**UNDG Iraq Trust Fund**

# ANNUAL PROGRAMME[1] NARRATIVE PROGRESS REPORT

## REPORTING PERIOD: 1 JANUARY – 31 DECEMBER 2011

| Programme Title & Number | Country, Locality(s), Thematic Area(s)[2] |
|---|---|
| **Programme Title:** Strengthening Primary Health Care System Phase II.<br>**Programme Number:** D2-25<br><br>**MDTF Office Atlas Number:** 54904 | Iraq<br><br>Sector D-Health and Nutrition |

| Participating Organization(s) | Implementing Partners |
|---|---|
| WHO and UNICEF | **National counterparts** *(MOH, MOHE,MOF and MOPDC).* |

| Programme/Project Cost (US$) | Programme Duration (months) |
|---|---|
| MDTF Fund Contribution:<br>WHO: **5, 930,368**<br>UNICEF : **5, 987,632**<br>Agency Contribution<br>WHO: **200,000**<br><br>Government Contribution<br>WHO and UNICEF:<br>**500,000**<br><br>Other Contribution (donor)<br>*(if applicable)*<br><br>**TOTAL: 12,618,059** | **Overall Duration**:<br>WHO: 48 months<br>UNICEF:42 months<br><br>**Start Date**[3]<br>9 December 2008<br>**End Date or Revised End Date,**<br>WHO: 30.06.2012<br>UNICEF: 31.12.2012<br><br>Operational Closure Date[4]<br>Expected Financial Closure Date |

| Programme Assessments/Mid-Term Evaluation | Submitted By |
|---|---|
| Assessment Completed - if applicable *please attach*<br>☐ Yes ☐ No Date: _____<br>Mid-Evaluation Report – *if applicable please attach*<br>☐ Yes ☐ No Date: _____ | o Name: Dr. Aqila Noori<br>o Title: Technical Officer, Health Systems Development<br>o Participating Organization (Lead): WHO<br>o Email address: nooria@irq.emro.who.int |

[1] The term "programme" is used for programmes, joint programmes and projects.
[2] Priority Area for the Peacebuilding Fund; Sector for the UNDG ITF.
[3] The start date is the date of the first transfer of the funds from the MDTF Office as Administrative Agent. Transfer date is available on the MDTF Office GATEWAY (http://mdtf.undp.org).
[4] All activities for which a Participating Organization is responsible under an approved MDTF programme have been completed. Agencies to advise the MDTF Office.

**Acronyms**

APW: Agreement for Performance of Work
BHSP: Basic Health Service Package
BOQ: Bills of Quantities
CBI: Community Based Initiative
CBPSS: Community Based Psychosocial Care Programme
DG: Director-General
DM: Diabetes Mellitus
DoH: Directorate of Health
EMRO: Eastern Mediterranean Regional Office
GoI: Government of Iraq
GDP: Gross Domestic Product
HRH: Human Resources for Health
HIS: Health Information System
HT: Hypertension
ITF: Iraq Trust Fund
ICI: International Compact with Iraq
IRFFI: International Reconstruction Facility Fund for Iraq
IDHS-FPA: Integrated District Health System- Based on Family Practice Approach
IMCI: Integrated Management of Childhood Illness
ICD-10: International Classification of Disease- $10^{th}$ version
IDPs: Internally Displaced Persons
MoH: Ministry of Health
MoHE: Ministry of Higher Education
MoE: Ministry of Education
MoLSA: Ministry of Labour and Social Affairs
MoPDC: Ministry of Planning and Development Cooperation
MH: Mental Health
MDGs: Millennium Development Goals
NGOs: Nongovernmental Organization
NDS: National Development Strategy
NTAs: National Training Activities
NHA: National Health Accounts
PHC: Primary Health Care
PHCCs: Primary Health Care Centers
SCSO: Steering Committee Support Office
SC: Steering Committee
SOTs: Sector Outcome Teams
SPHCS: Strengthening of Primary Health Care System
ToT: Training of Trainers
UNICEF: United Nations Children's Fund
WHO HQ: World Health Organization- Headquarters
WHO: World Health Organization

# NARRATIVE REPORT FORMAT

## I. Purpose

The aim of Strengthening Primary Health Care System (SPHCS) phase II project is to support the MoH efforts in the area of Health Sector Reform and strengthening the decentralized District Primary Health Care (PHC) System in Iraq. The restructuring of the system will improve equity, efficiency, effectiveness and responsiveness of system. This is in line with the Ministry of Health (MoH) articulated vision for PHC as 'an accessible, affordable, available, safe and comprehensive quality health service of the highest possible standard that is financially sound and founded on scientific principles in order to meet the present and future health needs of Iraqi people regardless of their ethnicity, geographic origin, gender or religious affiliation.' This vision calls for an integrated reform of the Health Care System which is the main objective of this project. This project is also in conformity with the MoH goal to transform inefficient, centrally-planned and curative care-based services into a new system based on prevention and evidence-based, equitable, high quality, accessible and affordable primary health care.

This project is a WHO-UNICEF joint project that builds on previous achievements under the Strengthening of Primary Health Care System (SPHCS) Phase I project in Iraq. The project is designed to contribute to upstream national policy level and at downstream health service delivery level.

The immediate objectives of phase II are to (a) invest in the national capacity of MoH/DoH staff in targeted areas to improve Integrated Health Services Delivery, including community psychosocial support (b) invest in improving the Human Resources Planning capacity for the MoH staff (c) strengthen the national capacity of National Health Information System (d) strengthen the National Health Care Financing System (e) strengthen the health governance and policy environment.

SPHCS Phase II project has been designed according to the national priorities and in conformity to the Health and Nutrition Sector goals, objectives and benchmarks as stipulated in the National Development Strategy (NDS) 2007-2010, International Compact with Iraq (ICI), UN Assistance Strategy for Iraq 2008-2010 and the Millennium Development Goals (MDGs). SPHCS project will contribute to successful accomplishments of the following strategic health and nutrition sector goals and objectives defined jointly by the government and partner agencies.

The implementation of this project has put in place the basic infrastructure for achieving the ICI goal for heath sector, which states: 'Improve health and nutrition of all Iraqis as a cornerstone of welfare and economic development, increase spending in health from 2.5% to a minimum 4% of GDP to secure access to basic health care for all while preserving the current share of payroll.

Similarly, the SPHCS project has been strongly linked to the national priories as stipulated in the National Development Strategy (NDS) for Iraq. In order to fulfill the benchmark commitments of ICI the NDS 2007-2010 has been put in place by the Government of Iraq (GoI) to address the various priorities which were identified by the government in a more concrete and precise manner. The NDS will contribute to the attainment of the ICI health sector goals by focusing on the following strategic priorities:

- Strengthen the national healthcare delivery system, and to reorient it from being hospital-focused to being based on Primary Health Care delivery.
- Strengthen emergency preparedness and response in order to address the needs of Iraqis, especially vulnerable populations, while promoting a healthy living environment.

Moreover, the SPHCS phase II project is in line with the UN Iraq Assistance Strategy 2008-2010. This assistance strategy which will guide UN activities from 2008-2010 has been developed in consultation with the government of Iraq, donor community and NGOs to ensure that it keeps with national priorities namely the National Development Strategy, objectives set forth in the International compact with Iraq (ICI) and MDG benchmarks. The SPHCS project will contribute substantially to the achievement of the Health &Nutrition Sector related objective of the UN Iraq Assistance Strategy which states that:

By 2010, health and nutrition related programs enhanced to ensure 20% increase in access to quality health care services with special focus on vulnerable groups.

It is also in line with the UN Development Assistance Framework (UNDAF) for Iraq (2011-2014) that presents and describes the UN collective response to national development priorities. This project is contributing to the 5 priories that were identified by the UNDAF with emphasis on priority number one and four stated below:

- Improved governance, including protection of human rights;
- Increased access to quality essential services.

It is worthwhile to reiterate the fact that the various outputs undertaken by this project will eventually contribute to the achievements of the following Health and Nutrition Sector related MDGs.

- Reduce child mortality (MDG 4)
- Improve maternal health (MDG 5)
- Combat HIV/AIDS, malaria, and other diseases (MDG 6)
- Eradicating extreme poverty and hunger (MDG 1)
- Ensure environmental sustainability (MDG 7)

## II. Resources

***Financial Resources:***

- Provide information on other funding resources available to the project, if applicable.

  WHO contributed to the completion of project activities under this project from its own financial resources through various direct and indirect mechanisms. Furthermore, the project was provided with a high level of technical and administrative support by the Country, Regional and HQ offices of WHO. This project also saw a high level of monitoring and supervisory support by the experts from the aforementioned various offices of WHO.

  Due to the price increases for labor and construction materials the estimated project budget is no longer sufficient to construct 13 PHCCs. UNICEF allocated nearly $1 million from its own resources to cover this shortfall contributing to construction of 3 PHCCs in Wassit, Diwaniyah and Basrah.
  UNICEF has also covered the cost of the Senior Manager who was part time overseeing project implementation from Amman with frequent missions to Baghdad.

- Provide details on any budget revisions approved by the appropriate decision-making body, if applicable.

Two requests for project extension were submitted to the Steering Committee Support Office (SCSO) and granted. The first request included a total of 12 months extension (end of December 2011) . The extension request involves only a change of a maximum of 10% of the budget lines.
The second request included a total of 6 months extension for WHO (end of June 2012) with no budget change and a total of 12 months extension for UNICEF (end of December 2012) with budget movement that included contract budget decrease by 18%, training budget increased by 387% and salary budget increased by 27 % (this is to note that these percentages are accumulated from both extensions).

