; provision of quality NCD/MH care through primary health care facilities, the introduction and strengthening of services for prevention and control of blindness and rheumatic heart disease, and the screening programme for early detection of diabetes and hypertension.

D) Partnerships:

The main partners to the project were WHO, MoH, Contractors and NGOs.

WHO is the sectariant and leading agency in the UN Health and Nutrition cluster which includes UNOPS, WFP, UNIDO, UNDP, UNICEF and others. Biweekly meetings of UN Health Cluster are led by MoH with the participation of international organizations and donors. During these meetings, policies are discussed and proposals are endorsed. This collaboration is to prevent overlap of programs between the different UN agencies and ensure consistency.

In addition to UN agencies, WHO also worked in close coordination with several developmental agencies such as USAID and the European Commission as well as a number of international and local NGOs including the Christian Blind Mission (CBM) in the area of prevention and control of blindness.

The MoH acted as the primary implementing partner for the programme. All WHO programmes were implemented by MoH staff with the active participation of WHO national staff.

The MoPD played a significant role in sample design and selection, data collection and statistical analysis through the Central Organization for Statistics and Information Technology (COSIT).

The MoH used the services of several private contractors to complete the rehabilitation and construction of mental health facilities including the Imar company, Al Bayena Company, Al Baqee & Areedo, Rasheed Company, Aumed Company, Al Hawra Company, Salwan Amjad, Al Mahdy, Al Aemar Al Hadeeth, Al Alwah Company, Mohammed Salman, Khudier Abbas and Al Nawars.

During the course of the programme, Iraq MoH established a bureau to liaise and coordinate activities between various volunteer organizations in the areas of health. Regarding mental health and substance abuse, MoH coordinates with four participating international NGOs specialized in mental health. Their names and contribution are as follows: Hearland Alliance (psychosocial support to victims of violence), Diakonia (psychotherapy services in Dahuk, Erbil and Suleymania), Movimondo (psychosocial support of children in Baghdad and Together (psychosocial support of children and families in Babylon). In the area of control and prevention of blindness, CBM international NGO trained staff and supported the conduction of field surveys on the causes of avoidable blindness in Iraq. In addition to the numerous newly formed local NGOs which have not yet acquired the required professional skills to conduct highly specific technical health projects due to limited expertise.

A National Council for Drug Misuse was re-established and chaired by MoH. The councilincludes representatives from the Ministry of Interior, Ministry of Social Welfare and other committees. A programme to address the issue of drug misuse was developed in collaboration with the regional WHO team and a Drug control Law was submitted to the cabinet for approval.

On top of the above, MoH is guiding, since a long time, many multi-sectoral steering committees and task forces in the area of prevention and control of cancers (Cancer Board), NCDs, Prevention and control of blindness, health, diet and Physical activities, care of the elderly and others.

Last but not least, partnerships were forged with community leaders and the local population, whose positive response and cooperation in the conduct of surveys was very crucial.

E) Sustainability:

- The project was officially closed on 31 December 2008. The NCD section in the MoH assumed overall responsibility for maintaining facilities and functions of the programmes. Cancer control activities are supervised by the Iraqi Cancer Board. The National Advisor for Mental Health office is in charge of mental health program. However, this is not a turn-key project but is rather a very huge undertaking, the future sustainability of which is much dependent on maintaining political commitment at the decision making level, uninterrupted funding and sustained cooperation with WHO technical staff, both at Headquarters and at the Regional Office.

  MOH staff interviewed reported that all project components sponsored by WHO were fully implemented and further expanded such as screening for diabetes and hypertension and integration of NCD care within PHC activities ,whereas other activities relevant to promotion of physical activity, Obesity prevention and care of the elderly are still in the development stage.

  Areas that require further development, monitoring and assessment comprise the following:

  - Capacity development of the MoH staff to upgrade their managerial and technical competences in the various intervention areas with a system to ensure retention of trained staff and transfer of knowledge and competences to counterparts.

  - A system for regular check-up and maintenance to ensure that basic equipment are in a functional condition.
  - Effective supervision and monitoring to ensure staff compliance with the technical guidelines and management protocols.
  - Completion of the process of integrating life skills education in schools.
  - Completion and expanding the process of integrating NCD and MH care into PHC services in all governorates.
  - Expanding the scope of the work of the multi-sectoral committees for promotion of healthy lifestyles and primary prevention of NCDs.
  - Capacity development of health and teaching staff in detection of psychological disorders and support to affected persons.

- During project implementation, WHO assisted MoH in drafting proposals and reports to facilitate processing of sufficient documentation and adopted effective payment mechanisms in the different regions of Iraq to overcome delays. WHO also provided indispensible support for capacity development of staff, preparation of technical guidelines and manuals and development of NCD surveillance system including cancer registry. The future sustainability of the programme requires development of the competencies of national staff in these areas.

  Full development of the various components of the NCD/MH prevention and control programme, is a long-term and very demanding process, that requires further follow-up and periodic assessments before evidence could be established on the impact of the programme on the health status of the country population.

F) Other considerations relevant to development:

- The programmes which were established through this project have a value-added in comparison with the alternative of focusing on curative and hospital care.

  As far as NCD prevention and control is concerned, screening for early detection of diabetes and hypertension, integration of NCD care within PHC services and establishment of multi-sectoral committees and plans of action for promotion of healthy lifestyles and primary prevention, all represent the most cost-effective approach to prevent, detect and manage these diseases ahead the

need to meet the high cost of treating their complications and disabling effects at the secondary and tertiary care levels.

Likewise, the programmes for early detection of mental health disorders through PHC facilities and schools, are very cost-effective initiatives that provide better opportunities for supporting the needs of affected people, especially women and children ahead the need to treat them in mental hospitals which a practice no more recommended by WHO, because it involves social stigma and impedes integration of affected persons in the society.

- Cross-cutting issues relevant to security, human rights, gender and employment were addressed in the context that all targeted people have an equal right to health services without discrimination regardless of gender, race, religion, political belief or socio-economic condition.

  In evidence 30% of the trained health personnel in and outside Iraq were women. In addition, special emphasis was placed on training of 180 women physicians on early detection of breast cancer including self-examination. Also psychiatric facilities were designed to provide separate wards for men and women.

- The project contributed to employment generation, by providing, 9,113 job opportunities during rehabilitation and refurnishing 13 mental health units. In addition, jobs were generated for providing external secretariat support to assist in preparation and facilitating the training activities inside and outside Iraq.

6) Lessons Learned and good practices

A) Lessons learned from the project included:

1. In spite of the tragic events and extreme hardship that they sustained over 3 decades, the Iraqi population were able to withstand difficulties and are highly motivated and geared towards improving their living conditions and the quality of services which had strongly facilitated the conduct of surveys and implementation of activities.

2. 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.

