FINAL NARRATIVE REPORT

IRFFI/UNDG IRAQ TRUST FUND (UNDG ITF) STRENGTHENING PRIMARY HEALTH CARE SYSTEM

IN IRAQ, 2004 -2010

IRFFI/UNDG IRAQ TRUST FUND (UNDG ITF)

Participating UN Organization(s) Sector(s)/Area(s)/Theme(s)

World Health Organization (WHO) Health and Nutrition Sector Outcome Team

Programme/Project Title Programme/Project Number

Strengthening Primary Health Care System in Iraq D2-03
ATLAS Award number: 54884

ATLAS Project number: 66884

Programme/Project Budget Programme/Project Location
UNDG ITF: USD 37,363,515 **Region (s)**: **National**
Govt. Contribution: USD **Governorate(s)**:

Baghdad, Babil, Anbar, Karbala, Diyala Najaf, Diwanya, Muthanna, Thiqar, Messan, Basrah, Wasit, Salah Al Dien, Kirkuk, Ninewa, Arbeil, Duhok, Sulaimanya.

Agency Core:

Other:
District(s)

This project is implemented in 19 districts, in 18
TOTAL: USD 37,363,515

governorates.

The districts are: Tilkeif, Dakok, Beiji, Baqouba.,Heet, Mahmoudia, Madaen, Swera, Numania, Amarah, Zubair, Suk Al Shyouk, Alurmaitha, Diwania, Manathera, Hindia, Al Musaiab, Akra, Shaklawa, Dokan,

Final Programme/Project Evaluation

Evaluation Done Yes

☐ No **Evaluation Report Attached** Yes

☐

☐ No

☐

Programme/Project Timeline/Duration Overall Duration

7th of July 2004-31st of December 2008

Original Duration

7th of July 2004-31st of December 2006

Programme/ Project Extensions

1st Request: movement between budget lines 2nd Request: 31.01.06-30.06.06 3rd Request: 30.06.06-31.12.06 4th Request: Movement between budget lines 8% 5th Request: 31.12.06-30.09.07 6th Request: 30.09.07-31.03.08 7th Request: 31. 03.08-31.07.08

FINAL NARRATIVE REPORT

I. PURPOSE

a) Provide a brief introduction to the programme/project

The aim of Strengthening Primary Health Care System (SPHCS) project is to facilitate the transition of the Iraqi health care delivery system from curative and hospital-based, into a decentralized Primary Health Care (PHC) based system, with a focus on community outreach and community involvement. This is in line with the 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 existing PHC system which is the main objective of this project. This project is also in conformity with the the Ministry of Health (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.

b) List programme/project outcomes and associated outputs as per the approved Project Document.

The expected outcomes of the project as per the approved project document are as follows:
Outcome 1: A sustainable and functioning 19 model PHC districts (including a functional referral system) one district in each of the 18 governorates (with 2 in Baghdad) that provide health care services to their population.
Outcome 2: 2,000 health personnel trained at all levels.
Outcome 3: A family physician and nurse practitioner model initiated.
Outcome 4: Enhanced community participation in health activities.

The expected outputs of the project as per the approved project document are as follows:
Output 1: 129 Primary Health Care Centres (PHCCs) rehabilitated, refurnished and operational; and Basic Health services Package provided in 129 (PHCCs).
Outputs 2: Capacity building activities for health and non health personnel is completed for the 19 model districts governorates and national level.
Output 3: Family physician practice is initiated.
Output 4: Community participation in decision making and health service provision is ensured.

c) List the UN Assistance Strategy Outcomes, MDGs, Iraq NDS Priorities, ICI benchmarks relevant to the programme/project.

UN Assistance Strategy for Iraq

This project was in line with the UN Country Team (UNCT) strategy document 2004 which was originally based on the needs assessment document prepared by the UN and the World Bank. The areas identified in the health sector that were in line with this programme are as follows:

Supporting the development of the capacity within the Ministry of Health, local health offices, as well as that of health professionals.
Providing technical and financial assistance for priority public and primary health initiatives (disease control and maternal and child health needs).
Establishing mechanisms for the transfer of financial and in-kind resources to Governorates so as to ensure strong coordination and rapid impact in priority areas and the implementation of activities with a whole range of stakeholders.
Designing and delivering an integrated primary health care package, planned and implemented at the Governorate level.
Giving short term focus at the local level on aspects of primary health care related to mother and child health, nutrition, water & sanitation and health & hygiene promotion.

This project significantly contributed to the overall UN goals and objectives within the UN Assistance Strategy to Iraq 2005-2007 through the following objectives:

Objective 1:

Improve the quality of and enhanced access to basic social services including food, as well as effective and coordinated humanitarian emergency preparedness and response.

Objective 2:

Rehabilitate and develop the country's social, economic, financial, physical and institutional infrastructure to ensure sustainable livelihoods and durable solutions to displaced populations in the country.

Moreover, the implementation of this project played a remarkable role in accomplishing the UN Health Sector Outcome goals under the UN Assistance Strategy to Iraq 2005-2007 which included substantially reduced maternal and child mortality and morbidity through the transitional period by addressing underlying causes, improving access to, and providing quality health care services.

National Development Strategy for Iraq:

This project was in line with the Government of Iraq's strategic direction stipulated by the National Development Strategy for 2005-2007 and its updated edition for the period 2007-2010.
The immediate short term strategy which is the principal element of the National Development Strategy for 2007-2010 includes the following statements:

Meeting urgent needs and improving services.
Strengthening results-based management.
Developing and implementing a 4 year plan for reconstruction.
Training and capacity building.

The multidisciplinary interventions which were undertaken by this project contributed to the reconstruction and development of Iraq by focusing on 2 dimensions, 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 population.

UN Millennium Development Goals (MDGs):

This project was based on a human rights based approach, which stipulates *promoting and encouraging respect for human rights and for fundamental freedom for all without distinction as to race, sex, language or religion*. Consideration was given to the following rights:

The right to health.
The right to a healthy environment.
The right to efficient health technology.
The right to access quality care.
The right to access to technical competence.
Access to healthy education.

It is worthwhile to reiterate that the broad scope and multidimensional interventions which were supported by this project at national and sub-national levels will contribute eventually to the attainment of the following UN Millennium Development Goals:

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).

International Compact with Iraq (ICI)

The implementation of this project 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."

All components of this project contributed either directly or indirectly to the achievements of the ICI benchmarks, which focused on the below mentioned priority areas:

Infant and Young Child Feeding Strategy implemented, including supplementary feeding programmes strengthened for pregnant and lactating women and vulnerable groups.
Review existing policy environment that promotes reproductive health and facilitate access to quality maternal health services, including emergency obstetric care, MCH, Family Planning.

As a result, this project provided us with an overarching framework to achieve health and nutrition sector related goals and objectives as stipulated in the National Development Strategy 2005-2007, ICI and MDGs.

d) List primary implementing partners and stakeholders including key beneficiaries.

This project supported a number of interventions pertaining to the areas of work and specialties of different sectors of the government at national level. In addition, it contributed to the capacity building of key ministries and DOHs through a number of diverse and innovative initiatives including trainings, workshops, fellowships and study tours. Hence, the active participation of the below mentioned ministries and national and international organizations was ensured throughout the course of the project.

1. Government of Iraq:

1.1 Ministry of Health
1.2 Ministry of Higher Education
1.3 Ministry of Education
1.4 Ministry of Environment
1.5 Ministry of Municipalities
1.6 Ministry of Agriculture

1.7 Ministry of Planning and Development Corporation
1.8 Ministry of Finance
1.9 Ministry of Human Rights
1.10 Governorate and District authorities

1 Parliament

2 **International Community**

2.1 Donors Support
2.2 United Nations Organizations

1 International NGOs

2 **Others**

3.1 Civil Society
3.2 Private contractors

Beneficiaries of the Project

This project was implemented at several levels, national, regional, district and local community levels, hence, majority of the population benefited from it either directly or indirectly. Below were the main beneficiaries of the project:

Nation-wide beneficiaries

A number of health related policies and strategies were developed during the implementation of this project which served as an advocacy tool to secure budgets for activities in partnership with the MoP and MoF.

The Iraq Family Health Survey (IFHS) that was conducted under this project has provided policy makers, decision makers and researchers with a reliable, useful and relevant data for the development of health and population policy. It will promote the culture of information and data use and will ensure evidence based decision making at various levels of the health system. A number of surveyors were trained during the implementation of this project. This trained cadre of surveyors will facilitate the future implementations of other health related surveys. The implementation of the survey also provided income opportunities for a huge number of local residents.