As per the agreement between WHO and the government of Iraq, WHO did not consider any payment in advance and the payments to all types of transactions took place after submission of the statements of account and other proofs of expenditure which facilitated the financial management of grants under this project as well as contributed to transparency and accountability of the funds used. However, payments were sometimes delayed due to the complexity of the operation, where most of the financial transactions are processed and certified in Amman before sending them back to Baghdad due to the absence of a reliable banking system in Iraq.

***Human Resources:***

**WHO National Staff:** One national technical officer and one administrative assistant who are based in Amman with frequent travels to Iraq, has been contributing to the implementation of the project activities by a regular follow up with the counterparts in the various ministries e.g. MoH, MoHE and MoPDC. These national staffs' inputs have been instrumental in the accomplishments of the various activities undertaken by the project. In spite of the huge challenges and security restrictions the staff has been able to contribute to health system strengthening and the capacity building needs of the mentioned partner agencies. In addition, WHO regularly utilizes the expertise of national consultants who are assigned to perform specific tasks under an Agreement for Performance of Work (APW).

**WHO International Staff:** The project was successfully managed and closely monitored by a full time international medical officer who is based in Amman with frequent travels to Iraq. The project has seen remarkable progress in a number of planned technical areas of strategic importance due to availability of the full time international medical officer.

**UNICEF National Staff:** two national staff – one in Baghdad and one assistant in Amman has been involved in day to day project management, liaising with the MOH, respective DOH, supervising monitoring engineers who are overseeing physical construction and verify quality.

**UNICEF International Staff:** One Senior Health and Nutrition Officer was part time involved in overseeing implementation of the project from Amman with frequent visits to Baghdad. Other UNICEF resources were used to cover the cost of this staff.

## III. Implementation and Monitoring Arrangements

The implementation of this joint project started in December 2008 and will continue up to June 2012 for WHO and December 2012 for UNICEF. The project has successfully completed its three years of implementation and is on its way to contribute to the accomplishments of the project outputs. The MoH is the main government partner with the primary responsibility for implementing this project. The project implementation is assisted by the technical counterparts at National and Sub National levels of MoH. Full

support has been extended by a large network of WHO national staff based in all governorates of Iraq to make sure the timely implementation of this project. The project implementation progress has been regularly monitored by the international medical officer and the National Technical Officer of WHO currently based in Amman. The project also enjoyed a high level of technical backstopping by the WHO Regional Office EMRO in Cairo and WHO-HQ in Geneva. Throughout its implementation the project contributed to the capacity building of a number of governmental ministries namely MoH, MoHE, MoF, MoEn and MoPDC as well as private sector and civil society organizations.

Close coordination was maintained with MoH and UN Health and Nutrition Sector Outcome Team (SOT) partners by the UNICEF Project officers, backed up by contracted facilitators based in Baghdad and in other governorates to oversee project implementation. The monitoring activities for this project include field visits as well as regular meetings with DoHs staff in all governorates, and the preparation of periodic reports. UNICEF staff in Baghdad and Amman, in coordination with MoH, prepare and finalize all technical and financial reports. In addition, all the provided support is coordinated with WHO through the Health and Nutrition Sector Outcome Team which has become now Health and Nutrition sub-PWG, whereby WHO provides overall technical as well as some financial support for routine and accelerated activities.

Up to date, 6 UNICEF Specialized Engineer Facilitators are assigned to monitor and assess the quality of reconstruction works. Assessments are done jointly with technical staff from the relevant MoH/DoH health department, including handover process, documentation of completed work (including photography showing construction stages) and certifying letter from GoI partners addressed to UNICEF. Payments are processed based on UNICEF's receipt of all the above documents.

Throughout the project implementation WHO has placed high emphasis on the principles of ownership and national solidarity. WHO has endeavored to apply these principles in every activity it has undertaken and every result achieved. This approach has been exemplified through the formulation of a Project Management Structure for the Programme:

**Project Steering Committee:**

This committee is a senior level committee to follow up on the progress of project implementation. It met once every three months in Baghdad and WHO is represented at this committee, through one of its national staff. The Steering Committee consists of the following staffs.

**Chairman:**

- H.E. Minister of Health

**Members:**

DG of Public Health and PHC Directorate; DG of Project and Engineering Services Directorate; DG of Planning and Human Resources Development Directorate; DG of Technical Affairs Directorate; Director of International Health Department; Director of PHC Centers Section; WHO Representative

**Executive Committee:**

This committee met once every month in Baghdad to follow up on the progress of the project implementation and WHO is represented at this committee, through two of its national staff.

Chairman:

- DG of Public Health and PHC Directorate

Members:

Director of Health Education Department; Representative of Project and Engineering Services Directorate; Director of Training and Development of Cadres; Director of Health Planning and Policies Department; Director of Health and Vital Statistics Department; Representative from the Center for Disease Control ( CDC); Representative from International Health Department; Representative from Technical Affairs Directorate; Representative from PHC Centers Section; Representative from Financial Department; Director of PHC Centers Section; Director of Nursing; WHO.

***Focal Points:***

Four focal points were contracted by WHO as APWs for the Primary Health Care facilities which needs to be rehabilitated under this project. The focal points are responsible to follow up the rehabilitation process and report regularly to the concerned DoHs and WHO on the progress.

Based on the initial implementation scope six UNICEF's Specialized Engineer Facilitators were assigned to monitor and assess the quality of reconstruction works.

**Provide details on the procurement procedures utilized and explain variances in standard procedures.**

WHO has well established procurement procedures and goods are generally delivered to Baghdad under international insurance coverage. The procurement process is being carried out based on WHO rules and regulations. These are aimed at ensuring quality, efficiency and cost effectiveness. In few cases, local procurement has been applied. That said, procurements and shipment of project material is a challenge in Iraq and delays due to difficulties at border crossings, processing and remote management is sometimes impacting the performance of programmes activities.

Iraqi contractors have been implementing most of the rehabilitation works, with close supervision from WHO focal points and WHO staff in Amman. All the equipments have been procured in Amman or Iraq (depends on the value), with announcements published through Iraqi and Jordanian newspapers, the IRRFI website and the WHO website. The contractors are generally responsible for delivery and security of goods to Iraq as part of the contract cost.

For the component supported by UNICEF, the detailed field assessment has been done by contracted facilitators in collaboration with MoH/DoH staff and local community council. Design work was prepared by the national staff in Iraq based on the detailed assessment. The preparation of tender documents, specifications, tender evaluation, contracting and procurement have been done outside Iraq by UNICEF support centre in Amman with the assistance of the UNICEF Regional Office in Amman as required. The bidding process was carried out through the following arrangements:

- Bills of Quantities (BOQ) are prepared inside Iraq by Iraqi engineers working for UNICEF under an institutional contract, in collaboration with the government engineers responsible for the work. These are costed jointly by the government and UNICEF-contracted engineers.
- The BOQs with a letter of request are sent by pouch to UNICEF Amman office where they are checked by technical staff from each section before being passed to the Contracts unit for bidding. A pre-qualification process was established in 2004 to evaluate the capacity of contractors/suppliers and NGOs.
- Bidding documents are delivered to Iraq by a courier service in sealed envelopes to the pre-qualified companies.
- The bid responses are subsequently collected in Iraq by ARAMEX in sealed envelopes and delivered to UNICEF Amman office for further action. UNICEF follows its standard procedures for procurement and award of contracts. After the award of contracts, the supervision and monitoring of

the program is undertaken by GoI partners and UNICEF Facilitators. After completion, a handover committee is responsible to undertake the quality control and certify completion of work before processing payment.

All the work is undertaken by local contractors. The monitoring and supervision mechanism rely on the use of local companies with coordination and administrative support role of the national staff in field offices in Iraq and the national/international staff in ISCA office. Periodic program review and coordination meetings conducted in Amman or Iraq as security situation permits.

There were no deviations from above described process except for procurement of basic supplies and furniture (for the newly constructed PHCs) which were included in the original project proposal, worth of USD 210,000. MoH-Iraq sent an official letter to UNICEF requesting utilizing the originally suggested budget mentioned above for constructing a new additional PHC, as MoH will provide the required supplies and furniture from their own resources. MoH has also committed themselves to deploy the necessary staff for the new PHCCs. The commitment of MoH to utilize their own financial and human resources to complement this project reflects the good partnership between MoH and UNICEF and the eagerness and firm commitment of MoH counterparts to expand the PHCCs services across the country and better investment on the children and women health. The request submitted to ITF steering committee and MoH request approved accordingly.

**Report on any assessments, evaluations or studies undertaken.**

It is worth pointing out that a number of capacity building activities were undertaken during the implementation period in order to prepare the ground and develop a core team of experts who will be equipped with the knowledge and skills on how to undertake assessment in the pivotal areas of Health Information System (HIS) and Human Resources for Health (HRH). It is worthwhile to iterate the active and timely support of MOH both in terms of welcoming the support in the area of HIS and HRH as well as formulating high level steering and technical committees which shall support the implementation of the mentioned assessments. All the members of the committees have been trained by WHO and oriented to the assessment tools in a number of consultative meetings and workshops both inside and outside Iraq. The assessments for both HRH and HIS were conducted, and the findings of these assessments will be used to formulate the National HIS and HRH strategic plans which will chart the direction of MOH and stipulate its priorities in the short to medium term with regard to the mentioned health system building blocks of HIS and HRH.