3. Knowledge of the local context and capacity to adjust to a new environment is a key factor to successful interventions. In evidence, inclusion of Iraqi counterparts at every stage of programme planning and implementation was essential to facilitate implementation, overcome difficulties encountered and to ensure a sense of ownership.

4. The clarification of roles assigned to responsible officers and the designation of the ultimate decision maker at the beginning of programme implementation process was an essential step to limit confusion regarding management structure. This practice should be encouraged in similar projects in the future.

5. Conflict situations increase the mental health needs of the population. Of the different population groups, children, women and those experiencing high trauma and losses are the

most vulnerable. The needs of these groups require immediate attention in the planning of intervention.

6. Investment in appropriate health care technology is a prerequisite for success of health interventions. It should be maintained and set as a priority in planning for improvement of quality health care services;

7. It has been shown that it is possible to address the psycho-social and mental health needs of the population through innovative community- based interventions. Mental health care is not limited to traditional psychiatric services from specialists, but extends to integration of mental health care into general health care and self-care by the general public;

8. Human resources development is a priority in rebuilding NCD and mental health services; the MOH should therefore continue the process of staff training targeting health personnel who could not participate in previous training sessions because of security considerations or recruiting new staff to compensate for the high turn-over. Assistance of WHO technical staff in this respect represents an added asset to capacity development.

9. Integration of mental health care within primary health services is a cost effective approach for providing appropriate care and providing services in a de-stigmatizing manner. The planning of the mental health care programmes should be linked to the development of general health services. Programmes aimed at fighting the stigma attached to mental illness and substance abuses are important elements of the mental health programme. Stigma can limit the utilization of the various mental health initiatives

10. Despite high staff turnover, building residue national capacity in Iraq is an essential element of support provided by the UN to Iraq;

11. A strategy consisting of various WHO focal points to regularly conduct site visits in order to monitor trainings, surveys and activities is essential to effective programme implementation;

12. Inter-sectoral collaboration, especially with the education and voluntary sectors, is vital for taking mental health beyond mental disorders and professionals level services;

13. International professional support has been effective for advocacy and technical support. The support of WHO and National psychiatric associations has been critical in the development of the mental health Programme in Iraq, especially the very early meeting organized by WHO in July 2003, and the periodic review with the Ministry of Health, Iraq;

14. Despite the fragile security situation during the course of the project, it was feasible to conduct field surveys and visits. Proper design and planning for field surveys and active community participation were key elements for the success of such initiatives.

15. The cost of primary prevention of NCDs and mental health problems represents a fraction of the high cost of their treatment. The continuity of timely intervention is the keystone of effective public health response.

B) Some of the good practices which emerged during project implementation included:

1. The creation of an NCD Task Force was a productive step towards integrating non-communicable disease care within PHC activities.

2. Ratification of the Framework Convention on Tobacco Control was a positive step towards starting a national initiative for reducing smoking hazards. The premises of the MOH are now smoking free places.

3. Multi –sectoral partnerships between the various ministries and community participation at the national level played a crucial role in implementation of the planned activities.

C) Recommendations that can apply to similar projects implemented in the future:

1. Effective payment mechanisms need to be developed to overcome delays during programme implementation, because feedback from staff interviewed pinpointed this as a major factor in disruption and delay of project activities.
2. There is a need for exercising greater flexibility in the procedures for awarding fellowships, recruitment of staff, purchase of supplies etc. for sustaining the active day-to-day coordination of activities at country level, with WHO country office.
3. Research should be an integral part of the mental health initiatives as research provides national data both for advocacy with planners and the choice of priorities and interventions.
4. Considering that security problems were the major obstacle for timely implementation of project activities and that several parties are involved in enforcing security arrangements ,WHO Iraq Office and MOH should ensure that all concerned parties are informed in advance about the planned activities and remain committed to facilitate movement of health teams during future projects. Iraq MOH need to follow new mechanisms to ensure prompt sending of payment claims to WHO country office immediately following the completion of activities.

1. Recommendations to WHO and MOH

1. All project components were implemented over five year interval instead of the original period (September 2004 – 31 December 2005).

   Under emergency situations there is always a tendency to blame delays and deficiencies on the security situation. Although the adverse effects of the unstable security situation cannot be denied or under-estimated, nevertheless WHO and MoH should maintain their longstanding cooperation in order to identify and address other contributing factors that hinder implementation, in order to develop plans to overcome these obstacles in the future.

2. The approach adopted in the development of the NCD prevention and control strategy and prevention and control of mental disorders is appropriate, feasible, practical and cost-effective. However, optimal results can be obtained through this approach by expanding its scope country-wide and ensuring its future sustainability by maintaining high level of political commitment, allocation of the necessary financial resources and further development of human resources at management and service delivery levels in order to promote national ownership of the system and strengthen multi-sectoral partnerships.

3. Commendable efforts were exerted through the fellowship programme, training, workshops, meetings and conferences both in-country, inter-country and abroad.

   However, plans should be developed to ensure that core teams of train-the-trainers are established in every governorate and district to transfer knowledge and skills to those who were not trained. This should be complemented by refresher training courses, on-the-job training and ongoing monitoring and supervision of staff performance at the management and service delivery level to ensure that the investment made through this project is not wasted or compromised.

4. Cardiovascular diseases, diabetes and hypertension are leading causes of morbidity and mortality both in developed and developing countries .Management of these diseases requires good knowledge of and full compliance with the recommended management protocols, selection of the appropriate treatment regimen for each individual case, continuous supply of the life-saving medicines and regular monitoring of treatment outcomes. To achieve best results, MOH should consider a gradual paradigm shift from control of blood sugar and pressure levels to risk-based treatment decisions, of patients with diabetes and/or hypertension.

5. Patients with established coronary heart disease and cerebrovascular disease should be targeted for secondary prevention through counseling and provision of essential drugs. This would reduce recurrent heart attacks and strokes by 75%, improve cost-effectiveness of the programme and reduce morbidity and mortality.

6. Patients' self-reliance and ability to contribute to own health and management of NCDs should be strengthened through targeted programmes that improve patient competence and skills for the use of self monitoring instruments such as blood pressure and blood glucose testing. This would help to improve self-monitoring skills and reduce health staff work loads.

7. MoH should carry out in-depth technical evaluation of the NCD programme in close cooperation with WHO technical staff in order to assess completeness of individual patient records, technical competencies at the PHC level and their compliance with the standard management protocols as well as to assess treatment outcomes of hypertension and diabetes in terms of complications and control status.

8. The emphasis on primary prevention of NCDs as well as early detection and management of emotional and behavioral disorders should be further developed within a multi-sectoral approach involving the health and education sectors, community organizations and mass-media. Not only that this helps to promote healthy lifestyle behavior, but it also helps to reduce the burden of these diseases ahead the need to meet the high cost of treating their complications and disabling effects.