A number of communicable and non communicable disease control programmes were strengthened during the implementation of this project which contributed either directly or indirectly to the reduction of morbidity and mortality, thus, contributed to the wellbeing and improved health status of the Iraqi population.

Population in Target Districts

During the course of this project 129 PHCCs were rehabilitated, fully equipped with medical and non medical equipments. The rehabilitated PHCCs provided good quality health services to around 4.4 million people in their catchments population. Besides good quality services advanced training opportunities were also provided by these PHCCs to a large number of health and non health workers.

This project put special emphasis on capacity building of the various cadres of health workers. Around 2000 health and non health workers working for different sectors were provided with different types of training, fellowships and international meetings according to their planned needs. The trained health workers were able to enhance the quality of health care services; they were supposed to provide at their health facilities. Availability of improved primary health services to the population closest to where they live facilitated the reduction in the load of patients at the secondary and tertiary health care facilities. The resultant reduced patient load at the secondary and tertiary level provided better opportunity for the care of those patients who needed to be seen and managed by the higher level of health care system.

As mentioned above, a large number of diverse activities pertaining to various sectors were undertaken successfully during the implementation phase of this project, which provided employment opportunities to a total of 162,400 beneficiaries.

II. ASSESSMENT OF PROGRAMME/ PROJECT RESULTS

a. Report on the key outputs achieved and explain any variance in achieved versus planned results. Who have been the primary beneficiaries and how they were engaged in the programme/ project implementation.

Output No. 1: 129 Primary Health Care Centres (PHCCs) rehabilitated, refurnished and operational; and provide Basic Health Service Package – achieved

1.1 Rehabilitation and Reconstruction and Equipments:

At the onset of the programme in November 2004 a rapid assessment was conducted in close coordination with the MoH within 6 days. 128 PHCCs and 144 sub-centers were assessed in the selected 19 districts. This process included assessing the physical conditions, manpower needs and assessment of services provided and equipments available and needed. Several meetings were held between the management committee of the project, engineers from the directorate of projects and engineering services and WHO Baghdad office engineers to formulate the final design of the assessment forms. Meeting with the focal points in all directorates of health in Baghdad and all governorates (including Kurdistan region) was arranged on 11 September 2004 to discuss the contents and the design of the assessment forms. (*Kindly refer to Annex I for details of the assessment report)*. Another revision was conducted through several video conferences between Baghdad and WHO Iraq Office in Amman to finalize the assessment forms, plan the suitable date for implementation and to expand the assessment teams at the governorate level. Further 2 meetings (1 day each) were arranged on 27 & 28 October 2004, to discuss the final details.

The two assessment teams at the level of DOH in the governorates consisted of one doctor (PHC section manager in one team and district manager in the other) and two engineers (one was civil engineer and the other was electrical engineer if available). (*See Annex II for details on focal points)*. At MOH level, four supervision teams were formed; each team was composed of a doctor from the PHC department of MOH with a civil engineer from the Directorate of Projects and Engineering services to visit the DOH in order to follow up the implementation of the assessment by spending two days in each DOH. Each supervisory team was responsible for 4-5 DOHs.

All assessment teams from all health directorates in all governorates were divided into two groups to train them on the method of conduction of the assessment in one day training course in October 2004 and covered Basrah, Meesan, Muthanna, Thi-Qar, Wasit, Kerbala, Najaf, Babil, Diwaniya, and Baghdad/Kerkh, Anbar, Diyala, Baghdad Rasafa, Salah Al-din, Kirkuk, Ninawa, Suleimaniyah, Erbil and Duhok. The results were:

1 Tap water situation in PHC facilities was critical and this problem had to be dealt locally in order to improve sanitary conditions in PHC facilities.
2 Transportation by car was one of the important means of communication in both directions from PHC centers upward to PHC districts and downward to PHC sub centers. However, the current situation of security prevents the flexible range of movements and use of ordinary cars, so it was helpful to depend on motor cycle.
3 One of the important needs to be provided to PHC facilities was the generators, because electricity was a critical issue for maintenance of good PHC services quality and only (38.62%) of PHC facilities had working generators.
4 The assessment showed that only some PHC centers got incinerators. This finding was used to advocate for Health Care waste management project by the Technical Affairs Directorate of MOH with support of WHO, focusing on the 19 districts.
5 Physical rehabilitation of PHC centers and sub centers is essential to provide a suitable environment of work.

In accordance with the assessment outcome, 129 PHCCs were selected in 19 districts, comprising 7% of the total centers and 56% of the total number of PHCCs in the 19 selected districts, 3 centers are located in Baghdad-Risafa and the rest are located in Tilkeif (5), Dakok (6), Beiji (6), Baquba (14), Heet (11), Swera (4), Amarah (10), Zubair (3), Suk Al Shyouk (10), Alurmaitha (6), Diwania (4), Manathera (4), Hindia (2), Al Musaiab (4), Akra (9), Shaklawa (16), and Dokan (12). (Dokan and Baqouba relaced Khalis and Chemchamal according to the request of DOH in these

respective Governorates. No contractor was available to do the construction work in Karkh (Baghdad) Instead; one additional PHC in Wasit was added to the list in Numania.

The reconstruction work started after the usual procedures.The scope of work generally included: maintenance or replacement of existing service system (i.e. electrical and sanitation systems), improving the finishing works (i.e. painting, tiling, juss (gips) plastering, cement rendering, roofing and others), repairing or replacing windows and doors and providing generators where requested. *(Kindly refer to annex III for further details)*. The 129 functional PHCCs are now serving a total population of 4.4 million. In addition, a high quality 8 beds mental health unit was constructed as part of the local hospital in the center of Kirkuk governorate. Similarly, based on the need of the local population for mental health services an 8 beds mental health unit in the vicinity of the local hospital was constructed in wassit governorate.

Hence, by completing this activity we have contributed to the increase of accessibility to quality health services in the selected areas.

The functioning of the PHCCs was complimented with procuring and delivering equipment worth of around USD 17 million (around USD 130,000 per facility) of medical equipments, supplies, drug skits, informatics equipment and furniture. Below are some of the examples of rehabilitation and reconstruction work supported by this project.

Al-Senya & Al-Furat Center PHC in Dewania, before WHO & MOH Intervention

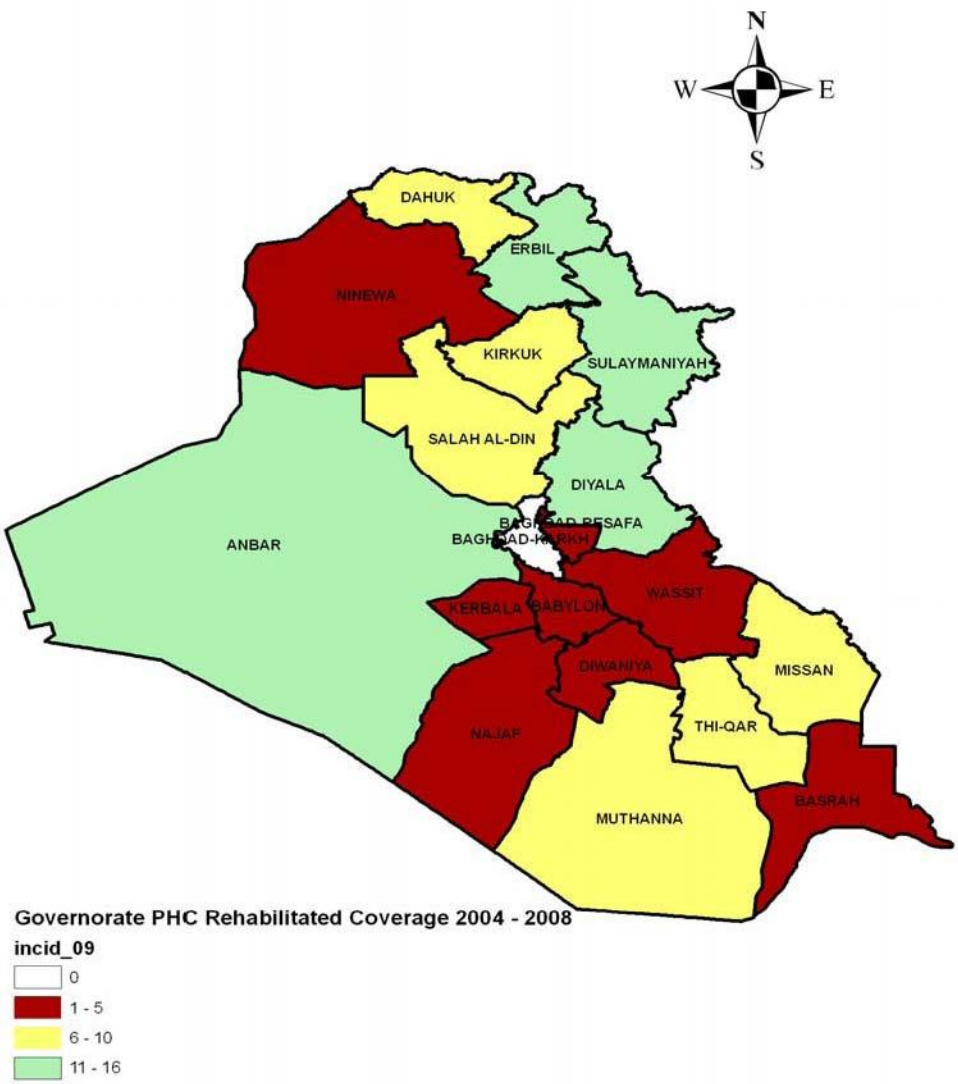
Al-Senya & Al-Furat Center PHC in Dewania, after WHO & MOH Intervention