In addition WHO assisted MOH in the preparation and completion of the *Health Expenditure Review for Basic Health Services in Iraq for the year 2008.*A national survey was conducted in July 2010 by the MoH with the technical and financial assistance of WHO. After the development of the survey instruments and its adaptation to Iraqi context the Iraqi team was trained on these instruments. After finalizing the training and the sampling the survey was conducted in July 2010. A period of one and a half month was needed to finalize the data collection. The survey was conducted in 16 district hospitals, 98 Main Primary Health Centers and 48 Sub Primary Health Care Centers, so all in all survey results were derived from 162 health facilities. The report was finalized and endorsed by the MoH in 2011.

UNICEF conducted prior to construction activities, a detailed field assessment by the contracted facilitators in collaboration with MoH/DoH staff and local community councils and design work was prepared by the national staff in Iraq based on that detailed assessment.

## IV Results

WHO as the lead agency is the overall coordinator of the project, while UNICEF remained accountable for attainment of the specific outputs. The progress and results linked to the original outputs are described below.

**Output 1. Capacity of the MoH in targeted areas developed for improved Integrated Health Services Delivery.**

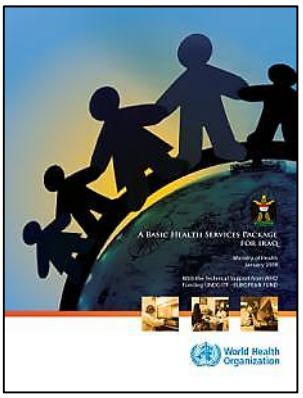
An array of vital measures were taken during the project reporting period to successfully accomplish the above output which is meant to strengthen the capacity of MoH in order to have a context specific services delivery model. The following achievements have been made in the following areas of strategic importance which will pave the way for the successful reform of health system based on the principles of PHC and will establish a successful model of health services delivery which will respond to the health care needs of Iraqi population in an effective and sustainable manner.

### *1.1 Implementation of Basic Health Service Package (BHSP) through Integrated District Health System based on Family Practice Approach (IDHS-FPA)*

The MoH with the technical and financial support of WHO developed the Basic Health Service Package (BHSP), the Basic Health Services Package (BHSP) is defined as a minimum collection of essential health services that all population need to have a guaranteed access to.

The package was approved by the MoH in a formal session that was conducted in Baghdad in February 2010.H.E. the Minister of Health declared that this package will pave the way for a successful reform of the health care system and will establish the basic and essential milestone of a decentralized PHC system which is based on the principles of Alma-Ata Declaration. This package was translated to Arabic, published and distributed.

An extensive policy support was given by MoH of Iraq in order to initiate the implementation of BHSP.A National Steering Committee headed by the Deputy Minister of Health for Donors Affairs and Technical Committee for BHSP implementation was formulated.



**Basic Health Service Package (BHSP) Report**

Implementation of the BHSP was initiated through improving the performance of Integrated District Health System based on Family Practice Approach (IDHS-FPA), which is a new World Health Organization Eastern Mediterranean Region initiative adopted by the Ministry of Health in Iraq which was introduced as a pilot in four districts in the country including Baghdad, Kirkuk, Missan and Erbil governorates. The initiative aims at assuring universal, equitable and efficient access to essential health services for every individual especially the most vulnerable (children, women and elderly) residing in the catchment area population of a Primary Health Care Facility

IDHS-FPA is the tie where health care delivery comes into direct contact with the community, strong participatory planning and close and effective communication of all segments of the community at district level play a vital role in enhancing the performance of the health system at both national and sub-national levels.

A District Health System Approach also allows detection of all the problems and shortcomings that may exist elsewhere in the health system. In other words, a district health system in many ways mirrors the status of the national health system and any attempt to improve it should eventually encompass the health system as a whole if sustainable outcomes are to be achieved.

The implementation of IDHS-FPA in the selected four districts will provide a golden opportunity to learn about the demographic and socio-economic factors, specific challenges affecting the health of population in the targeted districts which will enable the Ministry of Health (MOH) to take timely and appropriate actions to mitigate the negative impact on health services delivery and thus health outcomes.

In order to set the base line for this initiative, WHO Iraq Country Office in collaboration with the WHO Regional Office developed *Assessment Guidelines and Tools*. These tools cover eight areas:

National level indicators, district level indicators, PHC facility assessment, the policy commitment to DHS strengthening based on Family Practice Approach, District Health Management and Support System, Social Determinants of Health and Inter-sectoral Action for Health, District Hospital Information and Community Organization and Mobilization. Adaption of the assessment tools to Iraq context was initiated in February 2011 in Erbil and finalized in April 2011 in Beirut.

A three days meeting was conducted in Erbil during the period of 13-16 February 2011 with key MoH officials from the GOI central and KRG ministries. The objectives of this meeting were to: agree on the strategic direction of Primary Health Care Programme implementation for the coming 4 years; review the action plan of Basic Health Services Package Implementation (BHSP); revise the Assessment Tools for Integrated District Health Systems Based on Family Practice Approach (IDHS-FPA).

After three days discussion with the Director of Donors Section, Director of PHC Department, Director of Health Centers Section, Director of Family Medicine Section, the Head of Therapeutic Department/Technical Affairs, and the Director of Planning Department in Erbil, the IDHS-FPA was adopted in Iraq for the coming 3 years to implement the BHSP within this approach. The agreement was also to pilot the implementation of IDHS-FPA in four districts within four different governorates.

Erbil meeting was followed up by five days introductory workshop on implementation of Basic Health Service Package (BHSP) through Integrated District Health System based on Family Practice Approach (IDHS-FPA) which was held from 16- 21 April 2011 in Beirut, 41 high level government officials from all the 3 levels of government i.e. central MOH in Baghdad and MOH of KRG, piloted governorate and districts participated actively in the workshop. In addition the Representatives of USAID and UNRAW who are working to strengthen Primary Health Care in Iraq at their respective agencies participated also. The workshop was facilitated by WHO experts from Regional Office and country offices of Iraq, Jordan and Lebanon. The purpose of this workshop was to agree on road map needed for the implementation of BHSP through the IDHS-FPA in Iraq, identify the four districts following standard criteria, identify mechanisms for implementation, surface financial and human resources needs and agree on the contents of the eight assessment tools which will be used to undertake the baseline assessment in the selected districts.

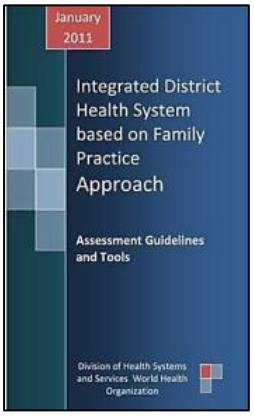
Based on the recommendations of Beirut workshop, another three days meeting was conducted in Amman-Jordan during the period of 13-15 June 2011 for the assessment teams of IDHS that were formulated after Beirut workshop.

It is worth mentioning that out of the 8 assessment tools that were developed, discussed and finalized in Cairo, Erbil and Beirut. Two modules number 6 and 7 which address assessing Primary Health Care Centers and assessing Hospitals in the 4 pilot selected districts needed field data collection and entry, hence, both modules were thoroughly discussed in another meeting in Amman from 13-15 June 2011 with the following objective: to train/supervise the data entry teams and ensure valid and reliable data entry in order to ensure robust data analysis and concrete findings and report. By the end of this workshop, modules number 6 and 7 were approved by the MoH team and coded by WHO consultant in preparation for conducting the assessment. The assessment teams were also trained on data collection and data entry on the Statistical Package for Social Science (SPSS) in preparation for analyzing the outcomes of this assessment and developing District Health System Profile for each pilot district.

Back in Iraq, the trained assessment teams collected the data in accordance with the 8 assessment tools and shared the raw data with WHO office, who in turn analysed the data with the help of WHO consultant and produced 4 different reports one for each piloted district, reflecting the situation of that particular district in terms of number of health facilities their current situation and functionality and the exact location. Information from these 4 reports will be used to establish a detailed report for each of the district entailing the proposed interventions and the strategies for those interventions aiming to address the bottlenecks and improve health services delivery in those districts.

The four district reports are expected to be finalised and launched during the first quarter in 2012 in a formal session. A detailed plan of action for each district will be finalised prior to the start of BHSP implementation.

### *1.2 Family Practice Approach*




**Integrated District Health System based on Family Practice Approach Report**

Iraq started the implementation of Family Practice in 2006 with the technical assistance of WHO and the co-financing of some activities with the MoH. Today, Iraq is running 40 PHC Centres that are implementing the Family Practice Approach.

In order to contribute to the already ongoing efforts WHO with the support of this project rehabilitated four PHC centers and fully equipped five PHC centers. These centers are located in Basra, Baghdad (Al Karkh and Al Rasafa), Mousel and Karbalaá. The five facilities will be able to establish a successful model of health services delivery by implementing BHSP based on the IDHS with focus on Family Practice Approach. The rehabilitation work was preceded by a *need assessment* which was conducted in the five facilities by the MoH assessment teams and the report was shared with WHO in March 2010. The findings of this report were used to determine the needs of these facilities in terms of rehabilitation and the supply of medical and non-medical equipment.

During 2011, all of the physical rehabilitation work started with a total cost of USD 567,748, two out of the four facilities were completed and handed over to the MoH, while the work is still on going in the other facilities. The rehabilitation was done in accordance with the WHO-MoH agreement, starting by finalizing the Bills of Quantities (BOQs), the bids announcement, bids opening and finally awarding the contracts for the selected contractors.