9. Parents and school teachers are better placed to detect sudden decline in school performance and identify emotional or behavioural changes among school children because they spend longer times with them and can observe signs of deviation from normalcy. Social networks should be established to link with facilities and primary health care team members and school teachers should be trained up to competency level on the essential of mental health care. The training should focus on the recognition of commons mental disorders, psychological counseling and support using non-pharmacological interventions. With an

   appropriate referral system, psychiatrists should act as resource persons to guide the mental health programme and monitor rational prescribing of mental drugs that could increase the risk of drug abuse.

10. Integration of mental health care into primary health care services and schools remains the most cost-effective approach towards reducing expensive institutionalized care, because it facilitates social integration of affected persons and provides better opportunities for early intervention before psychological disorders develop to long-term mental illness.

    The initiatives undertaken through this project should therefore, be strengthened and expanded with special emphasis on targeting women, children and victims of violence, who are the most vulnerable groups in conflict situations.

11. There is traditionally a tendency on part of trained health professionals to assume roles, beyond their skills and competencies that should be reserved to fully qualified psychiatrists,

MH training should focus on developing the capacity of health professionals at the PHC level on early detection of behavioural disorders and providing counseling support with minimal use of pharmacological treatment. This would avoid malpractice and misuse of mental drugs but it requires an effective referral system and feedback between the primary and secondary health care levels.

12. Because of the social stigma and fear of punitive measures, victims of substance abuse, hesitate to seek medical assistance. Iraq is situated in an area that is plagued by production and cross-border illicit trafficking of narcotics through neighbouring countries especially Turkey and Afghanistan.

    The long state of violence in the country might have also contributed to the spread of substance abuse.

    In the light of the above, it would be un-realistic to assume that the database on substance abuse reflects the actual prevalence in the country. More concerted effort should therefore, be exerted to conduct further situation analysis targeting high risk groups including ex-prisoners, detainees, former military personnel and physically impaired victims of violence.

13. Equipment should be provided to staff at the PHC level and staff trained on the use of information technology and computerization of data. Data management systems should be used for regular monitoring of non-communicable disease treatment outcomes and follow-up of patients. This can be done through phased implementation consistent with availability of funds and plans for human resource development. Data that is collected but not analyzed and shared stretches the capabilities of the already overburdened staff but remains of limited use for drawing conclusions and guiding policy -decisions.

14. Efforts should be exerted to decentralize decision-making processes and action-oriented activities within the framework of MoH approved policies and strategies. This will support the process of in institutional capacity building and reduce reliance on top management at central levels.

    Besides, it will help to overcome the difficulties of maintaining effective supervision and oversight of the programme. This is especially important if the current difficulties continue

    to impede effective communication and interaction between the MoH officials at the central level and the various governorates/districts.

15. Use of modern medical equipment at the PHC level requires adequate orientation of staff on the operation and regular calibration of the equipment .There should also be a system for carrying out regular preventive maintenance to ensure that the equipment remains functional and that services are not disrupted. For this purpose , all future procurements should be made through pre-qualified international suppliers, who meet the criteria of good manufacturing and who are able to provide after sale maintenance and repair services

16. According to WHO country office basic indicators, the available provision of PHC facilities per 10,000 Population is 0.6. During interviews, MoH staff reported that the daily workloads of medical personnel can be as high as 150 consultations .Based on these statistics, the available provision of PHC facilities in the country needs to almost be doubled over a reasonable period of time, if comprehensive NCD and MH care are to be provided through these facilities. Iraq does not lack the resources to rehabilitate and expand its infrastructure of PHC facilities but rather needs the stability and the will to implement development plans that are responsive to the basic needs of the population, both in urban and rural areas.

Annexes

Annex A: ToR

Evaluation Terms of Reference
"Emergency Public Health Assistance to Iraq: Strengthening Non-Communicable Diseases and Mental Health Control and Prevention Programme"

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 Health Care 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 equipments, 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 main goal of the Strengthening Non-Communicable Diseases (NCD) and Mental Health (MNH) Control and Prevention project was to improve the prevention and control activities of Non-Communicable Diseases and Mental Health services with special focus on integrating them within the Primary Health Care (PHC) system in Iraq. The developmental goals for the project were to contribute to the reduction of mortality and morbidity due to Non-Communicable Diseases which constitute the main causes of death among adult population and morbidity due to mental health disorders of the crisis affected population in Iraq.

Immediate objectives for NCDs were described as follows:

1. To assistant MOH in carrying out needs assessment to obtain representative baseline data about major risk factors on NCDs and in establishing a surveillance system for NCDs including a well functioning cancer registry
2. To support MOH in developing and in initiation the implementation of comprehensive multi-sectoral strategy for NCDs covering surveillance , prevention and management of common diseases
3. To support MOH in establishing model projects for integrating health care of people with common NCDs into PHC
4. To assist MOH in supporting the urgent needs of health facilities dealing with chronic diseases – cancer , CVD , renal problems and Diabetes

Immediate objectives for Mental Health component of the project were:

1. Assess the mental health situation including substance abuse and analyze the local cultural context that determines mental health planning
2. Upgrade mental services provided by the health facilities
3. Improve types and quality of services through training to cover promotive and preventive services including school mental health and rehabilitation
4. Initiate national substance abuse data collection system

With that context, the expected outputs and outcomes of the project were as follows

The expected outcomes of the programme are as follows:

- Enhanced surveillance systems that provides data on a regular basis in the areas of hypertension, diabetes, cancer, violence and injuries to guide ongoing policy development and provision of health care services;
- Strengthened health care services for NCD/MH at PHC level.
- Services for prevention and control of blindness initiated.

The expected outputs of the programme are as follows:

Non-Communicable Diseases

- Standardized baseline data on common NCD risk factors and causes of injuries established;
- A surveillance system for cardiovascular diseases, diabetes and injuries and violence strengthened; and
- integration of hypertension and diabetes care into primary health care established;
- The national cancer registry system strengthened;
- A multi-sectoral committee and plan for the promotion of healthy lifestyles and primary prevention of NCDs established;
- Health services for rheumatic fever and rheumatic heart disease introduced and implemented .
- Services for control and prevention of blindness strengthened with a focus on primary eye care; baseline data on prevalence of blindness established.

Mental Health

- Situation analysis of mental health needs assessed; the functioning of existing mental health facilities strengthened; training to improve the quality of mental health care within primary health care implemented; services for the prevention and management of common disorders provided; mental health services in schools established.
- Situation analysis about substance abuse assessed and flow of data established.
- Construction of new and rehabilitation of existing MH units in selected hospitals in Iraq,

The NCD and MH project was implemented during the period of 21st September 2004 – 31 December 2008 at a national level with some interventions focused on selected districts. It was funded from UNDG-ITF with a total budget of USD 11 million.