Basrah PHC, before & after WHO & MOH Intervention

In each of the 19 model districts, one training halls was constructed and fully equipped with approximately 1,216 teaching assets (such as TVs, data shows, cassette recorders, digital cameras etc). These halls ensured continued medical education for at least 5,000 health professionals serving in this area. Wasit-Numania replaced Baghdad Karkh so that Wasit has two training halls in Numania and Swera. In Diyala, the training Hall was established in Baqouba instead of Khalid. In addition, Dokan replaced Chamchamal according to the request of DOH Suleimania.

The design was made by WHO and MOH engineering team following international guidelines considering local needs. Structural wise the walls are load bearing using local material responding to the local climate. The halls can accommodate 50 participants at the same time. In addition, 3 nursing training centres were rehabilitated in Suliemaniyah, Baghdad and Basra in order to meet the training needs of the nurses and other paramedical staffs in the 3 governorates. A temporary maintenance support was also provided to the nursing training centre in Basra. The diagram below shows a snapshot of the rehabilitation and reconstruction work done in one of the training center.

Training center



Map (1) Governorate PHCC Rehabilitated Coverage 2004-2008

Governorate	PHC Rehabilitated Total
ANBAR	11
BABYLON	4
BAGHDAD-RESAFA	3
BASRAH	3
DAHUK	9
DIWANIYA	4
DIYALA	14
ERBIL	16
KERBALA	2
KIRKUK	6
MISSAN	10
MUTHANNA	6
NAJAF	4
NINEWA	5
SALAH AL-DIN	6
SULAYMANIYAH	12
THI-QAR	10
WASSIT	4
Total	129

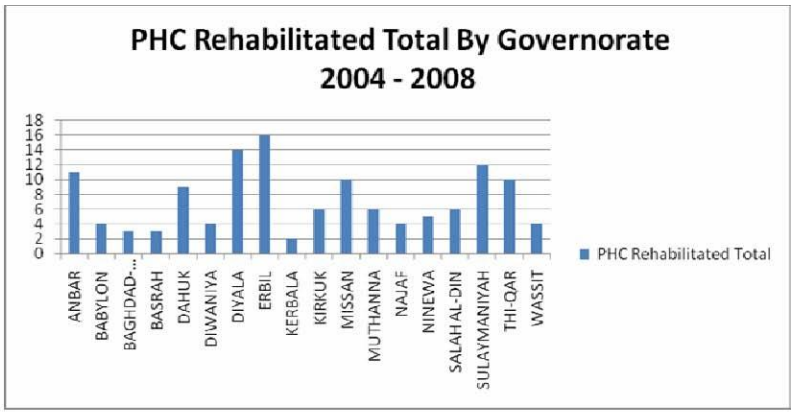


Figure #1 The total Number of Rehabilitated PHC 2004-2008

Table #1 the total Number of Rehabilitated PHC 2004-2008

Governorate	District	Total
BABYLON	AL-MUSAYAB	4
BASRAH	AL-ZUBAIR	3
DIWANIYA	DIWANIYA	4
ERBIL	SHAQLAWA	16
KIRKUK	DAQUQ	6
MUTHANNA	AL-RUMAITHA	6
NINEWA	TILKAIF	5
SULAYMANIYAH	DOKAN	12
WASSIT	AL-NA'MANIYA	1
	Total	129

ANBAR	HEET	11
BAGHDAD-RESAFA	Al-Rasafa	3
DAHUK	AKRE	9
DIYALA	BA'QUBA	14
KERBALA	AL-HINDIYA	2
MISSAN	AMARA	10
NAJAF	AL-SAMAWA	4

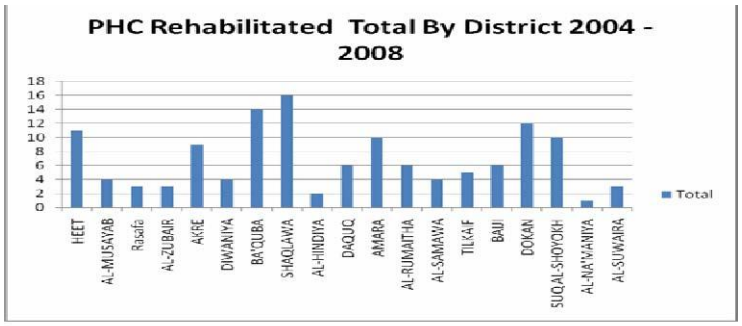
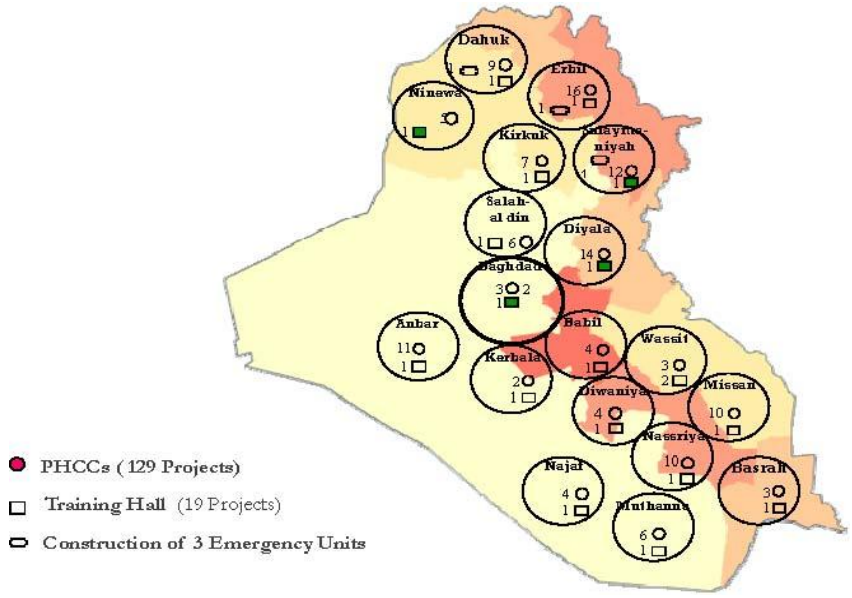


Figure #2 (the number and distribution of PHCs and training halls and Emergency Units)

Note: Further information on the Emergency Units is provided under the Emergency Response Section

SALAH AL-DIN	BAIJI	6
THI-QAR	SUQ AL-SHOYOKH	10
WASSIT	SUWAIRA	3

Table #2 the number of Rehabilitated PHCCs by district 2004-2008



Equipments:

In order to meet the needs of the selected PHCCs, needs assessment was carried out and a draft list of equipment and supplies required was prepared. Extensive consultations with MOH were held to agree on the final requirements.