It is to note that Karbala PHC center will not be rehabilitated (even though it was initially on the list) because the need for rehabilitation was minor and despite several announcements no one applied to take

care of the rehabilitation. As a result MOH through a written request, urged WHO to only equip the Karbala PHC with needed equipment and the minor rehabilitation need of the facility will be taken care of by Karbala DOH.

| | Name of PHC center | Governorate | Estimated Cost in USD | Implementation Period | % of implementation by the end of Dec. 2011 | Hand over to the MoH |
|---|---|---|---|---|---|---|
| 1 | Al Shohadaa | Al Karkh / Baghdad | 223,267 | 120 days | 90% | Pending |
| 2 | Bab Al Muadam | Al Rasafa / Baghdad | 134,007 | 120 days | 5% | Pending |
| 3 | Al Abbas | Basra | 70,725 | 120 days | 100% | Handed over |
| 4 | Tammoz | Mousel | 82,678 | 75 days | 100% | Handed over |
| Total cost | | | **567,748** | | | |

The rehabilitation work was monitored by four engineers who were contracted on short term basis by WHO to support and technically oversee the implementation progress of physical rehabilitation in close co-ordination with MoH focal points.

The work is still ongoing to finalize the pending PHC centers, it is expected to be completed and handed over to the GoI by the first quarter of 2012.

Based on the needs assessment mentioned earlier, the five facilities were fully equipped with medical and non-medical equipment with a total cost of USD 713,636. All these equipment were procured, shipped and delivered to the MoH. Overseas training was also provided prior to the installation of the some of the equipment such as the dental units, where two engineers from Mousel were trained in UK.

| | Procured Items | Total Cost USD | Type of procurement |
|---|---|---|---|
| 1 | General and Laboratory Equipment | 203,506 | International procurement |
| 2 | Dental units and devices | 73,573 | International procurement |
| 3 | Imaging equipment | 298,500 | International procurement |
| 4 | Medical Instruments | 28,033 | International procurement |
| 5 | IT equipment | 40,200 | Local procurement |
| 6 | Medical furniture | 48,142 | Local procurement |
| 7 | Non-medical equipment | 30,685 | Local procurement |
| Total cost | | **713,639** | |

### *1.3 Integrated Management of Childhood Illness (IMCI) and Nutrition:*

#### Integrated Management of Childhood Illnesses

IMCI is an integrated approach to child health that focuses on the wellbeing of the child and aims to reduce death, illness and disability, and to promote improved growth and development among children under 5

years of age. IMCI include both preventive and curative elements that are implemented by families, communities and health facilities.

The IMCI strategy includes three main components:

1- Improving the case management skills of health care staff.
2- Improving overall health system.
3- Improving family and community health practices.

**Participants during the workshop on Integrated Management of Childhood illness training course**

MoH conducted the following training activities on IMCI supported by WHO:

1. Four national training courses (11 days IMCI case management course) for 88 physicians in Baghdad, Basrah a and Erbil facilitated
2. Two training 7 day facilitator training course and follow up trainees in for 16 national facilitators from Baghdad, Babil and Anbar governorates
3. Expansion in the Implementation of IMCI strategy in another 4 governorates, 21 districts and 170 PHC centers which makes the total number of governorates implanting IMCI 14 governorates
4. Adaptation of the IMCI nursing training modules by the adaptation committee
5. provision of 500 copies of the Arabic version of Infant and young Child feeding counseling course

### *1.4 Construction of 13 Primary Health Care Centers*

To improve access to quality primary health care services for the remote rural communities, including those how have been affected by high influx of IDPs and Returnees in the south/center part of the country. UNICEF within the current joint ITF project with WHO and as agreed with the SOT in consultation with Ministry of Health, Ministry of Marshland and the health directorates, utilized the available allocation to construct 13 PHCs and two residence houses for the medical staff in the following Governorates (one PHC in Ninewa, Kerbala, Muthana, Babil, and Salah Al-Din; and two PHCs in Basra, Missan, Wassit, Diwaniyah, and ThiQar and 2 staff residences.

**Rehabilitation and expansion of one of the PHC centres in Baghdad - AlKarkh**

**Rehabilitation and expansion of Bab Al Mouadham PHC centre in Baghdad - Resafa**

The Original Number was 15 PHCCs, but the number decreased to 13 due to inflation in prices; however UNICEF succeeded to mobilize other funds - mainly emergency funds - to construct residency for 9 PHCs instead of 2 PHCs only, to ensure sustainable availability of medical staff throughout the week in the remote

rural districts. Additionally MOH request to transfer the amount of money allocated for supplies of PHCCs to construct another PHCC in Makhmoor district of Ninawa governorate which make the number of PHCCs 12.

Two model designs for the new PHCCs and staff residence have been developed in consultation with MOH engineers including the detailed BOQs:

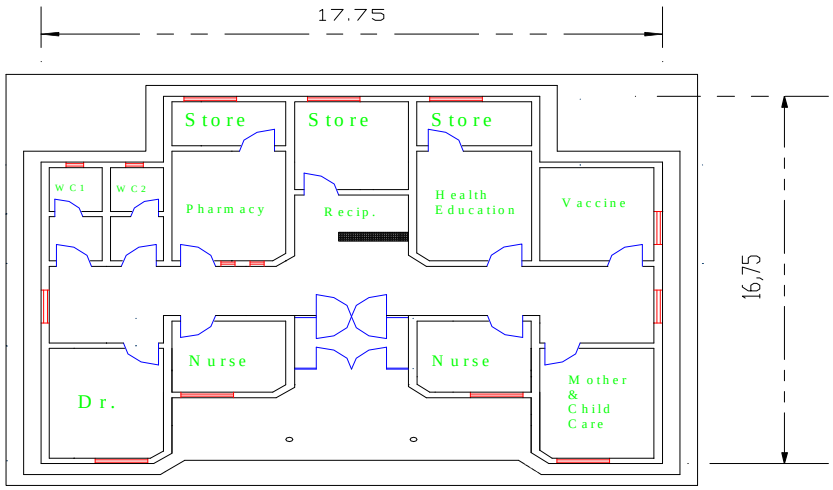



**Figure 1 Type A PHC center**

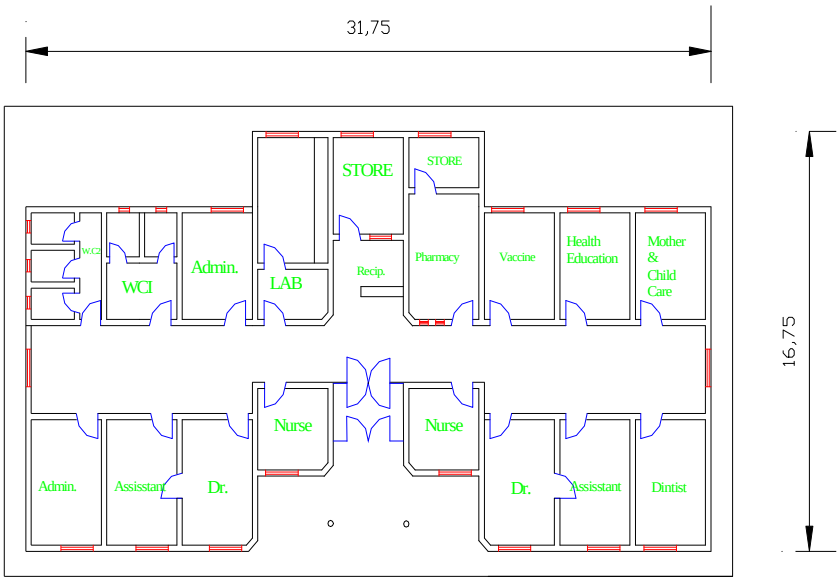



**Figure 2 Type B PHC Center**

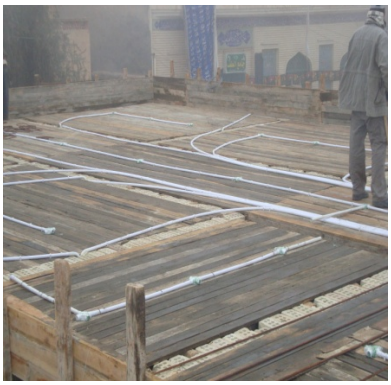




**Figure 3 UNICEF engineers closely monitor & document the day to day work**

Up to date, all the 12 PHCs were completed and handed over to MOH/DOHs, the remaining two sites (Babel and Basra) that were delayed due to the land ownership and soil testing issues were cancelled by MOH and they commit to construct these PHCCs with their own resources and requesting UNICEF to utilize the remaining balance to:

a) Train different levels of medical and paramedical staff on proper primary health care interventions (i.e. immunization, management of diarrhoea and malnutrition, etc.).
b) Technical exchange with international institutions on health program planning and management.
c) Support MOH to conduct job training and focused monitoring and supervision at the peripheral level.
d) Demand creation on utilization of the available services through conducting targeted social mobilization activities.

**Status of construction progress as of to March 2012**

| Description | Implementation Site | 24-March-12 |
|---|---|---|
| **Construction of new PHC centerType B with residence in Al-Fuhood District** | Thiqar | 100% |
| **Construction of new PHC centerType A with residence in Al-Hamza/Al-Sadair District** | Qadisiya | 100% |
| **Construction of new PHC centerType A with residence in Al-Shanabrah area, Al-Sumawa District** | Muthana | 100% |
| **Construction of new PHC in Garmet Bani Saeed Type B** | Thiqar | 100% |
| **Construction of Al-Rafaee PHC type B with residence in Al Kahlah District** | Missan | 100% |
| **Construction of Al-Usir PHC Type B with residence in Al-Hindia District** | Kerbala | 100% |
| **Construction of Al-Khoumis new PHC centerType B with residence in Al-Maymouna** | Missan | 100% |
| **Construction of new PHC in Al-Medaina District with residence** | Basra | 100% |
| **Construction of new PHC in Nu'mania** | Wasit | 100% |
| **Construction of new Medical Staff Residence in Chibayesh district** | Thiqar | 100% |
| **Construction of new PHC with residence in Tureisha village** | Salahiddin | 100% |
| **Construction of new PHC- Type A in Makhmoor** | Ninawa | 100% |

Additionally, 213 different level PHC staff working in the same selected districts has enhanced capacity on quality PHC services through conducting several training courses on emergency obstetric care, safe delivery practices, essential neonatal care, growth development and monitoring, and proper management of diarrheal cases and acute respiratory tract infections. Some of these courses are still ongoing and targeting additional health care staff.
Another 3 proposal for a total of 215 doctors and paramedics received from MOH for training on essential new born care, breast feeding promotion and CDD/ARI programme in 3 DOHs.