WHO's major implementation partner was the Ministry of Health. All WHO programs are implemented by MoH staff with the active participation of WHO national staffs in Iraq who are considered experts in

their specified technical areas. Other ministries are those of Education, Higher Education, Environment, Human Rights, Finance and Planning. In addition a number of organizations were involved in the implementation of this programme including international NGOs e.g. Christian Blind Mission (CBM).

Morover, a number of private contractors were hired for the rehabilitation and construction of mental health facilities including the Imar Company, Al Bayena Company, Al Baqee & Areedo, Rasheed Company, Aumed Company, Al Hawra Company, Salwan Amjad, Al Mahdy, Al Aemar Al Hadeeth, Al Alwah Company, Mohammed Salman, Khudier Abbas and Al Nawars.

The Iraqi population as a whole has benefited from various public health control activities of this project through support in the following areas: rheumatic fever control; improved surveillance of cancer, cardiovascular disease and diabetes; screening of hypertension and diabetes; rehabilitation of existing psychiatric units; construction of

new psychiatric units; surveys in areas of mental health and substance abuse; prevention and control of blindness; provision of essential medical supplies and equipment and violence and injury surveillance.

The implementation phase of the project has witnessed a complex and volatile security situation. The 2005-2007 time periods was referred to as the 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 migration of the 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 have also affected the implementation of this project resulting in prolonged and extended implementation period

2. Purpose of the Evaluation

This evaluation is part of the UNDG-ITF projects evaluations where specific criteria were applied to select some projects for evaluation purposes. This independent evaluation comes at the end of the implementation cycle of the project and aims to assess the overall contribution of the project towards strengthening of the prevention and control of NCDs and Mental Health programs in Iraq while distilling lessons and good practices to feed into future programming. 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 enhanced partnership with MOH and NGOs in addressing critical issues affecting NCDs and Mental Health Programs in Iraq

The evaluation findings will be disseminated to all stakeholders at different levels including decision makers both within the Government of Iraq and the UN 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 Health Care System (PHC), with a focus on community outreach and community involvement.*

The evaluation findings will serve as an advocacy tool to demonstrate the results and feasibility of NCDs and MH program integration in PHC which is currently adopted by GOI as cornerstone for the health care system in Iraq. The project will also provide donors within a comprehensive assessment of the outputs and utilization of their investment in these programmatic areas. In addition, The 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.

Last but not least, the evaluation will also contribute to the next WHO Country Cooperation Strategy (2010-14) for Iraq that guides the partnership and joint programming between WHO and GoI

3. Evaluation Objectives

The evaluation will address the Organization for Economic Cooperation and Development –

Development Assistance Committee (OECD-DAC) evaluation criteria including relevance, effectiveness, efficiency, 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 improved Mental Health and NCDs Control Programs in Iraq ;
2. To assess the efficiency and effectiveness of the interventions included in the project
3. To assess the relevance of project components in strengthening the integration of NCDs and Mental Health in the primary healthcare in Iraq vis-à-vis needs in the catchments areas of the selected 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 results from similar initiatives in comparable situations

4. Scope of the evaluation

This evaluation will follow the project geographical coverage and will be of national scope. However, for specific interventions and as guided by the project document, more focus would be given to the facilities and districts where integration of NCDs and MH into PHC was piloted. The project will target activities implemented across all selected PHC facilities at the target 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.

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

- A national survey on the major NCDs risk factors
- Public Awareness activities including workshops and educational materials
- Policy support to NCD control including the formulation of multi-sectoral committees and review of legislations
- Training activities including fellowships in areas of mental health and NCDs
- Provision of supplies and equipments in selected PHCs facilities for NCDs and other facilities within the control and prevention of blindness.
- Development of manuals and guidelines in the different technical areas
- Support to data collection and surveillance.
- Cancer registry strengthening.

- Mental Health assessment survey
- Institutional support to mental health departments
- Integration of NCD/mental health in PHC
- Provision of Mental Health drugs and supplies

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 NCD and MH programs at a national level and the selected governorates?
- What has been the contribution of this project towards national priorities identified in NDS, ICI and MDGs?

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 access and coverage to MH and NCDs services i.e. coverage, improved services utilization, and NCDs management.

Relevance

- Has the project been responsive to the overall issue of NCDs and Mental Health 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 the project 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?
- Are there any specific recommendations to be considered when designing similar projects in the future?

Other considerations:

- Value-added of the programmes and projects in comparison with alternatives
- UN's partnership strategy and its relation to effectiveness in achieving the outcome
- UN's strategic positioning and its comparative advantage
- Cross-cutting issues applicable to the project/ programme
- Operational effectiveness of the programme/ project and the extent to which underlying strategies, processes and management structures contribute to development effectiveness of each UNDG ITF programme/ project
- Each evaluation question should be substantiated with evidence and disaggregated information by gender, ethnicity, location and/ or other relevant criteria

Please also refer to Annex 1 and Annex 2 of the Terms of References and Guidance from RCO which provide recommended questions on development and operational effectiveness respectively. The

suggested questions will generate the necessary evaluative evidence and information at programme/ project level to feed into the UNDG ITF Lessons Learned Exercise.

6. Evaluation Methodology

A detailed evaluation methodology, approach and programme of work will be agreed upon between WHO, MOH 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 and the national counterpart (MOH). An inception report will be prepared by the Evaluation 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 and MOH, 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 project sites and meetings will be held with all partner institutions including primary health centers where NCDs and MH control is integrated. 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 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 health care service delivery
- Efficiency of the project components/ approaches in delivering quality health care 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 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 after the concurrence of MOH/Iraq
- 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 MOH 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 Task Force.

MoH-WHO Task Force:

A 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	November and Dec 2009	Evaluation Team, WHO and MOH

	Participate at the initial stakeholder meeting to launch the evaluation process	January 2010	WHO (Lead) Evaluation Team
Field work/ Data Collection	Review of documents, reports, supporting materials	ongoing	Evaluation Team
	Meetings with MoH/DOHs, Baghdad on the field work	January 2010	
	Finalize questionnaires for primary data collections	January 2010	
	Visit project facilities	February 2010	
	Meeting with secondary beneficiaries (community leaders, sheikhs and project beneficiaries)	February 2010	
Data Analysis	Undertake data analysis of the qualitative and quantitative data acquired from the field work and data collection processes	March 2010	Evaluation Team
Reporting preparation	Preparation of the draft evaluation report	March 2010	Evaluation Team
	Presentation on draft findings/ report to WHO and Ministry of Health	April 2010	
	Finalization of the Report based on feedback from peers, MOH and WHO	April 2010	
	Submission of Evaluation report to WHO and MOH	April 2010	
Dissemination		To be advised	WHO

Annex B: Source of Information

Annex B I: Key Official WHO documents

Project Documents

- UNDG-ITF D2-05- project document

Progress Reports

- UNDG-ITF Progress Reports
- Draft Final Narrative report

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.
- Iraq Mental Health Survey
- Iraq NCDs Risk Factors Survey