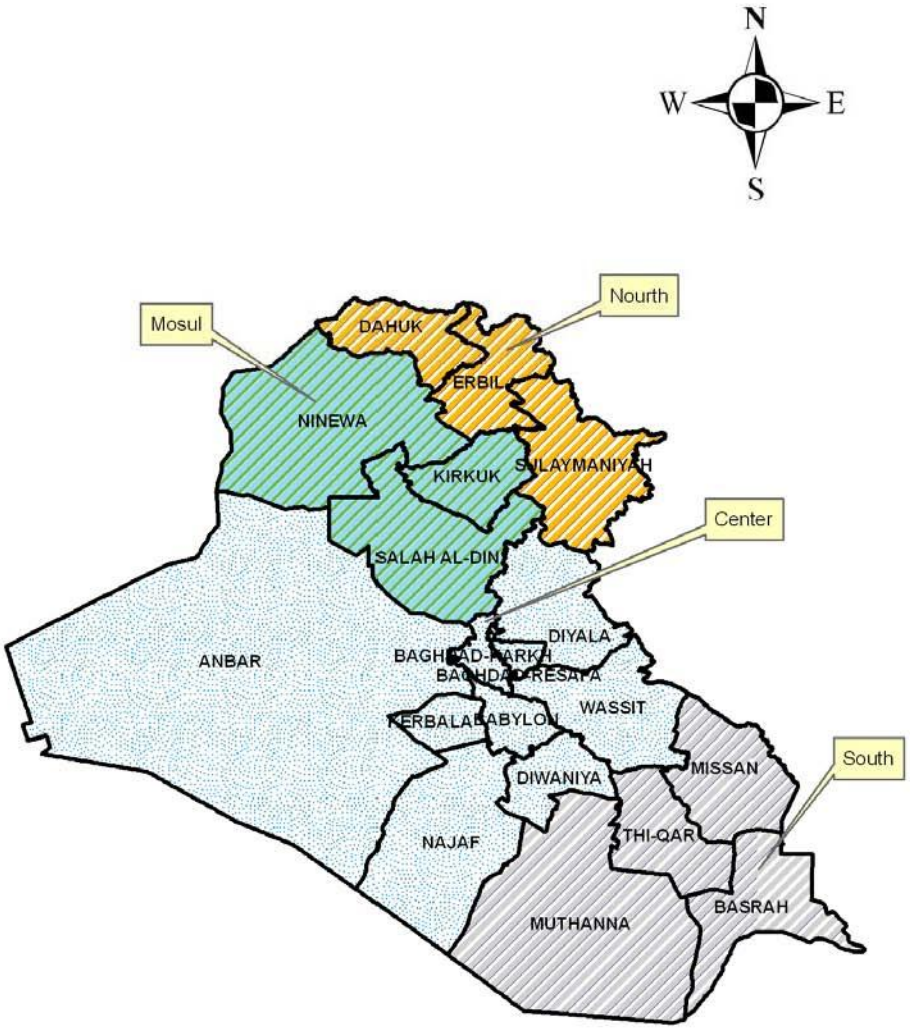
The Technical specifications for all the items of required medical equipment, supplies and medical furniture were prepared, with cost estimates. Finally, the list was handed over to the MOH for their final review and approval.

The approved list was submitted to WHO Regional Office, where WHO procedures for tendering and contract awarding were applied to the purchasing and delivery of equipment and supplies.

All the needed equipments which were procured by the Regional Office were delivered to Iraq for installation in the PHCCs. With the ever-changing security situation in Iraq, it was agreed to have four distribution points as storage points for the equipment and supplies in transit for final distribution to the 19 PHC districts *(Please refer to annex IV for details on the equipment)*.

1 Distribution point in Erbil to supply the selected districts in Erbil, Dohuk, and Suleimaniyah
2 Distribution point in Mosul to supply the selected districts in Ninewah, Tameem, and Salah Eddin
3 Distribution point in Baghdad to supply the selected districts in Baghdad Karkh, Baghdad Rasafa, Diwaniyah, Anbar, Karbala, Diyala, Najef, Babylon, and Wassit.
4 Distribution point in Basrah to supply the selected districts in Basrah, Muthanna, Missan and Thi-Qar.

Equipment, supplies, furniture (medical and non-medical), and informatics equipment were provided to the 19 PHC districts through the MOH. The PHC system was further supported by procuring and delivering 19, 4wheel drive (4WD) ambulances, 38, 4-wheel drive pick up trucks and 300 motorcycles to be used for outreach activities. These items covered the needs of target population and contributed to increased access and utilization of health care services by the catchment population. The below map reflects the distribution points which were used for the distribution and supply of medical equipments.



Map (3) Equipments Distribution Points 2006-2008

1.2 Support to health services, health system and public health programmes

1.2.1 Health Information System (HIS)

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

1) **Information technology infrastructure** included procurement of USD 1.6 million worth of data network infrastructure and HIS equipment *(Kindly refer to annex V for further details)*. These equipments were procured, delivered to the end user and installed. It is worth mentioning that 19 engineers underwent oversees training to support this system.

2) **Software applications** involved data base management software for health records, health statistics, surveillance and mapping. In order to assist the installation process 21 statisticians were trained on the usage of the software applications. The process of developing patients' files has been recently initiated by MoH with the support of WHO in the 19 model districts which will include information on all the families in the catchments area.

3) **The telecommunication and connectivity** network was installed between MoH Baghdad and DOHs which ensured the flow of data from DoH to MoH Baghdad and vise versa.

1.2.2 Iraq Family Health Survey (IFHS)

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

The Iraq Family Health Survey (IFHS) was a cross-sectional, nationally representative survey of 9345 households. The sampling frame that was used in the southern and central provinces was derived from the 1997 Iraq census, which had been updated for the 2004 Iraq Living Conditions Survey. The sampling frame used in Kurdistan was based on information provided by the Statistical Offices in the region. Population estimates for Iraq for the survey period were projected by Iraq's Central Organization for Statistics and Information Technology (COSIT).

A Steering Committee was formed to oversee the management of the implementation. This committee comprised of representatives from each of the key partners and was headed by the Technical Deputy Minister of Health with representatives from the MoH, COSIT and the MoHK.
Training of central and local supervisors from all 18 governorates was conducted in Amman, Jordan. Training of interviewers was done separately in each governorate for one week during May and June of 2006 and a one day refresher training session was conducted the day before the start of the survey in each governorate. Following interviewer training, the survey instruments and procedures were pilot tested in all governorates. The survey fieldwork was conducted during August and September 2006 in the 14 South/Centre governorates. In Anbar governorate, the fieldwork was conducted in October and November 2006, while fieldwork for the Kurdistan region was conducted during February and March 2007. Overall, 407 personnel participated in the implementation of the survey, consisting of 100 central, local and field supervisors, 224 interviewers evenly split between males and females, and 83 central editors and data entry personnel.

The results of this survey indicate that access to essential health services is a major problem for the conflict-affected communities. This has adversely affected public health programmes such as immunization, maternal and child health and nutrition.

The same survey indicates a threefold decrease in maternal and U5 mortality rate compared to 1999 published results, still U5 mortality rates (46 per 1,000) and maternal mortality ratio (84 per 100,000) are high for the region. Children and pregnant women are the most affected by the lack of access to primary health services and nutritional support, leading to increased risks of morbidity as well as child and maternal mortality.

Moreover, IFHS indicated that around 151,000 violence related deaths occurred in three years prior to 2006, which translates into 137 deaths per day, although other sources provide higher estimates.

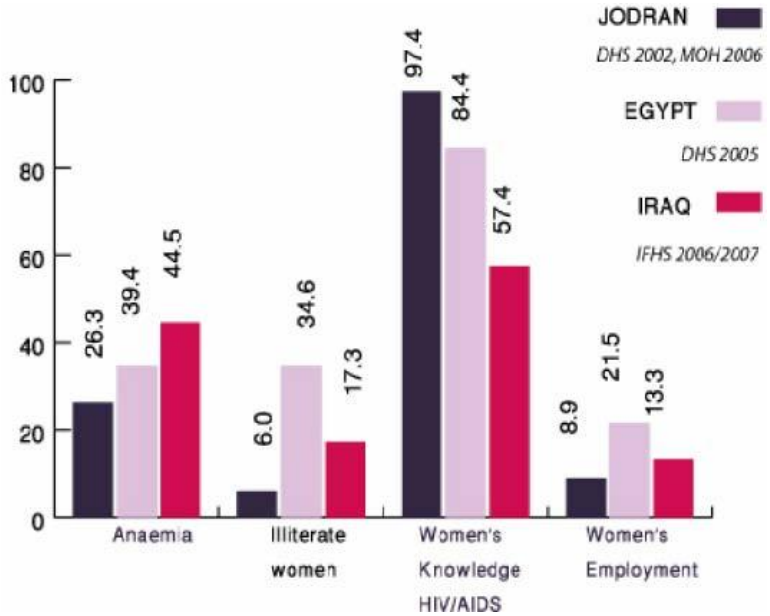


Figure #3 Comparing some of IFHS key indicators with other countries of the region Note: Please refer to annex number VI for all IFHS key indicators

1.2.3 Iraq Mental Health Survey

In addition to IFHS this project supported the highly needed survey to determine the magnitude and burden of mental health disorders in Iraq. Iraq Mental Health Survey (IMHS) was carried out by the Iraqi Ministry of Health (MoH), in partnership with the Ministry of Planning and Development Cooperation/Central Organization of Statistics and Information Technology (COSIT), the Ministry of Health/Kurdistan region (MoHK) and the Kurdistan Regional Statistics Office (KRSO), to better inform mental health policies and strategies. It studied the nature and extent of mental health disorders and the impact of violence on the Iraqi people. The technical and financial support was provided by the World Health Organization (WHO).