### *1.5 Child Protection*

In collaboration with the Child Protection section within the UNICEF Iraq country office, and the "Play Therapy Africa – NGO partner" rolled out a Community Based Psychosocial Support study/assessment, which is the first of its kind in Iraq and its output will convey crucial understandings and valuable data on psychosocial situation in Iraq. The study has been endorsed by MoLSA and is currently ongoing. Based on the result of this study:
1. Parents, caretakers and community members will reach a deeper understanding of boys and girls emotional and developmental needs enabling the provision of better care practices in selected communities.
2. Selected communities will be empowered and capacitated to enhance internal (resilience) and external (social capital) protective factors for Iraqi children and youth.
3. Boys and girls in Iraq will enjoy a renewed protective environment and an expanded psychosocial wellbeing as a result of strengthened processes of community mobilization, participation and empowerment geared around positive caring practices.
4. Institutional capacity of Government of Iraq to develop and implement psychosocial support programmes for boys and girls and their families.

## Output 2: The ability of MoH on Human Resources planning is enhanced.

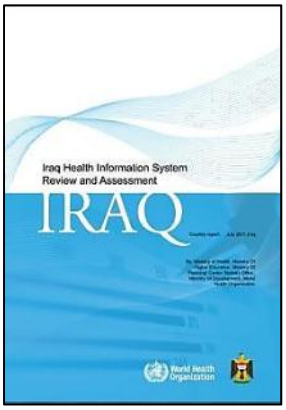
WHO assisted MoH in order to strengthen its capacity to precisely plan, deploy, retain and train the right number and right mix of human resources according to the forecasted needs. Among the efforts it is worthwhile to focus on the importance of two workshops which were specifically held to assess the current situation of MoH and understand the current HRH needs and challenges of the MoH.

**A group photo during the HRH training workshop June 2011**

The first training workshop was held in Amman from 9-10 June 2010.The workshop was attended by officials from MoH, MoHE, MoE, MoP and WHO/EMRO and a representative from the High Health Council -Jordan and Iraqi Embassy in Amman-Health Attaché.

The objectives of the workshop were to: Share the evolving concept of HRH function of the health system; review the current state of national HRH, including Country Cooperation and Facilitation (CCF) to pave the way for development of HRH coherent and CCF framework; present the concept of HRH observatory and best approach to establish and maintain its structure and core functions in Iraq; and draft work plan for development of nation-wide health workforce plan with WHO technical support.

As a follow up on the recommendations of the above mentioned workshop, WHO Iraq Country Office in coordination with WHO Regional Office and WHO HQ organized the 2nd training workshop in Amman which was held from 24 to 27 October 2010. The main theme of the workshop was to train the participants on the Assessment tools and Strategic Planning on HRH. The workshop covered a number of areas of strategic importance i.e. introduction to the framework and capacity assessment tool for HRH; introduction to the strategic planning, coordination mechanisms, communication and monitoring of HRH. In addition, a six months action plan was designed and approved which will assist MoH to carry out HRH assessment which once completed will be used as an input in the formulation process of HRH strategic plan.



**Iraq Health Information System Review Assessment Report**

The above efforts were continued in 2011, helping the MoH in drafting the Human Resources for Health (HRH) strategy, where a shortened version of the HRH assessment tools (originally developed by WHO Regional Office) was finalized by WHO Regional Office and it was shared with the MoH. Under the request of the MoH, a 2nd training on the shortened version of the assessment tools was conducted for the HRH Steering Committee members in Amman during the period of 21-23 June 2011. By the end of this training, the following objectives were achieved: Revisit the key challenges and opportunities for improving HRH situation in Iraq; Identify the technical constrains in using HRH assessment tools; and agree on the way forward.

It is worth mentioning that the HRH assessment was conducted after this training and the draft report was produced, but this activity was completed under Iraq Public Sector Modernization Project, which is also implemented by WHO team.

On another hand, as part of the capacity building development 3 MoH officials working for Human Resources for Health Directorate has successfully completed 8 weeks fellowship in the Faculty of Medicine- Suez Canal University-Egypt. The aim of this fellowship was to motivate the health managers to develop and implement strategies to achieve an effective and sustainable health workforce.

**Output 3: National Health Management Information System Strengthened**

Reliable and timely data is essential to delivering public health services. Over the past few years, Iraq invested significantly in a Health Information System (HIS) through the acquisition of hardware and software equipment and technical expertise. However, ad-hoc and fragmented efforts to revamp the various components of HIS have had little tangible effects especially on the quality information that could adequately support evidence-based health care planning and decision making. This drawback has been attributed, to a large extent, to lack of a clear HIS vision, policy and strategy. Hence, the exercise of developing a national Health Information System Strategy was initiated under this programme.

The exercise started by conducting a Stakeholders Meeting for Health Information System (HIS) in Amman October 2010, by the end of this meeting the MoH officials and other stakeholders decided on

developing HIS strategy and the team was trained on the assessment tools that were based on the *International WHO Health Metrics Network*. Hence, the team raised this issue with H.E. the Minister of Health, who in turn approved this initiative and supported it by being the Head of the Steering Committee for developing the HIS strategy.

The MoH formulated also the Technical Committee to follow up on the assessment, the tools consist of a questionnaire with 197 questions divided into the six components: resources essential, health indicators, data sources, data management, information products and dissemination and use. Three national meetings were conducted by the Technical Committee during which the regional assessment tools were adapted to Iraq context.

Under the request of MoH another meeting was organized by WHO in Erbil 16-17 February 2011 with the HIS Technical Committee with the objectives to: re-orient the HIS technical committee with the standards and components of HIS including the HMN framework for assessment; review and exercise the HIS assessment tools; Present the Rapid Assessment (RA) tool for Civil Registration and Vital Statistical (CR&VS) system and prepare ground for the RA of CR&VS in Iraq; and agree on the timeline for the assessment finalization.

Based on the outcome of the above mentioned meeting, the assessment took place in Baghdad in a national workshop on 8-10 March 2011, after finalizing the draft the assessment report was shared with WHO on 31st of March 2011. WHO in turn technically revised this report and shared it back with the MoH for final revision. The final report was endorsed by H.E. the Minister of Health and WHO worked on the publication and dissemination of the findings of the final report. This report will be used as a basis for the development of the national HIS strategic plan.

It is worth mentioning that the report calls for identifying the pressing needs and implementing the most effective interventions to reform and strengthen the HIS and to prioritize and streamline the inflow of resources into the health care system.

The assessment has identified a number of issues, problems and gaps in the existing HIS. Each will be scrutinized from various perspectives in order to produce quality information in a timely manner and ensure their adequate use by all relevant stakeholders. Below table presents the assessment findings of the six HIS components.

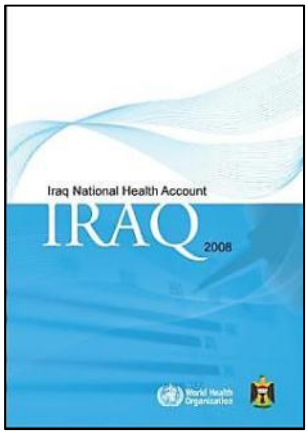
| Categories | Scores | | Percentage (%) |
|---|---|---|---|
| | Maximum | Assessed | |
| 1. Resources | 75 | 33.5 | Present but not adequate (45%) |
| 2. Essential Health Indicators | 15 | 10.0 | Adequate (67%) |
| 3. Data sources | 228 | 135.5 | Adequate (60%) |
| 4. Data management | 15 | 8.0 | Adequate (53%) |
| 5. Information products | 207 | 151.0 | Adequate (73%) |
| 6. Dissemination and use | 30 | 15.0 | Adequate (50%) |
| **Overall HIS** | **570** | **353.0** | **Adequate (62%)** |

The assessment report concluded that the NHIS in Iraq was assessed adequate (62%). This score is interpreted as weak NHIS. To serve its perceived objectives, the system needs to be reformed and strengthened. Therefore, it is recommended that the current assessment exercise should lead to developing a HIS Strategic Plan for Iraq, as soon as possible. The Strategic Plan should reflect the findings of this report and the above recommendations.

**Output 4: Sustainable Financing and Social Protection System of MoH Developed.**

***National Health Accounts and Health Expenditure Review:***

The first National Health Account Report for Iraq has been published. The NHA is a powerful analytical tool used to assess health care financing function in health system. NHA will lay out solid foundations for government of Iraq to manage and sustain scarce resources in the health sector and provide basic information related to health financing needed to develop health care financing policies. The findings and conclusions of national health account analysis will have a great impact on shaping policy reforms in the field of health financing in Iraq. The first round of national health account that is finalized represents an excellent achievement of national health teams and represents a milestone in assessing health care financing in Iraq and in improving the overall health system performance in order to achieve the health system goals of improving health, reducing health inequalities, securing equity in financing and responding to the population's needs and expectations



**Iraq National Health Account Report**

The NHA exercise started in late 2004, under Strengthening Primary Health Care System Phase I project, but due to the deteriorating security situation especially in 2006 and 2007, and the change in Ministry of Health priorities of that time, it was decided to withhold the work on NHA. In 2009, the NHA was revitalised by WHO under the financial and technical support of Strengthening Primary Health Care phase II project. The field work took place in 2010, while the finalization and publication of the 1st round of National Health Accounts Report was completed in 2011.