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

Letter Number	Letter Date	Department
11383	18/Feb/2010	DoH/Baghdad
13417	15/March/2010	DoH/Baghdad
12533	10/March/2010	DoH/Baghdad/Karkh & Rusafa
54571	15/March/2010	DoH/Baghdad
30028	28/May/2009	MoH
383	29/July/2009	DoH/Baghdad /Karkh
396	6/ August /2009	DoH/ Baghdad
47348	18/ August /2009	DoH/Baghdad/Karkh & Rusafa
16574	29/March/2009	DoH/Baghdad/Karkh & Rusafa
5039	5/Apr/2009	MoH/DoH/ Wassit
16574	2/March/2009	DoH/Baghdad/Karkh & Rusafa
3679	28/June/2009	DoH/Baghdad/Karkh & Rusafa/All governorates
283	8/June/2009	MoH/DoH
29856	27/May/2009	DoH/Baghdad/Karkh & Rusafa
4391	17/Jan/2010	DoH/Baghdad/Karkh & Rusafa/All governorates
40532	15/July/2010	MoH
320	24/Jun/2010	MoH
52883	13/Sep/2009	MoH

277	12/Jun/2008	MoH/DoH
19127	27/Apr/2008	DoH/Baghdad/Karkh & Rusafa/All governorates
45135	11/Oct/2007	DoH/Najaf
46020	22/Oct/2007	DoH/Baghdad/Karkh & Rusafa/All governorates
45136	11/Oct/2007	DoH/Basrah
287	18/July/2007	MoH/DoH
28916	23/Nov/2009	MoH/DoH
4975	22/Jun/2009	MoH/DoH
318	2/March/2009	MoH/DoH
5189	7 / Jun /2007	MoHE
17792	2/Nov/2008	MoH
10837	19/Dec/2006	DoH / Babel
2031	22/Oct/2009	DoH / Babel
3268	24/Jan/2007	DoH / Babel
16019	13/Dec/2006	DoH / Babel
9017	11/Nov/2009	DoH / Mosel
6069	26/Oct/2009	DoH / Mosel
9388	26/Nov/2009	DoH / Mosel
9914	13/Dec/2009	DoH / Mosel
18021	2/Dec/2009	DoH / Mosel
50670	22/Sep/2009	MoH / Erbil, Duhuk, Sulaymania
20765	17/Sep/2009	MoH / Erbil, Duhuk, Sulaymania
15145	16/Aug/2009	MoH / Erbil, Duhuk, Sulaymania
1393	20/Jan/2009	MoH / Erbil, Duhuk, Sulaymania
12861	27/Oct/2008	MoH / Erbil, Duhuk, Sulaymania
14055	17/Nov/2008	MoH / Erbil, Duhuk, Sulaymania
3836	12/Oct/2008	MoH / Erbil, Duhuk, Sulaymania
1454	17/Nov/2008	MoH / Erbil, Duhuk, Sulaymania

Annex B III: Desk Study Documents

1. CDC /WHO. Global youth tobacco survey , CDC; -2008
2. Ministry of Health. KAP study on smoking , school smoking free project ,2008 2009. (activity report)
3. Ministry of Health. Smoking free medical college ,2008 (activity report)
4. Ministry of Health. Rapid Assessment for Avoidable Blindness (RAAB) at central districts in Basra and Sulaimaniya; 2009 (draft report).
5. Ministry of Health. Non-Communicable Diseases Prevention and Control Programme , Screening for Hypertension and Diabetes; 2009 (draft report).
6. List of Multi-Sectoral Committee on NCDs (document)
7. Summary of national training Activities on NCDs (document)
8. Plan for distribution of ECGs, spectrophotometers and ophthalmic equipment by DoH
9. Fellowships on NCDs
10. Ministry of Health/ WHO. Teacher's Guide on Health Education Publisher (Arabic)

11. Ministry of Health/ WHO. Iraq Cancer Registry (years 1999 – 200). WHO2007 (English)
12. Ministry of Health/ Ministry of Planning and Development Cooperation-COSIT/ WHO Chronic Non-Communicable Diseases Risk Factors in Iraq , ,2006. WHO; 2007 (English)
13. Ministry of Health/ WHO. National Guidelines for Primary Health Care Physicians: Hypertension ,Prevention, Diagnosis and Treatment .WHO; 2008 (English)

14. Ministry of Health/ WHO. National Guidelines for Primary Health Care Physicians: Diabetes Management .WHO; 2008 (English)
15. WHO/ Global Status Report on Road Safety.2008
16. Health Education Guide (Arabic)
17. Ministry of Health/ WHO. Puberty ,, Characteristics , needs and problems ,WHO/MOH 2009 (Arabic)
18. Ministry of Health/ WHO Rheumatic Fever and Rheumatic Heart Disease ,MOH, 2008(Arabic Booklet)
19. Ministry of Health. Health Education Guide on Breast Cancer ,MOH in collaboration with the National Committee on Early Detection of Breast Cancer (Arabic)
20. Health Educational Pamphlet on Breast Self-Examination (Arabic)
21. Five educational pamphlets on diabetes, healthy diet, physical activity, smoking and, anemia ,MOH (Arabic)
22. National Indicators for Monitoring MDGs ,,2009 (Arabic)
23. Erbil DoH Statistics

Awareness Campaign Documents / Brochures:

- وزارة الصحة العامة / داء السكري
- وزارة الصحة / ممارسة النشاط البدني
- وزارة الصحة/ الفحص الذاتي للثدي
- وزارة الصحة /بعض الحقائق عن التدخين
- وزارة الصحة / الغذاء الصحي والنشاط البدني
- وزارة الصحة / الغذاء الصحي والمجتمع
- وزارة الصحة / العناية بالقدمين للمصابين بالسكري
- وزارة الصحة /رسائل صحية عن فقر الدم
- وزارة الصحة / تغذية المراهقين
- دائرة صحة البصرة/ اساسيات التغذية في شهر رمضان
- وزارة الصحة / بعض الحقائق عن التدخين
- مشروع مدارس خالية من التدخين /استبيان المعارف و التوجيهات لطلبة الصف الخامس الابتدائي
- Smoking free medical college project (KAP Study)/MoH/ Iraq
- Global Youth Tobacco survey (GYTS)
- Hypertension /prevention, diagnosis and treatment/DoH-NCDS
- Diabetes Management /DoH-NCDS
- Chronic Non-Communicable Diseases / Risk Factory Survey in Iraq
- Iraqi Canter Registry booklet