It is the first mental health epidemiological survey in Iraq and the second one in the Middle East after Lebanon. It covered the whole country and was carried out successfully despite conditions of extreme instability and total lack of security in the country. It produced Life time, previous 12 month and last 30 day prevalence rates of common mental disorders and correlated them to socio-demographic variables.

The objective of the study was:

To identify the prevalence of mental disorders; to indentify the impact of mental disorders in the adult population of 18 year and older including both males and females; to find out the relationship between the prevalence of mental disorders, trauma exposure and socio-demographic characteristics e.g. age, gender, education, marital status, family income etc.; to assess the treatment utilization by persons with mental disorders; to provide policy and decision makers and researchers with reliable, accurate and relevant data for the development of mental health plans and strategies.

Major findings of this Survey were as follows:

Lifetime prevalence of any mental health disorder was 18.8%.
Females have higher prevalence rates of mental disorders than males in 30 day, 12 month and lifetime prevalence.

Males had been more exposed to trauma.
Urban populations had higher prevalence rates of mental disorders than rural populations in 30 days, 12 month and lifetime prevalence.
The prevalence rates of anxiety disorders were higher in the Kurdistan region.
The most prevalent class of disorders was anxiety disorders (18.8%).
The most prevalent individual lifetime disorder was major depressive disorder (7.2%).
People 50 years and older had higher rates of mental disorder than younger age groups.
The majority of people with phobias in Iraq had their first onset during childhood or in their adolescent years.
The lifetime prevalence of panic disorders was more than 5 times higher in the younger generation than the older generation.
Women were found to have a higher prevalence of anxiety disorders than men.
Women were found to have a higher prevalence of behavioral disorders than men
Those with a higher level of education reported having a higher prevalence of anxiety disorders than those with lower levels of education.
The higher the exposure to trauma, the greater the chance of having mental illness.
Only 2.2% of the IMHS respondents reported receiving treatment for emotional problems within twelve months before the survey. Most healthcare treatment was of low intensity.
Overall, there is a relatively low rate of Post-Traumatic Stress Disorder (PTSD) and this could reflect the resilience of the population of Iraq.

Both IMHS and Iraq Family Health Survey (IFHS) were conducted simultaneously based on the same sample design. It was a unique experience in comparison with other implemented surveys in the world. The linkage between the data of the two surveys will provide more indicators on mental disorders and family history.

1.2.4 Public Health

Control of public health threats and the implementation of a systematic surveillance system were partially supported under this project.

Technical and logistical support was provided to prevent and control Malaria and Leishmaniasis, tuberculosis, Noso-comial Infections, and to implement vaccine management and the Expanded Programme on Immunization (EPI). In order to provide management support including close monitoring and supervision of the day to day activities of the surveillance system 17 focal points have been assigned in all governorates of Iraq. *(Kindly refer to Annex VII for details on the Focal Points*) More specific activities to control and prevent malaria and some other communicable diseases included the following:

Early diagnosis and treatment.
Availability of treatment and diagnostic facilities.
Training inside and outside Iraq.
Entomological surveillance activities.
Timely spraying and fogging activities.
Provision of long-lasting insecticide treated bed nets.
Community awareness and participation.
Rodent control activities.
Malaria and Leismaniasis spraying campaigns.

In year 2004, despite security concerns 10 rounds of 2nd national polio campaigns were supported by this project in all 18 governorates of Iraq. Additionally, apart from supporting social mobilization activities supervisory, monitoring and logistical support was provided under this project to 9 rounds of measles campaigns in different governorates of Iraq.

Furthermore, this project provided technical and financial support to the national efforts to prevent and control Tuberculosis. In these lines timely, technical, financial and logistical support was provided by this project to the conduction of training workshops on Directly Observed Treatment Therapy (DOTS) in all governorates of the country.

Moreover, some of the health care provision facilities were assessed and supported either partially or fully, in order to meet the specific needs

related to the various technical areas. This work involved strengthening public health labs in (Baghdad, Erbil, and Mosul), the central blood bank, National Drug Quality Control Lab, food safety services and enhancing surveillance systems to counteract any public health threats. This entailed training staff, rehabilitation of buildings and/or equipment.

1.2.5 Emergency Response

Health Action in Crises (HAC) is one of the global WHO strategic priorities. HAC strategic goal is to support communities and health stakeholders as they prepare for, and respond to, the health aspects of acute and long term crises so as to minimise suffering and death, open the way to recovery of sustainable health livelihoods.

Hence, part of the WHO emergency response was supported under this project. WHO supported MoH in the provision of medicine and medical supplies including life saving items, water quality control kits for water, testing for environmental contamination and limited emergency medical oxygen supplies for the use of 57 hospitals during 2005 emergencies resulting from rising number of injuries as major public health problem. Finally, in order to further strengthen the emergency services three Emergency Units were rehabilitated and equipped in Dohuk, Erbil and Sulyaimania. The blood bank center in Baghdad and the first aid unit in Dohuk were fully furnished with all the necessary items with the funds from this project.

1.2.6 School Health

The Action Oriented School Health Curriculum (AOSHC) was adopted in Iraq in 1996 by the health education department. It was then piloted within six schools in each of the three selected governorates and a first assessment of the project was conducted in 26 schools in all governorates except Kurdistan.

Under this project, WHO supported the study proposal on the *second* assessment of the AOSHC, submitted by the MoH/Health Education Unit at the directorate of Public Health and Primary Health Care. This assessment was conducted in December 2005 in cooperation with the School Health Unit/MoH.

The objectives of the assessment were to assess the knowledge and attitudes of students' and the knowledge of families and caretakers of students as well as to evaluate the knowledge of teachers and evaluate the school health environment. Three questionnaires were distributed to the targeted 26 schools addressing the above said objectives, filled and analysed. The assessment required a total of 64 survey teams, 32 supervisors (16 local and 16 central), and 2 general supervisors.

The assessment final report listed the following recommendations based on the findings: 1) training activities for the teachers serving in the schools that are part of this project is needed, especially that there was a high turnover among trained capacities over the last few years; 2) support the technical review of the teacher's manual by both MoH and MoE, print and distribute the final version; 3) expand this programme to include more schools, especially that the number of schools are increasing inside Baghdad and in the governorates; 4) implement the same programme in Kurdistan Region, and 5) provide support for printing children educational material that address the major health problems and attitudes identified in this assessment.

Based on these recommendations, WHO provided technical and financial support to MoH and MoE and ensured to strengthen the school health service through the implementation of Health promoting schools project funded by UNDG ITF. The work done to initiate the Health promoting School has laid the foundation for further strengthening of the School Health Programmes in Iraq, one of the elements of BPHS.

1.2.7 Health Sector Reform, Health Governance

This project has also contributed to the initiation of the health sector reform necessary to build the capacity of national MOH for decentralization and PHC. Reform efforts included the formulation of policies that have a direct impact on successful transformation from tertiary to primary health care, especially in the areas of health care financing, human resource development, and strengthening district health systems. It also contributed to the review and update of public health legislation and regulations and the improvement of health governance, especially in the area of health information system (HIS).

The development of the following strategies was supported by this program:

1 Initiation of National Health Accounts including costing of BPHS.
2 Financing Options for Iraq's Health Sector.
3 Nursing and Midwifery Strategy for Iraq.

4. Integrated Management of Childhood Illness (IMCI) plan of action.

1.2.8 Basic Health Service Package (BHSP)

A Basic Health Service Package is defined as a minimum collection of essential health services that all population need to have a guaranteed access to. Essential services are health services that provide a maximum gain in health status on the national level, for the money spent.