The following main steps were taken in 2010 in order to support the implementation of the mentioned two exercises. A detailed NHA work plan was drafted; a multi-sectoral Steering Committee (SC) and Executive Committee teams for NHA were formulated and ToRs were drafted.

A national training for NHA team took place during 17-20 January 2010 in Baghdad. The aim of this training was to understand the context and reasons for the development of NHA methodology; be able to communicate the basic concept of NHA, what it attempts to measure, and its role as a tool for the policy process; and recognize the distinctions and similarities of various tools for measuring health expenditures. Finally, costing methodology manual for the BHSP in Iraq was drafted and a national training for the MoH officials on this manual took place in Baghdad in May 2010.

Based on the above proceedings a nationwide National Health Account (NHA) survey was launched by MoH with technical and financial support of WHO. The aim of this survey was to collect the needed information for the NHA exercise from the different stakeholders and thus to provide MOH with the best financing options which will serve as a critical input to the formulation of National Health Financing Strategy.

The data collection started in mid July 2010 and was completed by the end of August 2010. The data entry and analysis was completed by the end of November 2010. The survey included 16 district hospitals, 98 Main Primary Health Centers and 48 Sub Primary Health Care Centers, so all in all survey results were derived from 162 health facilities. The final report of the preliminary NHA for Iraq will be ready by mid-March 2011.

The work continued in 2011, where Iraq Country Office in collaboration with EMRO organized a three days training workshop on Health Care Financing (HCF) in Amman during the period of 27, 28 February- 1 March 2011. This training workshop aimed at finalizing the 1st NHA report for Iraq. During the above mentioned workshop the National NHA Steering Committee was trained on different topics of HCF. In order to enhance the hands on experience of the National NHA team, the team was assigned to use the real data during the group work sessions as well as guidance was provided on how to populate the NHA matrices using the figures of Iraq. The aim of this practical exercise was to enhance the skills of the National NHA team on the use of software and thus institutionalize the capacity building efforts which will enable the National team to carry out the upcoming rounds of NHA with minimal or no external assistance.

**Group photo during the Health Care Financing training workshop in Amman**

After the above said workshop, the draft report was finalized by the Iraqi team, endorsed by H.E. the Minister of Health, edited, translated into Arabic, published and disseminated to all concerned parties, including MoH, WHO Regional and HQ Offices and other UN agencies.

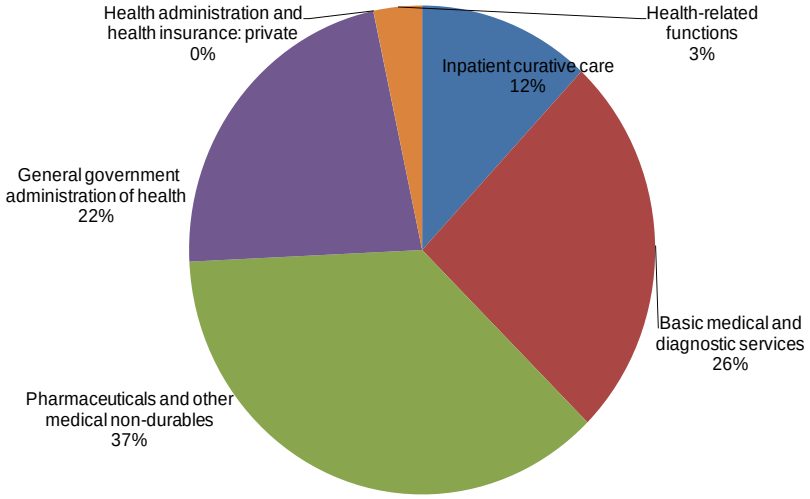
This first attempt of this report shed some light on health care financing in Iraq and has provided some important findings. The level of health care spending, as per capita and as share of GDP, remains less than the average of countries with similar income. However the structure of health care financing shows a fair degree of equity in view of the limited burden on households who share only one fourth of the total health bill.

The high level of government contribution in health care financing reflects the constitutional commitment of the state to secure health and social security to individuals and families. Government through MoH is providing universal coverage by social health protection, which constitutes an important achievement of the Iraqi health care system.

In general, Iraqi health funds are primarily spent on curative care (more than 37%). A considerable share, 36.8%, goes towards pharmaceuticals dispensed for outpatient care, and 22.4% is spent on administration cost and salaries (Table 5, Figure 4).

**FUNCTIONAL DISTRIBUTION OF HEALTH CARE EXPENDITURES, 2008**

| Function | Amount (ID) | Percentage | Per capita ID | Per capita US$ |
|---|---|---|---|---|
| Inpatient curative care | 614 161 503 474 | 11.99 | 19353.95 | 16.54 |
| Basic medical and diagnostic services | 1 303 505 329 730 | 25.45 | 41053.06 | 35.09 |
| Pharmaceuticals and other medical non-durables | 1 885 500 625 470 | 36.81 | 59331.50 | 50.71 |
| General government administration of health | 1 147 085 680 919 | 22.39 | 35963.72 | 30.74 |
| Health administration and health insurance: private | 473 633 600 | 0.01 | 14.85 | 0.01 |
| Health-related functions | 171 947 747 017 | 3.36 | 5390.95 | 4.61 |
| Total | 5 122 674 520 210 | 100.00 | 161108.03 | 137.70 |




**Classification by function**

As mentioned above findings related to spending on major line items, show a relatively high share of total spending on health and bio-medical technology, similar to countries of middle income in the WHO Eastern Mediterranean Region. Total spending on medicines is shared almost equally between government and families, which highlights the importance of technology as an important cost center and as an area where efficiency savings are needed in terms of procurement system, appropriate selection and rational use.

The present structure of health care spending for both ministry of health and households does not allow a refined analysis of utilization of financial resources inside the health care system. However spending on health workforce, as a percentage of national budgets, remains lower than the average of countries of the region of similar level of income, despite a higher health workforce density.

Based on the preliminary analysis provided by the first national health account, the following recommendations are offered to the Ministry of Health and government officials.

- Secure ownership of the national health account exercise by internalizing it within the Ministry of Health set up, by coordinating the efforts with major stakeholders including the Ministry of Finance, planning and development cooperation, Central Organization for Statistics and Information Technology, private sector, etc. and by providing more training on national health accounts methodology.

- Ensure wide dissemination of the first national health account findings among health professionals, stakeholders, parliament, media and the public at large in order to increase knowledge and awareness about the health care financing function and its contribution to improving health system performance.
- Improve quality of data collected from various related ministries and agencies and initiate a better costing system and financial management inside the Ministry of Health. In order to improve data on household expenditures, it is recommended to implement a survey on dedicated household health expenditures and utilization with technical support from WHO and other partners.
- Promote a culture of costing and cost analysis in the health system in order to improve financial management and cost containment strategies.
- Make a case for investing in health by mobilizing additional resources from government budget, local government, taxation and communities in order to rationalize the use of free public services.
- Initiate feasibility studies related to the development of contributive systems of social and preventive health insurance, with technical support from WHO, International Labor Organization and other development partners.
- Strive to improve the efficient use of public resources through better selection of technology, rational use and the development of a health technology assessment function.

**Output 5: Enhanced MoH leadership and Governance.**

### *5.1 Millennium Development Goals (MDGs)*

The United Nations Millennium Development Goals (MDGs) are eight goals that all 191 UN member states have agreed to try to achieve by the year 2015 including Iraq. In 2009, Iraq tailored the international MDGs to the Iraqi context, and a national MDGs Steering Committee was formulated, where the MoH was an integral part of this committee. In light of this and in order to further raise the capacities of MoH officials at central and governmental levels on MDGs WHO Iraq Office in collaboration with UN ESCWA organized a national training workshop in Erbil during the period of 6-10 February 2011 on (MDGs). This activity comes as a follow up to September 22-28/ 2010 training workshop, which was conducted for 20 Senior Leaders from the MoH and other line ministries at the Central and Southern Governorates, who met under WHO auspices in Beirut, for an intensive leadership development experience designed to strengthen the pursuit of MDGs for the people of Iraq. The February 2011 activity was initiated under the request of the MoH in order to cover the Northern Governorates needs to be trained on MDGs.

**Group photo during the MDG national training workshop in Erbil**

The training workshop objectives were to raise the awareness on the global MDGs and the national MDGs tailored for Iraq with a special focus on Health related MDGs. The main discussion focused on the current situation of Iraq with regard to health MDGs; strengthening Planning, Monitoring and Evaluation as well as reporting functions of the government officials, taking into account the National Development Plan and the Health Sector Strategy in addition to other related national strategies.

A total of 20 participants from both Central Ministry of Health in Baghdad and Central MoH in Erbil as well as from DoH in Erbil, Sulemaniyah, Dohuk and Kirkuk. The private sector was represented in the

mentioned workshop by the Head of the Dental Syndicate in Baghdad. By the end of this training workshop, the following was agreed as recommendations and way forward for MDGs: Advocate for formulation of an inter-sectoral committee for MDGs; Assign a focal point for MDGs at the central MoH in Erbil; Conduct National Training Activities in all the 3 governorates on MDGs; Alignment of Strategies, Plans with NDP, MoH Strategic Plan and MDGs for Iraq; Repeat the workshop for policy makers in the region; National awareness for MDGs in the media; Involvement of private sector and other line ministries in MDGs.