Books

- وزارة الصحة / دائرة الصحة /المراهقة /دليل استشاري للملاكات الطبية والصحية والاباء والمربيين والتربويين
- وزارة الصحة /دليل المثقف الصحي
- وزارة الصحة / دليل تثقيف صحي حول سرطان الثدي /الفحص الذاتي للثدي
- منظمة الصحة العالمية /دليل المعلم في التثقيف الصحي / برنامج المنهج الصحي في المردود العلمي
- وزارة الصحة / الجدول الوطني لتلقيحات الاطفال
- وزارة التخطيط / المؤشرات الوطنية لرصد الاهداف الانمائية للالفية

Newspapers' Articles:

- الاقل ذكاء اكثر عرضة للاصابة بامراض القلب
- التمارين الرياضية تقلل من خطر الاصابة بحصوات المرارة
- انخفاض السكر في الدم الانواع و الاسباب ، العلاج
- تسوس الاسنان انواعه و كيفية المعالجة
- واحد من خمسة مرضى مصابين بالسكري في بريطانيا

- التخلص من البدانة صحة و جمال
- السجاد سبب حدوث الربو والحساسية
- مدن الصين الجديدة خالية من المدخنين

Annex B IV: Preliminary Interviews

Preliminary interviews took place with the following organizations

- WHO Amman Office
- WHO Iraq
- MoH

Annex B V: Attendance of Pre - evaluation meeting:

MoH	WHO	UNDG	SOC
• Dr. Muna Ata Alla – PHC department • Dr. Salahdin Ahmed – KRG • Dr. Zainab Abdul Hussain – Planning department. • Dr. Hiyam Muzahim – Cancer Council • Dr. Dalal Muhsein - Psychological consultant office • Dr. Amani Talib – International health department.	• Dr. Naeema Al-Gasseer-WR • Dr. Faris Farid • Dr. Eltayab Mansour • Dr. Omar Makki • Dr. Ezechiel Bisalinkumi • Eng. Mohammed Hamasha	Mr. Usman Akrum - RCO	SOC evaluation team

Annex B VI: In-depth Interviews

Governorates	Location / Job description	Names
Baghdad	Director of Non-communicable Diseases Section and NCD program manager – Directorate of Public Health/Ministry of Health	Dr. Muna Ata Alla
Baghdad	MoH	Dr. Lujain Kadhum
Baghdad	MoH / Cancer Council	Dr. Hiyam Muzahim
Baghdad	MoH/ National Consultant / Mental health office	Dr. Emad Abdul Razaq
Baghdad	MoH/ National Consultant office	Dr. Dalal Muhsen
Baghdad	DoH / Rusafa	Dr. Liqa Abdul Latif
Baghdad	DoH / Karkh	Dr. Entidhar Assad
Baghdad	PHCC / AlKadhimiya	PHCC manager & Employees
Baghdad	Al Yarmok Hospital	Dr. Ali Abass
Baghdad	Al Emam Ali Hospital	Dr. Haitham assem
Baghdad	Al Zahra PHCC	Dr. Emad Humud
Baghdad	Al Zahra PHCC	Ms. Fadhila Hasan /Vision tester
Baghdad	Al Shaab PHCC	Dr. Zaid Adbul Nafia
Baghdad	Al Shaab PHCC	Ms. Zian Jaber /Vision tester
Babel	Director of Non-communicable Diseases Section and NCD program manager	

Basra	Director of Non-communicable Diseases Section and NCD program manager – Directorate of Public Health	Dr. Nihad Qasim
Basra	Eye care department	Dr. Riyadh Ahmed Al Hakim
Basra	Mental health department	Dr. Nazhat Abdul Jabar
Basra	Non-communicable Diseases Section	Ms. Huda Abdul Jabar
Basra	Non-communicable Diseases Section	Ms. Nagham Habib
Basra	Medical operations department	Dr. Salah Ahmed
Basra	Data analysis department	Dr. Raad Khames
Basra	Pharmacologist	Dr. Haider Ghalib
Kirkuk	DoH	Dr. Ahlam Ez al din
Mosel	Director of Non-communicable Diseases Section and NCD program manager – Directorate of Public Health	Dr. Rafah Fakhri
Mosel	DoH	Dr. Mahir Tawfiq
Mosel	Al Mansour PHCC / Director	Dr. Faris Abdul Khaliq
Mosel	Al Noor PHCC / Director	Dr. Mohammed Taha
Mosel	Al Hamdaniya PHCC	Dr. Audai Hana
Mosel	Al Hamdaniya PHCC / Director	Dr. Nagham Abdul Had
Mosel	Al Tilkaif PHCC / Director	Dr. Atiya Thanon
Mosel	Al Tilkaif PHCC	Dr. Rafiya Shukri
Duhuk	Director of Planning Department / DoH	Dr. Surur Sadik
Duhuk	Director of Non-communicable Diseases Section and NCD program manager	Dr. Wafa Salih Rasheed
Duhuk	Mental Health department / Director	Dr. Nazar Esmat
Duhuk	Cancer unit manager	Dr. Elham Haji
Duhuk	Director of Non-communicable Diseases Section	Ms. Azhar Hakeem
Erbil	Director of Non-communicable Diseases Section and NCD program manager	Dr. Hushi Mohammed Rasheed
Erbil	Directorate of Public Health	Dr. Ashwak hana
Erbil	Directorate of Public Health	Dr. Sarhank Jalal
Erbil	Mother & Child care department	Dr. Berevan Adnan
Erbil	Eye care department	Dr. Sazan Kamal
Erbil	Emergency Hospital	Dr. Abdulla Rizani
Erbil	Emergency Hospital	Dr. Hilamt Hameed
Sulaymania	DoH	Dr. Razkar Ali
Sulaymania	Director of Non-communicable Diseases Section and NCD program manager	Dr. Fraidon Fahmi
Sulaymania	Director of Non-communicable Diseases Section and NCD program	Dr. Hankar Ali
	Beneficiaries from all targeted Communities	

Annex C: Field evaluation Guidelines & Questionnaires

STRENGTHENING NON-COMMUNICABLE DISEASES AND MENTAL HEALTH CONTROL AND PREVENTION PROGRAMME

Activity # 1:

1. **Objective:** To assist the MOH in carrying out needs assessment to obtain representative baseline data about major risk factors in NCDs and in establishing a surveillance system for NCDs including a well-functioning cancer registry.

2. **Stakeholder for this activity**

- WHO Representative/Technical staff
- MOH at central and governorate level
- Ministry of Planning and Development cooperation.
- Central organizations for statistics and Information Technology
- Benefited PHC staff

3. **Identity of Respondent:**

Post title: ____

Gender: ____

Ethnicity: ____

Location: ____

In position since: ____

Qualifications: ____

4. **Key Evaluation Guidelines:**

4.1 Achievements and results:

- Did the national survey achieve the contemplated results with regard to establishing a standardized baseline data on common NCD risk factors and causes of injuries?
- To what extent did the screening for diabetes and hypertension reinforce the findings of the national survey?
- Was the screening carried out based on uniform criteria and procedures?
- What difficulties were faced during the conduct of the national survey and screening activities?
- Did the MOH use and benefit from the results of survey for developing the NCD prevention and control strategy?
- To what extent, the results of the survey will contribute to improving NCD services?
- Was the quality and scope of training adequate to build the capacity of staff, at all levels, to implement and maintain the NCD surveillance system?