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

The BHSP was developed by MOH with the technical support of WHO. The development of this crucial package was financially supported under this project. This package will be implemented in selected districts during the implementation of SPHC System phase II. The process started with a review of the health status of the Iraqi population to determine major health problems and to identify health services essential for addressing these problems. The PHC network was also assessed in terms of its infrastructure and human resources so as to determine the scope and type of services it is capable of delivering.

Results from the situational analysis were concluded into suggestions for a range of basic health care services to be delivered as a standardized package along a "continuum of care" that links communities, local PHCCs and hospitals. The BHSP represents the vision of the MoH for a standardized package of basic health services that would form the core of service delivery in all primary health care facilities. The package is a "living document" and needs to evolve over time and to be updated to changing needs. With experience of its use, the package can be further improved and services significantly improved.

Delivery of the BHSP will build on the existing system, despite its limitations, to meet the immediate necessary needs while initiating change over time. The approach adopted for developing a BHSP for Iraq emphasized *"ownership*" by the Iraqi Government so that product generated would emphasize *"relevance*" to the needs and priorities of the Iraqi people.

The package was developed by a core team of MoH specialists with expertise in all relevant areas. The vision was that successful implementation and sustainability are only possible if it is a "national" rather than a donor-driven product.

The collaborative process involved several months of assessment and planning and capitalized on existing studies and previously completed work:

1 A Planning Workshop was held in Amman in March 2008 with the purpose of defining the product, agreeing on a conceptual framework and brainstorming about the content of the BHSP.

2 An assessment of health status and infrastructure was conducted to identify the current health priorities in Iraq. The analysis was rapid and relied on secondary data sources since the focus was to feed into the package rather than conduct a thorough situational analysis.

3 The content of the package (as defined by the services to be delivered at the different levels of the PHC network) was drafted by the relevant MoH experts. A participatory process was used to deal with

cross-cutting issues. Several rounds of email and phone exchanges were utilized to refine and reach consensus on the content.

4. The trade-off between what's affordable or doable and what's ideal was the biggest challenge that the team had to struggle with given the current implementation realities in Iraq.
5. With the technical assistance of the SPHCS consultants, equipment and essential drug lists for the agreed upon services to be included in the BHSP, were drafted.

Finally, a series of videoconferences were held in Amman in May 2008 to finalize the BHSP and initiate dialogue regarding implementation priorities and strategic planning issues that the Iraqi government needs to address to ensure that nation-wide implementation of the BHSP is successful and sustainable.

1.2.9 Primary Health Care (PHC) Training Manuals

Under this project, comprehensive, nationwide PHC Training Manuals were drafted. These manuals have been initially reviewed by 26 MoH experts and WHO Iraq technical staff during a workshop held in Amman June 2007 to ensure that they were scientifically correct, culturally sound, and factually consistent. The package of modules was finalized during a meeting held in Amman in December 2007 and Training of trainers completed consisting of 20 multidisciplinary staff working at sector and PHC level.

The principal aim of these manuals is to enhance the PHC staff competencies in acquiring the skills of knowledge management. These manuals are a guide for future national trainings using the updated and feasible accessible teaching and training methodologies to transmit health messages.

The manual consists of 10 prioritized training modules: 1) Reproductive Health, 2) Child Health and EPI, 3) Communicable Diseases, 4) Non Communicable Diseases, 5) School Health, 6) Oral Health, 7) Mental Health 8) Environmental Health 9) PHC Management Guide 10) Nutrition and food safety.

1.2.10 Integrated Management of Childhood Illnesses (IMCI)

IMCI was another new concept that has been integrated within the PHC programme. The aim of implementing IMCI programme is to reduce the under 5 (U5) child morbidity and mortality rate by combating the three main killing diseases: acute respiratory tract infections, acute diarrhoeal diseases and malnutrition by increasing detection rates and actions taken by the health care staff. IMCI include both preventive and curative elements that are implemented by families, communities and health facilities.

Ministry of Health in Iraq adopted the IMCI strategy in 1998.

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.

As shown in the tables below, this project component was piloted in 19 PHCCs in five different governorates: Baghdad (Karkh and Rassafa), Ninwa, Thi-Qar and Babel. Similarly, as reflected by the table below during the course of this project, the IMCI implementation was rolled out to 5 new districts located in 4 governorates i.e. Baghdad Karkh, Baghdad Rassafa, Thi-Qar and Babil.

Table #3 Primary Health Care Centers that have started IMCI Implementation in 2008

	PHC Center	Name of District	Directorate of Health

1	AL-Kafel	Hilla	Babil
2	AL-Baqer	Hilla	Babil
3	AL-Imam AL-Hussain	Hilla	Babil
4	AL-Zahraa	Hilla	Babil
5	AL-Washash	AL-Karkh	Baghdad –AL-Karkh
6	AL-Zahraa	AL-Khadmia	Baghdad –AL-Karkh
7	AL-Khadraa	AL-Adil	Baghdad –AL-Karkh
8	AL-Qanat	ALRusafa	Baghdad –Rusafa
9	Zayona	Baghdad AL-Jadeda	Baghdad –Rusafa
10	Babil	Rusafa	Baghdad –Rusafa
11	Baghdad AL-Jadeda (First)	Baghdad AL-Jadeda	Baghdad –Rusafa
12	Baghdad AL-Jadeda (Second)	Baghdad AL-Jadeda	Baghdad –Rusafa
13	AL-Sindbad	AL-Rusafa	Baghdad –Rusafa
14	AL-Karda	AL-Rusafa	Baghdad –Rusafa
15	AL-Dawia	AL-Shatra	THI-QAR
16	AL-Aroba	AL-Shatra	THI-QAR
17	AL-Naser	AL-Rifaie	THI-QAR
18	AL-Jababesh	Jababesh	THI-QAR
19	AL-Arabi	AL-Aysar	Nienawa

Table #4 New Districts that have started IMCI Implementation in 2008

ID	Governorate	District
1	Thi-Qar	Jababeesh
2	Baghdad –AL-Rusafa	Baghdad AL-Jadeda
3	Baghdad-AL Karkh	AL-Karkh
4	Baghdad AL-Karkh	AL-Adil
5	Babil	Hilla

Child malnutrition remains a concern according to the WFP-COSIT comprehensive food security and vulnerability analysis (CFSVA 2008) for Iraq. This study showed that national average of child malnutrition in Iraq is estimated as 4.7 percent for wasting, 21.8 percent for stunting and 9.1 percent for underweight. The midterm impact evaluation of this programme on PHC services shows that 88.8% of doctors assessed symptoms of acute respiratory tract infections and acute diarrhoeal diseases correctly while 100% of health professionals correctly checked immunization status of under 5 children. More on IMCI.

IMCI community component focused on teachers, women support groups, Community Child Care Units (CCCUs) volunteers and community leaders in awareness sessions on the 12 key health messages that improve health of mothers and children. Trainings and capacity building of the staff on this new concept has been conducted and training manuals were produced by MoH with the technical assistance of WHO and the consultation of WFP, UNICEF and USAID.

As shown by the below tables, a number of training and capacity building activities were carried out by this project in order to strengthen the initiation and management of IMCI activities in a number of governorates. Similarly, as reflected in the table below a number of facilitators were trained in different governorates who will carry forward the job of training other health workers on IMCI.

Table #5 Number of Health care providers trained in 2008

Type	Male	Female	Total
Doctors	17	10	27
Paramedical	21	10	31

Total #6 of IMCI Facilitators in Iraq

Governorate	Number
Baghdad	23
Mousul	3
Babil	1
Wassit	1
THI-Qar	4
Najaf	2
Dayala	6
Total	40

Follow up training of doctors and nurses trained on Integrated Management of Childhood Illnesses (IMCI)

Output No. 2: Capacity building activities for health and non health personnel is completed for the 19 model districts; accomplished

The capacity building of MOH staff was an important element and a major pillar of the project. Because of the security situation within Iraq during the implementation period (2004-2008), major workshops and training initiatives were placed outside Iraq, especially in Amman. Awareness and advocacy meetings, Policy, planning and supervisory training exercises were directed to lead personnel within MOH while the health care delivery level was trained on various elements of the Basic Package of Health services to be provided which has to do immediate improvement of health conditions in target areas and in the country at large. Training of trainers on these issues was held in Amman and the further training was done by MOH within Iraq using these trainers.