### *5.2 Social Determinants of Health*

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Responding to increasing concern about these persisting and widening inequities, WHO- Iraq Organized on the 3rd of May 2011 a three-days training workshop on "Social Determinants of Health (SDH): Concepts and Tools to Promote Equity in Health in Iraq" was conducted in Amman to raise the profile of SDH and health equity in Iraq. In this connection, the workshop was initiated to build on the fact that health systems are themselves social determinants of health. The main objectives of the workshop were to identify the challenges to the achievement of health equity in a conflict setting, and to propose a Plan of Action and identify sustainable structures to address these issues. It is worth mentioning that incorporating Health in All Policies will assist leaders and policy-makers to integrate considerations of health, well-being and equity during the development, implementation and evaluation of policies and services. During the workshop, the participants from different ministries and syndicates including the Ministry of Health, Finance, Women Affairs, Defense, Labor and Social Affairs, Education, head of the Medical Syndicate and Head of the Nursing Syndicate were introduced to each other and had the opportunity to engage in group work to identify and prioritize six SDH and health inequities in Iraq and to work on a plan of action to put the multi-sectoral structure of SDH Steering and Technical Committees within the MoH.

### *5.3 Leadership and Strategic Planning*

To date, a total of 45 countries have developed/revised their National Health Strategic Plans showing an increase of 42% in the past 4 years. These plans are more comprehensive and are based on good situation analysis. In many countries these plans are the basis for harmonizing partnerships, ensuring alignment and facilitating coordination. They also contribute to strengthening country ownership and establishment of mutual accountability for results.

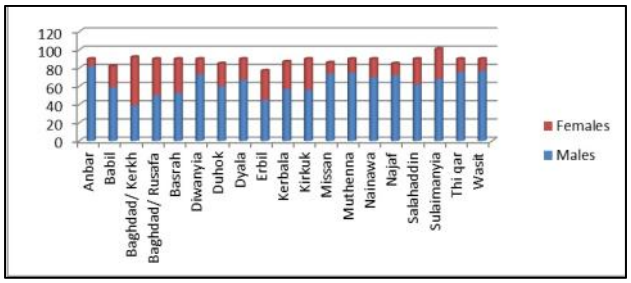
Based on the above, WHO in collaboration with John's Hopkins University, organized a five days training workshop on Leadership and Strategic Planning in Istanbul-Turkey during the period of 23-27 May 2011.
The main objective of this training was to strengthen the capacity of the members of technical committees of the MoH responsible for updating the national MoH strategies on the strategic planning cycle, in order to equip them with the knowledge and skills needed to revise and update the Health Sector Strategic Plan for 2008-2013. This training is considered as an initial step towards revising the PHC part of the mentioned strategy, where WHO technical assistance was requested earlier by the Ministry of Health.
The delegation was headed by the Deputy Director General for Planning and Resource Development from Baghdad MoH and Director General of Planning from MoH of KRG. It is worth pointing out that representatives of planning departments of most governorates i.e. Karbalaa, Najaf, Salah ELDean, Basra,

Wassit, Diala, Anbar, Babil, Mousel, Sulymania as well as Baghdad took part in the mentioned training. By the end of this training workshop, a set of recommendations was agreed among all participants on the way forward for revising the Health Sector Strategic Plan (2008-2013) in both the Central Ministry and KRG Ministry of Health.

### *5.4 Mental Health*

Mental illness is particularly important because its burden is often underestimated. It remains a stigma and has detrimental effects on the person and society. According to Iraqi Mental health survey 2007, although 35% of Iraqi people are suffering from distress and 16% had at least one mental illness during their life span, mental services is provided to 2.2% of mentally ill people. Due to the above facts, public awareness and early intervention at the very first level of care become increasingly essential.

Raising awareness of the PHC workers on the role of mental health as a basic foundation to achieve general health for the person himself and his family, and the possibility of prevention of mental disorders was one of the main objectives that was achieved during the implementation of this programme; as well as raising knowledge in mental health situation and mental disorders.



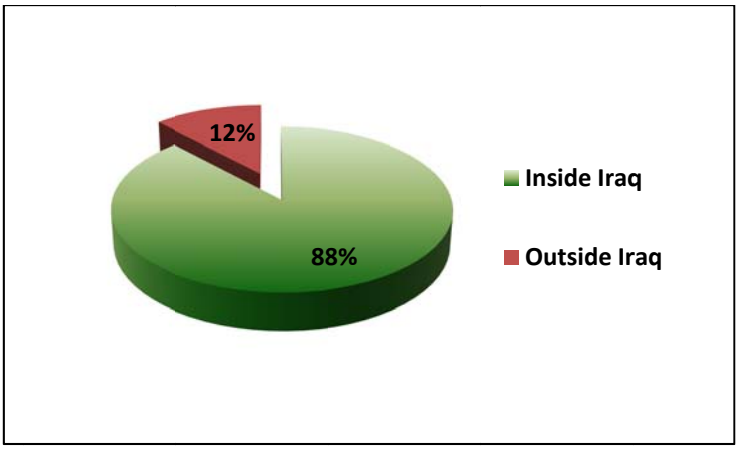

**Number of provinces in Iraq covered by Mental Health training activities**

Improving skills of the PHC health workers to provide proper mental health services for the needy people was the ultimate goal of this project. A total of 57 National Training Activities (NTAs), three NTAs for each directorate of health, 4-days each, for general practitioners and nurses at primary health care level has been conducted successfully as per the agreed action plan. A total of 1685 health professionals have been trained, out of which 1218 were male participants and 467 were female participants. These trainings covered all the 19 governorates with an average participation of 25-30 trainees in each session and will make sure that mental health services are provided under the umbrella approach of primary health care.
This capacity building programme was initiated in a Training of Trainers (ToT) workshop organized in April 2011 in Erbil, with the objectives to: revise WHO mental health training modules and produce a standardized training package adopted to the context of Iraq; assess the current situation of mental health in Iraq; identify the suitable WHO national mental health manuals to be used for training PHC health workers.
This workshop was followed by another ToT in Erbil in May 2011, where the training modules that were used as the training material for the 57 NTAs where updated, finalized and adopted as the formal curriculum, in addition trainers where oriented on these modules and action plan for NTAs implementation was also agreed.

In order to evaluate the 57 conducted NTAs as part of ‘integration of mental health in primary health care ’, WHO is organizing along with the MoH officials for mental health a follow up workshop, to come up with lessons learnt and recommendations for the future implementation of the mental health programme. This workshop is expected to take place in February 2012.

**Capacity building activities pertaining to all the five outputs:**

Institutional development including capacity building of Human Resources for Health has been identified as one of the main priority area which has to be considered by partners working in health sector. In these lines a large array of capacity building activities have been carried out by WHO Iraq office to strengthen the various building blocks of health system and mainstream the principles of PHC in all initiatives especially related to health services delivery. During the last two years of PHC phase II project 3602 health professionals have been trained in technical areas related to all the 6 building blocks of health system. Out of this total number 2507 were male health professionals and 1095 were female health professional from all levels of health system. 88% of all these capacity building activities were convened inside Iraq and the remaining 12 % took place in countries of the region.

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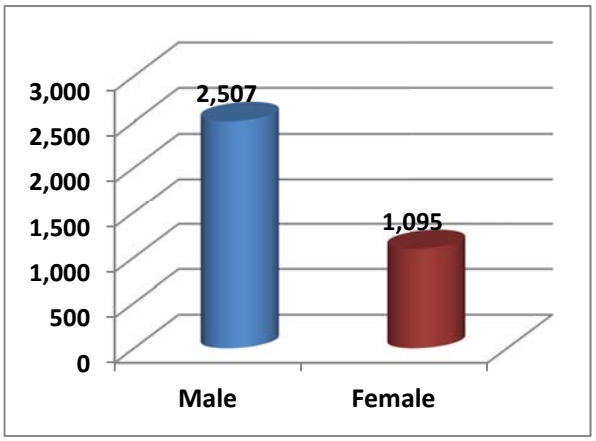


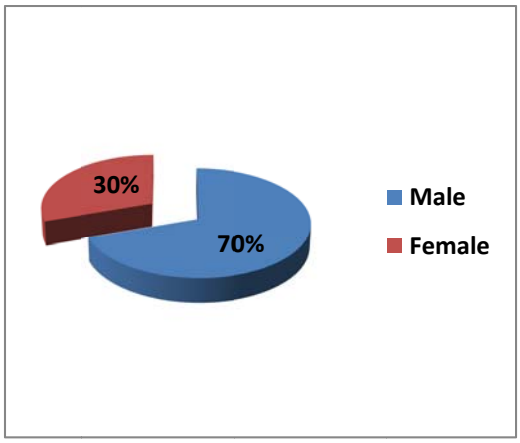


ed by gender

## V Future Work Plan (if applicable)

Follow up on the above five project outputs will be ensured during the year of 2012, it is worth to mention that WHO will be funding the future plan using the remaining budget of this project, in addition to using other funding sources (UNDG-ITF and bilateral sources of funding). The expected outputs in the year will be as follows:

**Output number 1**: The implementation of BHSP which has been initiated in 2011 will be further strengthened in the coming period. The capacity building needs of the selected districts which have been identified by the detailed situation assessment will be addressed in collaboration with MoH and other relevant partners. The ongoing rehabilitation of the 2 PHCs centers in Baghdad will be completed.

**Output number** 2: The development of the HRH strategic planning will be initiated based on the findings of the assessment which was conducted during 2011.