- Has an appropriate information system been established to ensure regular exchange of evidence-based information on cancer morbidity and mortality, between the primary and secondary health care levels?

- Was the cancer registry up-dated on regular basis?

4.2 Efficiency and effectiveness:

- To what extent were the project activities implemented in a cost-effective manner vis-a-vis the Iraqi context?

- How did the NCD surveillance system and cancer registry contribute to improve data recording, reporting and feedback?

4.3 Relevance:

- Was the design of the national survey able to establish the impact of war-related hazards and environmental degradation on morbidity and mortality from NCDs?

4.4 Partnerships:

- Had the level of cooperation, between the MOH and other involved ministries, been satisfactory during all phases of planning and conduct of the survey?

4.5 Sustainability:

- What is the current status of the surveillance system and cancer registry? Are functions still maintained?

- Who assumed responsibility for the management and oversight of the surveillance system and cancer registry?

- Had the project results in knowledge transfer from those who were trained and capacitated in different competences and how?

- How were the issues of insecurity addressed during the conduct of the survey?

4.6 Lessons learned and good practices:

- What are the good practices that have resulted from this project component? Substantiate with evidence?

- What are the key lessons learned from conducting the national survey?

- What recommendations could be replicated for conduct of similar surveys?

- Are there any specific recommendations to be considered when designing similar need assessments in the future?

4.7 Other Considerations:

- Did the survey design take into account the needs of marginalized, vulnerable and hard-to-reach groups?

- Had there been significant gender, ethnicity and location differences with regard to people's response to the survey?

Activity # 2:

1. **Objective**: To support MOH in developing and initiation the implementation of comprehensive multi-sectoral strategy for NCDs covering surveillance, prevention and management of common diseases.

2. **Stakeholders for this activity:**

   WHO (WHO Representative and technical staff)
   MOH (at central and governorate level)
   MOHE (for questions marked with*)
   Participating NGOs (for questions marked with**)

3. **Identity of respondant**:

   Post title: ______________________________
   Gender: ______________________________
   Ethnicity: ______________________________
   Location: ______________________________
   In position since: ______________________________
   Qualifications: ______________________________

4. **Key Evaluation Guidelines:**

   4.1 Achievements and results:

   - How did the strategy contribute to realization of the underlying project objectives?
   - Has the strategy been able to achieve the contemplated project results?
   - How did the strategy contribute to strengthening the NCD programme at the national level and various governorates?
   - Who prepared the technical guidelines, operation manuals and management protocols?
   - Were the technical guidelines and operation manuals made available to PHC facilities and staff adequately oriented on their contents?
   - Did the strategy comprise targeted programmes to strengthen patient self-reliance, competence and skills?
   - Did the strategy involve use of clinical records providing information on risk profile, complications and management outcomes?

- Did the competency-based training develop adequate capacity of staff for active surveillance, prevention and management?

- What were the main deficiencies of the training in terms of quality and coverage?

- Has a system of clinical audit, on-the-job supervision, monitoring and formative evaluation been considered?

- What means were used at the PHC level to raise community awareness on major NCD risk factors and healthy lifestyle modifications?

- (*)Had arrangements been made to integrate life skills education into the activities of teaching institutions/community awareness activities?

- Were community leaders involved in community awareness activities?

- How were services for prevention and control of blindness strengthened?

- (*)Has a system for screening and early detection of eye diseases and vision disorders been established and implemented in schools?

- What activities were undertaken to introduce and strengthen services for rheumatic fever and rheumatic heart disease?

- Were the results of the KAP study on the harmful effects of smoking analyzed and disseminated?

4.2 Efficiency and effectiveness:

- To what extent was the strategy developed in a cost-effective way vis-à-vis the Iraqi context?

- How did the strategy contribute to the realization of the underlying project objectives?

- Did implementation of the strategy contribute to improved access utilization and management of NCDs?

4.3 Relevance:

- Has the strategy been responsive to the overall issue of NCDs in Iraq?

- Was the strategy developed consistent with WHO strategic approaches and guidelines?

- Was the strategy tailored to the current Iraqi context and in line with national policies and strategic plans?

4.4 Partnerships:

- *Did partners to the multi-sectoral committee on promotion of healthy lifestyles maintain regular communication, co-ordination and interaction through all phases of the planning and implementation?

- (*) What plans were developed to expand use of the mass-media for raising public awareness and promoting healthy lifestyle modifications?

- (*)What factors hindered or fostered effective partnership development?
- (*)To what extent did the project contribute to capacity development of the involved partners?
- (**)What role did the involved NGOs play in strengthening services for prevention and control of blindness?

4.5 Sustainability:

- What is the current status of the project component?
- Who assumed responsibility for project management and oversight after the end of the project cycle?
- Had the service provision been affected after the end of the project cycle?
- Did the project result in knowledge and experience transfer from those who were trained and capacitated in different competences and how?
- What risk mitigation measures were undertaken to address the issues of insecurity during the implementation phase?

4.6 Lessons learned and good practices:

- What are the good practices that have results from this project?
- What were the key lessons learned from the project implementation?
- What recommendations could be replicated in similar projects implemented in compatible situations?
- Are there any specific recommendations to be considered when designing similar projects in the future?

4.7 Other considerations:

- What value-added did the multi-sectoral approach bring compared to vertical interventions?
- What were the main cross-cutting issues applicable to this project?
- Did the project give sufficient attention to promote gender equality and sensitivity?
- Did the project take into account effects on marginalized, vulnerable and hard-to-reach groups?

Activity # 3:

1. **Objective**: To support MOH in establishing model project for integrating health care of people with common NCD into PHC.

2. **Stakeholders for this activity:**

   WHO (WHO Representative and Technical staff)
   MOH (at central, governorate and district level)
   PHC staff
   Direct beneficiaries (Questionnaire in Arabic attached)

3. **Identity of respondent**:

   Post title: ____

Gender: ____

Ethnicity: ____

Location: ____

In position since: ____

Qualifications: ____

4. Key Evaluation Guidelines:

4.1 Achievements and results:

- How did the model NCD projects contribute to the realization of the underlying project objectives?
- Were the model units able to achieve the contemplated project results?
- How did the project contribute to strengthening the NCD programme at national and governorate levels?
- What competences did concerned staff develop through training?
- Did staff develop adequate capacity for knowledge/experience transfer to others?
- What difficulties were encountered in staff compliance with the technical guidelines and management protocols?
- How do you describe patient compliance to health advice on lifestyle modifications and management plans?
- Had a data recording and reporting system been maintained?
- Has the NCD surveillance system been introduced and maintained in the model units?
- To what extent had screening and early detection activities for hypertension and diabetes been undertaken?
- Were the laboratory equipment and supplies adequate to support implementation of the various components of the intervention strategy?
- What efforts were exerted to improve patient competence and skills for assuming responsibility for own health and self-reliance?
- How were services for prevention and control of blindness strengthened?
- How were services for rheumatic fever and rheumatic heart disease strengthened?