The huge number of trainees was to respond to the continuous brain drain especially in the health sectors, where hundreds of health professionals were killed, kidnapped or is forced to leave the country. This aspect has actually undermined the efforts to improve health services and besides insecurity and limited access has disrupted the public health programmes including those such as immunization of children, access to maternal and child health services.

Under this project, over 2,000 workers from different sectors participated in PHC related trainings. Capacity building activities were carried out for various categories of staff working for the following areas:

- Access to Quality Health Care.
- Social Determinants of Health.
- Prevention and Control of NCD.
- Prevention and Control of CD.
- Mother and Child Health.
- Human Resource Development.
- Health Policy Planning and Sustainable Development.

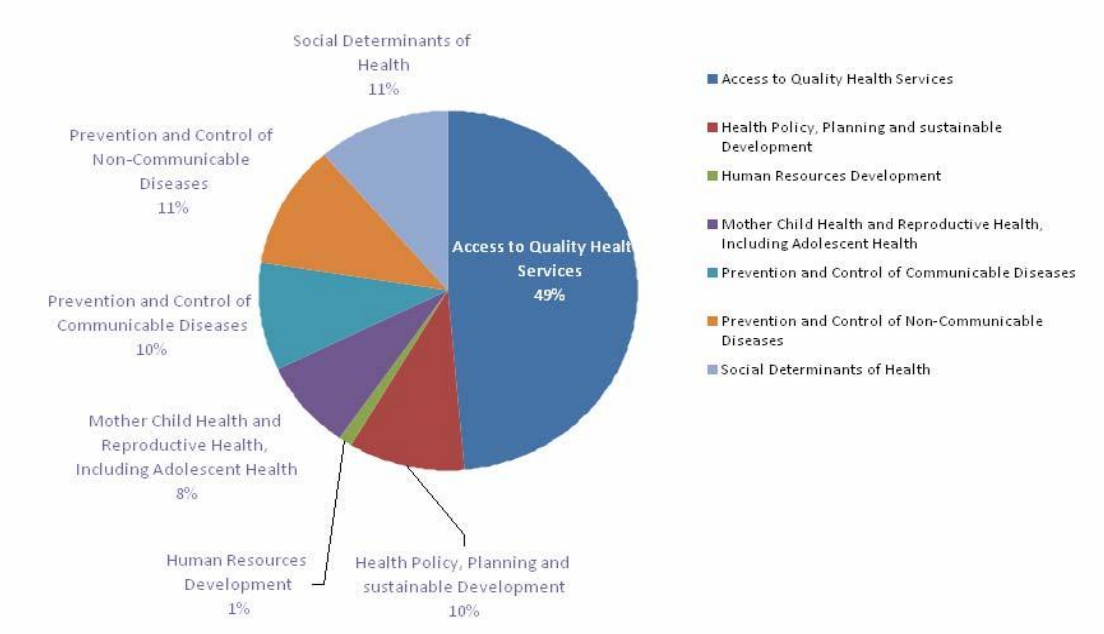


Figure #4 Capacity Building areas addressed under SPHCS

The capacity building activities were implemented in all the 19 Governorates, with a focus on Baghdad. Gender equality has been considered as a basic working principle during the planning and implementation phases of capacity building activities under various technical areas. Figure #4 illustrates the distribution of trainees through out country.

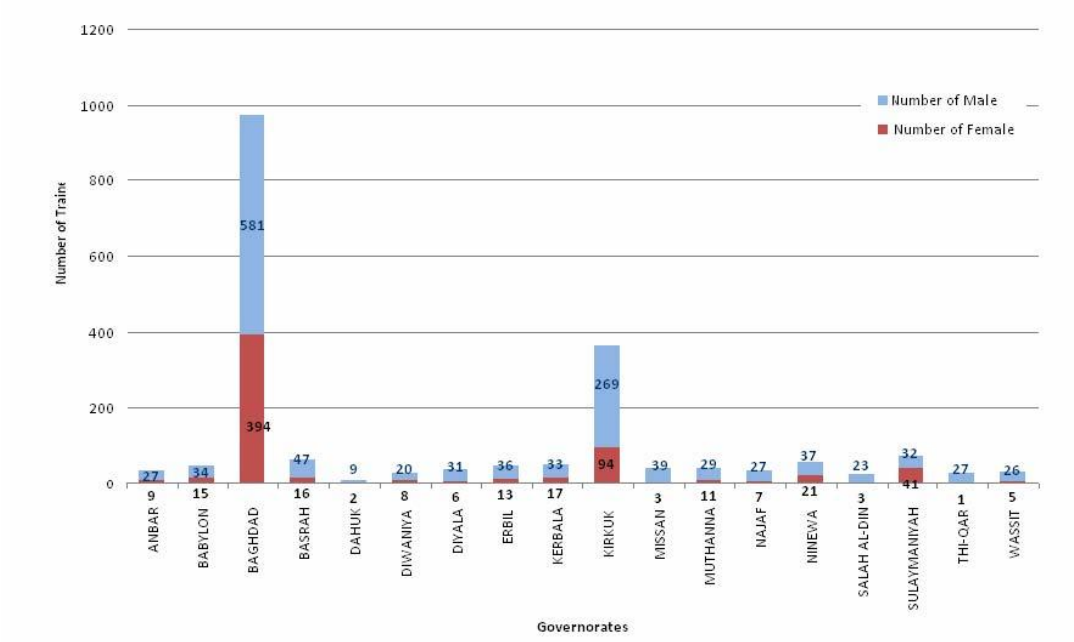


Figure #5 Capacity Building Activities Distributed by Governorate

As shown in below chart the capacity building activities were undertaken in various forms under this project.

Similarly, these capacity building activities were carried out inside the country and abroad. Whilst most training activities were conducted in Iraq in order to ensure the participation and the representation of trainees from remote and underserved areas of the country. The abroad activities were conducted in three forms 1) workshops & trainings 2) fellowships and 3) international conferences and meetings. (*For details on TOT trainings please refer to Annex VIII*) These activities were conducted in different countries to exchange experiences, knowledge and lessons learnt.

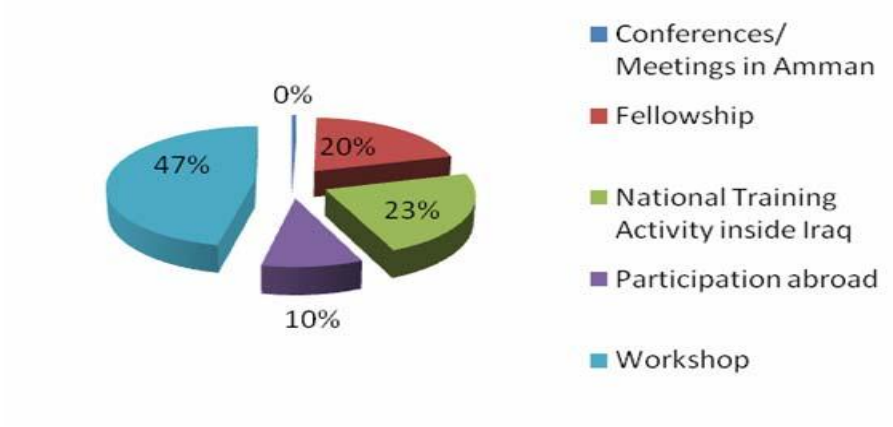


Figure #6 Various Forms of Capacity Building Activities

Choosing the host country for the training activity depended on the cost efficiency, high quality of academic institution, best practices in the health sector within the region and at international level. The major countries that hosted the Iraqi participants in the region were Jordan, Egypt, Syria, Lebanon, Oman, Bahrain, Tunis, Saudi Arabia, UAE and Morocco. Some of the capacity building activities were carried out in UK, Italy, Sweden, Holland, Thailand and Switzerland. All these activities were in line with the ministry priorities.

Output No. 3: Family physician practice is initiated– Accomplished

3.1 The Family Medicine

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

-North: Al Qudus PHCC in Al Aysar District-Mousel (Mosul), serving around 3,678 families.

-South: Ez Al Deen Saleem PHCC-Basra, serving 4,927 families.

-Center: Al Salam PHCC in Karkh District-Baghdad, serving 6,400 families

The project objective was to improve the health and nutrition status in the general population, with access to

integrated basic health services improved as an expected outcome of the project.

A Task Force led by the MoH was set up to provide administrative, supervisory support to the implementation of this project.