**Output number 3:** The development of the National Health Information System Strategy for Iraq will be initiated, based on the findings of a thorough HIS assessment which was successfully completed in year 2011.

**Output number 4:** Technical assistance will be provided to KRG regional government in the establishment of the National Health Accounts System in 2012.

**Output number 5:** Further technical assistance will be extended to support MoH in the implementation of manuals and guidelines related to the integration of MH into PHC at both policy and implementation level.

**Explain, if relevant, delays in programme implementation, the nature of the constraints, actions taken to mitigate future delays and lessons learned in the process.**

WHO part of the PHC phase II project have now moved towards a phase of rapid implementation. In the past, the project progress has been slowed down by a number of factors some of which were beyond WHO sphere of control and influence. For instance, the scope of this project is nationwide and requires strong political commitment and will given the policy and strategy development component it has, the implementation of such element was seriously hampered as a consequence of the delay of in the formation of the new government. It is worth to mention that this situation have been compounded by the challenging security situation that have lead to restricted movement of staff needed to implement various elements of the project, and hence, delayed implementation.

For UNICEF's part, there were two main reasons for the delays in the implementation of the Psychosocial Support component of the aforementioned project: a) There was a delay in recruiting an institution to assist the MOLSA and UNICEF to develop the Framework and the Strategy for the Community Based Psychosocial Care Programme (CBPSS); b) Once the development of the framework and the strategy was completed, MOLSA was undergoing the Council of Ministers' decree to decentralize so for nearly four months we had no contact with the focal point for the CBPSS in MOLSA and so it took time before the CBPSS Framework and Strategy to be cleared by MOLSA.

Fortunately, in collaboration with the Child Protection section within the UNICEF Iraq country office, the "Play Therapy Africa – NGO partner" has been contracted and rolled out a Community Based Psychosocial Support study/assessment, which is the first of its kind in Iraq and its output will convey crucial understandings and valuable data on psychosocial situation in Iraq. The study has been endorsed by MoLSA and is currently ongoing.

## VI. INDICATOR BASED PERFORMANCE ASSESSMENT

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| **Programme Title:** | Strengthening of PHC system in Iraq phase 2 | | | | | | |
| **NDS/ICI priority/ goal(s):** | NDS<br>Strengthen the national healthcare delivery system, and to reorient it from being hospital-focused to being based on Primary Health Care delivery.<br>Strengthen emergency preparedness and response in order to address the needs of Iraqis, especially vulnerable populations, while promoting a healthy living environment<br>ICI<br>Protecting the poor and vulnerable groups from the deprivation and starvation and provide the Iraqi citizens with proper standards of public social services | | | | | | |
| **UNCT Outcome** | Improved performance of the Iraqi health system and equal access to services, with special emphasis on vulnerable, marginalized, and excluded. | | | | | | |
| **Sector Outcome** | By 2010, health and nutrition related programmes enhanced to ensure 20% increase in access to quality health care services with special focus on vulnerable group**.** | | | | | | |
| **IP Outcome 1** | Enhanced access to and delivery of integrated equitable sustainable quality health service | | | **NDS / ICI Priorities:**<br>4.4.1.4(Health) | | | |
| **IP Outputs** | **UN Agency Specific Output** | **UN Agency** | **Partner** | **Indicators** | **Source of Data** | **Baseline Data** | **Indicator Target** |
| IP Output 1.1:<br>Capacity of Ministry of Health in target areas developed for improved integrated health delivery services | FM and IMCI program expanded for enhanced integrated health service delivery | WHO | MoH/<br>DoH/<br>MoHE | Number of FM clinics rehabilitated<br>Number of clinics implementing IMCI | WHO report/ MoH reports | 3 clinics are currently rehabilitated and implementing IMCI | 8 clinics ( 3+5 ) to be rehabilitated and implementing IMCI |
| | Ministry of Health supported to undertake the development and implementation of referral policies at national level | WHO | MoH/<br>DoH | Referral policy developed<br>MoH adopts and implements referral policy | WHO report/ MoH reports | No policy is available | National referral policy in place |
| | Improved capacity of MoH at the national level in the | WHO | MoH/ | 5 health system researches | Project reports | 0 | 5 |

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| | area of health system research (specific areas of research will be identified based on need) | | DoH | completed | Research reports | | |
| | MOH supported to integrate MH services into PHC system | WHO | MoH/ DoH | Number of Nurses and GPs trained on delivery of mental Health services (gender disaggregated<br>% of trainees passing the individual skills evaluation<br>Guidelines for mental health service delivery developed | Training reports | 0<br>Pretest results<br>guidelines are not available | 75 GPs and nurses trained<br>100% of trainees<br>Guidelines for mental health service delivery in place |
| | Ministry of health supported to construct 15 PHCs in selected governorates | UNICEF | MoH/ DoH | 15 new PHCs constructed in selected governorates | | 0 | 15 PHCs constructed |
| | Improved capacity of community-based psychosocial support structures | UNICEF | MoH/ NGO partners | Number of community volunteers trained<br>% of community volunteers passing the individual skills evaluation | Project progress report<br>Training report<br>Pre-post tests results | 0 | 200 community volunteers trained on Psychosocial support<br>100% of the Community volunteers passing the individual skills evaluation |
| IP Output 1.2:<br>Enhanced ability of MOH on Human resources planning | Enhanced capacity of MoH to undertake sound human resources planning | WHO | MoH/ DoH/ MoHE | Guidelines on human resources planning is developed | Project report<br>MOH / WHO records | 0 | 1 |
| | Enhanced ability of the health staff in selected districts on delivering basic health services package | UNICEF | MoH/ DoH | Number of health staff trained on delivering basic health services package (gender disaggregated | Project progress reports | Training of 750 MOH staff ongoing | 1,500 (750+ 750) will be trained on delivering basic health services package |

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| | | | | % of health staff passing the individual skills evaluation | Pre and post tests results | Pre-test results | 100% of the Community volunteers passing the individual skills evaluation |
| IP output 1.3<br>National Health Management information system strengthened | Strengthened institutional capacity of MOH at national level to manage national health information systems | WHO | MoH/ DoH | No of staff trained on managing health Information systems 9 gender disaggregated)<br>% of trainees passing the individual skills evaluation | WHO Reports<br>Pre-post tests results | 0<br>Pre-test results | 15<br>100% of health staff trained passing the individual skills evaluation |
| | MoH supported to develop and implement 10 emergency sentinel surveillance system in selected governorates | WHO | MoH/ DoH | Surveillance system set up in 10 more governorates | MoH records WHO progress report | 3 governorates | 13 ( 3+10) governorates implementing emergency sentinel surveillance system |
| | MoH supported to expand VSAT connectivity to the district level | WHO | MoH/ DoH | Number of districts connected through VSAT with MoH | MoH records WHO progress report | 19 DoHs | 19 DoHs and 19 Districts |
| IP output 1.4<br>Sustainable financing and social protection system for MoH | Ministry of Health is supported for the revitalization of the national health accounts program | WHO | MoH/ MoP/ DoH | National accounts program is implemented by MoH<br>***Further indicators pending programme implementation*** | MoH records WHO progress report | 0 | National accounts program is implemented by MoH |
| | Basic health service package piloted in 5 selected governorates | WHO | MoH/ DoH | Number of governorates with trainied staff to implement Basic Health | MoH reports<br>WHO | 0 | 5 governorates implementing Basic Health Service package |

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| developed | | | | Service package<br><br>***Further indicators pending programme implementation*** | progress report | | |
| | Ministry of health is supported to develop a healthcare financing policy | WHO | MoH/<br>MoP/<br>MoF/<br>Parliament | Policy document on health care financing policy developed | MoH reports<br>WHO progress report | A health care financing policy is not available | Policy document developed |
| | Ministry of Health supported to develop a National Health Insurance policy | WHO/ HNSOT | MoH/<br>MoP/<br>MoF/<br>Parliament | Health Insurance policy document submitted to MoH for approval | MoH / WHO reports | No policy health insurance policy is available | Health Insurance policy document approved |
| IP output 1.5<br>Enhanced MoH Leadership and Governance for | Ministry of Health supported to develop a national health strategy<br>( 5 years) | WHO/ HNSOT | MoH/<br>Parliament | National Health strategy developed | MoH / WHO reports | No strategy is available | 5 years National Health strategy in place |
| | Enhanced national capacity to develop and National inter-sectoral action framework for health focusing on community development | WHO/ SOTs | MoH/<br>Civil Society | Inter-sectoral framework on community development and submitted to MoH for approval | MoH / WHO reports | No Inter-sectoral framework on community | Inter-sectoral framework on community development approved by MoH |
| | National MDG forum developed to monitor progress of health indicators | WHO/ SOTs | MoH/<br>Parliamnet/ MoHE/<br>MoEv/<br>MoP/Mo Water resources /MoE | Multi sectoral MDG Forum is available<br>Progress reports on health indicators | MoH / WHO reports<br>Forum meeting minutes and progress reports | No forum is in place<br>No reports are aailable | An MDG forum is in place<br>Regular progress reports ( quarterly) |
| | Ministry of Health supported to set up coordination | UNICE | MoH/ | Number of coordination | MoH / WHO | No | Coordination mechanisms on |

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| | mechanisms on mental health and psychosocial support within MOH central and governorate level structures | F/<br>WHO | MOLSA | meetings<br><br>A national coordination mechanism in place | reports<br>Minutes of coordination meetings between central and district levels of MoH<br><br>Official TOR for national coordination mechanism | coordination mechanism in place | mental health and psychosocial support between central and governorate levels is in place |