4.2 Efficiency and effectiveness:

- To what extent the project activities were implemented in a cost-effective manner vis-à-vis the Iraqi context?
- How did the project results contribute to improve access, service utilization and NCD management?

4.3 Relevance:

- Was the project responsive to the needs of the served population under the prevailing situation?

4.4 Partnerships:

- Were there any partners involved in implementation of this project? Who were they?
- What factors hindered or fostered effective partnership development.

- To what extent did the project contribute to capacity development of the involved partners?

4.5 Sustainability:

- What is the current status of the project? Are function and facilities still maintained?
- Who become responsible for the management and oversight of project facilities after the end of the project cycle?
- Has the services provision been affected after the end of the project cycle?

4.6 Lesson learned and good practices:

- What are the good practices that have resulted from this project?
- How and why some of these practices could be labeled as good practices? Substantiate with evidence?
- What are the key lessons learned from the project implementation?
- What specific recommendations can be considered for generalization of this experience country-wide?

4.7 Other considerations:

- What value-added did integration of NCD services into PHC activities bring about compared to the fragmented vertical approach?
- What cross-cutting issues were applicable to this project?
- Were these significant gender, ethnic or socio-economic status variations in utilization of project activities?

Activity # 4:

1. **Objective:** To assess the mental health situation including substance abuse and upgrade mental health facilities and services.

2. **Stakeholders for this activity:**

   WHO (WHO Representative and Technical staff)
   Ministry of Planning and Development Cooperation
   Ministry of Health/Kurdistan Region
   The National Mental health council
   Ministry of Education
   Ministry of Higher Education
   Ministry of Human rights
   Ministry of Justice
   Academic Supervisors
   PHC staff
   Contractors
   Direct beneficiaries (2 Questionnaire in Arabic attached)

3. **Identity of respondent**:

   Post title: ____

   Gender: ____

Ethnicity:____

Location: ____

In position since: ____

Qualifications: ____

4. Key Evaluation Guidelines:

4.1 Achievements and results:

- How did the project components contribute to realization of the underlying project objectives?
- Did the Iraq Mental Health Survey (IMHS) contribute to assessment of the burden of mental health problems among the target population?
- How were the findings of the IMHS used to determine needs for service provision, capacity building and legislation?
- How did the situation analysis of substance abuse contribute to establishment of data flow and setting targets for substance abuse programmes?
- To what extent did mental health manuals contribute to capacity development of health and teaching staff in the areas of psychological support and provision of mental health care through the PHC systems and schools?
- To what extent did the training programme contribute to capacity building of professionals and improvement of psychiatric skills?
- To what extent was a school mental health programme established and implemented?
- Was the school mental health progamme designed to provide counseling and rehabilitation services to affected children? How? Elaborate.
- Did the competency based training of health and teaching staff contribute to capacity development for early detection of behavioral changes, providing psychological support and promoting constructive coping mechanisms?
- Were all projects for construction of new mental health units on rehabilitation of existing MH units in the selected hospitals, completed and become operational?
- Has a referral system and feedback between PHC facilities, schools and hospitals been established?
- Were essential mental health drugs made available in adequate quantities at all times?
- Have technical guidelines and regulations been developed and health staff trained on rational prescribing practices?
- Had control measures been established to avoid miss-use of mental drugs?
- Has the project been able to achieve the contemplated results?
- What was the contribution of this project towards national priorities identified in the Millennium Development goals and Convention on the Rights of the Childs?

4.2 Efficiency and effectiveness:

- To what extent the project was implemented in a cost-effective manner vis-à-vis the Iraqi context?
- How did the projects results contribute to improved access and coverage of MH services?
- To what extent were MH activities integrated into PHC activities?

4.3 Relevance:

- Has the project been responsive to the overall challenges generated by the prolonged violence and socio-economic hardship?
- Were the project strategies developed in line with the National Mental Health Act and the UN convention on psychotropic substances?

4.4 Partnerships:

- Did the project partners actively participate in developing and implementation of the planned activities?
- Did the project strengthen existing partnerships, forge new partnerships and how?
- To what extent did the project contribute to capacity development of the involved partners?

4.5 Sustainability:

- What is the current status of the project? Are functions and facilities still maintained?
- Who assumed responsibility for the management and oversight of project facilities and functions after the end of the project cycle?
- What is the current status of service provisions in PHC facilities, hospitals and schools?
- Did the project result in knowledge transfer from those who were trained and capacitated to other heath and teaching staff?
- Were risk mitigation measures undertaken to address the issues of insecurity during implementation? If yes, how?

4.6 Lessons learned and good practices:

- What are the good practices that have resulted from this project?
- How and way some of these practices can be labeled as good practices? Substantiate with evidence?
- What are the key lessons learned from the project implementation?
- Are there any specific recommendations to be considered when designing similar projects?

4.7 Other considerations:

- What was the value-added of integrating mental health services into PHC facilities and schools in comparison to institutionalized care?
- What were the main cross-cutting issues applicable to this project?
- Did the project give sufficient attention for promoting gender equality and gender sensitivity?
- Did the project take into account the adverse psychological effect on marginalized, vulnerable and hard-to-reach groups?
- Have there been any signification variations in access to and utilization of project services in relation to gender, ethnicity and socio-economic status?
- Did the project give adequate attention to the needs of women and children in conflict situations? In particular, management of post-trauma stress disorders?

ANNEX D: SOC Background

SOC background:

Stars Orbit Consultants 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 Monitoring and Evaluation aiming to evaluate the past, monitor the present and plan for the future.

Between 2004 and 2009, SOC successfully performed Monitoring and Evaluation activities on more than 200 programmes and grants on behalf of donors and international organizations in various parts of Iraq including (Baghdad, Basrah, Missan, Thi Qar, Mothanna, Qadissiya, Najaf, Babil, Karbala, Anbar, Mosel, Salah El Din, Diyala, Kurkuk, Erbil, Sulaymanyia and Dohuk), the Monitoring and Evaluation activities have been carried out by more than 30 qualified, well trained and professional employees stationed in all the 18 governorates.

Since most of the projects implemented in Iraq are now remotely managed from outside Iraq, the need for professional, effective, objective and honest monitoring and evaluation mechanism starts to grow to ensure that the program meets its original objectives, donor perspective and expected outputs.

For more details on SOC and its activities, please visit www.starsorbit.org