All the components of Family Medicine project were technically supported by WHO, while the cost was coshared between WHO (ITF) and the MoH.

The following activities were supported by the ministry:

The rehabilitation of the three PHCCs to develop model family clinics.
The local survey in the above-mentioned three localities.
Three training courses for 12 paramedical and 12 doctors in the selected PHCCs.

While WHO funded the following activities:

A study tour to Bahrain for 8 MoH and MoHE staff to get familiar with family medicine experience of Bahrain.
Part of the medical and non-medical equipments, supplies and furniture was procured by WHO and was received at end user level.

A project proposal was developed by the Ministry of Health-the Iraqi Family Physicians Society with the technical assistance of WHO to set the road map to introduce this initiative. The project proposal was based on a SWOT analysis (Strengthens, Weaknesses, Opportunities and Threats) exercise of the current situation. In accordance with the outcome of this exercise, the implementation was divided into four phases as per the below details:

Phase I: Performing a Study Tour for the Family Medicine Committee.

A study tour to Bahrain for 8 MoH and MoHE staff with the aim of getting acquainted with Bahrain experience in Family Medicine was supported by WHO.
This activity was followed by a workshop that included the members of the Family Medicine Committee and experts in the primary health care to discuss and adopt the

Standard Operating Procedures and Guidelines to train medical health workers, in addition to developing suitable modifications regarding the procedures of: family health records, referral system, Health Information System (HIS) and communication with other health services and finally propose a training course for the PHC personnel.

Phase II: Adopt the Family Medicine Initiative in three model PHCCs.

Ministry of Health supported three Trainings of Trainers (ToTs) for 12 paramedical and 12 doctors in selected PHCCs.

This training was followed by conducting a local survey in the three selected locations (Basra, Baghdad and Mousul) where the initiative will be implemented. Based on the outcomes of this assessment, three PHCCs were rehabilitated by the ministry and WHO supported with the provision of some of the needed medical and non

medical equipments as per the ministry's request *(kindly refer to annex IX for details)*. It is worth mentioning that the below criteria were taken into consideration while choosing these centers:

They were located within the university hospital with easy and quick referral and the capability of the doctors to follow-up on their patients.
The clients are from all over the area and medical services are not limited to those on campus.
The location of the center and its academic affiliation makes it excellent for training from the academic point of view.

The expected outcome of these model FM PHCCs is to improve access to integrated basic health service package, with the following outputs:

Functional three model family medicine centers.
Enhance the capacity and skills in the area of FM.
Proper record keeping in the selected centers.
Enhance quality of service provision and management at PHC level focusing on team work and integration of psycho-social care.
Establishment of proper referral system.
Have an electronic information base to the population of the catchment area.

Phase III: Academic Exchange

This phase included initiation of the training course in family medicine for medical and health workers in the three model PHCCs that are implementing FM. Each medical unit was responsible for training 15 doctors and 15 health workers. An agreement was reached with MOH to arrange academic exchange opportunities with International Universities and Medical Societies in order to build and strengthen the local capacity with regards to family medicine practice.

In addition, a training workshop on Family Medicine was conducted in Amman, Jordan September 2007. The workshop was attended by 20 physicians from MoH and MoHE from Baghdad and Kurdistan region. The expected outcomes were:

1 Situation analysis (SWOT) on Family Medicine in Iraq presented and gaps identified;
2 The current curriculum implementation, teaching/learning methods and evaluation of such a program reviewed.
3 A comprehensive plan of action on strengthening Family Medicine in Iraq based on WHO / EMRO guidelines and strategies developed.
4 The accreditation of the Iraq FM program and granting of certificate by the Arab Board.

Phase IV: Evaluation and Expansion

This project has been evaluated by the independent evaluation which has been conducted by a third party for SPHCS-Phase I project.

As per the MoH direction to expand the Family Medicine Initiative, WHO will be contributing to this expansion

through Strengthening PHC System-Phase II, where it is planned to rehabilitate, equip and provide capacity building activities to additional 5 PHCCs.

3.2 The Referral System:

A referral system is a continuum of health care moving from the initial contact at the PHCC to the provision of treatment at the hospital and a referral back to the initial contact. WHO provided the MoH with technical support at national and local levels in establishing an effective referral system that minimizes duplication of services and inefficient use of resources.

A draft policy for the 'Referral System' was prepared by the MoH and reviewed by WHO. By the time of completion of the project, this policy has not yet been implemented however; the policy of the Referral System was piloted in the three PHCCs centers where the Family Health Practice project was piloted. In order to strengthen the referral between the various levels of primary health car e system additional support was delivered in the form of provision of new equipment including 19 four wheel drive ambulances, 38 four wheel drive pick up trucks and 300 motorcycles to be used for outreach activities. These items covered the needs of approximately 9 million Iraqis and contributed to health quality improvement.

Output No. 4: Community participation in decision making and health service provision is ensured(accomplished).

WHO established the concept and structures of community-based programming in Iraq to address social determinants of health and community-driven programming through adopting the Community-Based Initiatives (CBI) model in Iraq as a link between the primary healthcare system and the population, as well as a tool of participatory governance, civil engagement, and health as a bridge for peace.
CBI facilitates community participation in the decision making process as related to health service provision while providing basic services to badly impoverished areas of Iraq and health education to the community members as well as selected “cluster representative/community volunteers” to increase health literacy and communal responsibility. The program address health outcomes through integrated approaches to health conditions prevention, detection, and management (using the healthcare system, the home, and the community) and goes beyond the health system in engaging all other sectors (housing, environment, municipality, education, religious endowments etc.) that have impact on health and well-being of the community in partnership through organized dialogue and local steering committees. It provides the structures and empowers communities to assess and

prioritize their socioeconomic needs, plan based on available resources, actively involve in monitoring and supervision of the programme's implementation and rehabilitate the local economic and social institutions and place community priorities on local and national development agendas.

CBI techniques were used to facilitate cooperation between local community members, local DoH, and the MoH to assess community needs, analyze that assessment, and develop and implement plans to address those needs. The program was adopted officially by Iraq in 2005 through the Healthy City and Healthy Village models, using health as the primary entry point in addressing the requirements of social and human development determinants of health in communities according to the local context. MOH and WHO have developed six healthy villages in Iraq in the following areas: Al-Intisar (Baghdad); Jalela &Anab (Sulaimaniyah); Al-Mjbis (Missan); Al-Dasm (Najf); Al-Suleman (Thiqar); Al-Dahera (Muthnana), and two healthy cities: 79 sector in Al-Sader city, Baghdad, and, Al-Waali (al-thora) in Hilla, Babel. The Al-Jmaher in Fallujah, Aanbar was discontinued for security reasons. The program had over 150,000 beneficiaries.

The program further established a sustainable national mechanism to continue the communities' programs and expand the program to other areas of Iraq. The project supported the establishment of two national structures: First, the national programmatic/managing CBI structure in the Department of Primary Healthcare in the Ministry of Health, Iraq; and secondly, the National Steering Committee, which is the national legislative and inter-sectoral policy body composed of two high-level representatives from the thirteen following ministries, in addition and under leadership of the Ministry of Health, chaired by the Deputy Minister of Health: Ministry of Planning, Ministry of State for Women's Affairs, Ministry of Higher Education, Ministry of Human Rights, Ministry of Education, Ministry of Industry, Ministry of Municipalities, Ministry of Agriculture, Ministry of Water Resources, Ministry of Social Welfare, Ministry of Interior, Ministry of Youth and Sports, and Ministry of Religious Endowments.

It is worth noting that all costs of the activities under this project were shared with the Government and the community.

This project started by undertaking a baseline assessment with the aim of identifying the gaps and priority areas of work. Based on the results of this assessment the following activities were implemented with the support of MoH, MoEn, MoA Ministry of Municipalities, local communities, etc.

The cost for these activities was co-shared by the community and religious funds. A number of achievements have been accomplished by the government in the following sectors:

- In **the area of community health**: extensive health awareness campaigns have been undertaken by the staff of 129 PHCCs which were rehabilitated under this project. In addition Community Based Rehabilitators (CBR) who were trained previously under this program provided great support to the health system in terms of home visits and reporting of public health incidents. In addition to that the nutrition programmes were strengthened by providing related capacity building activities and growth monitoring tools. Many of the mentioned capacity building activities were conducted at the local level addressing PHC programmes such as MCH, vaccination, school health, breast feeding, NCD, healthy life style, control of diarrheal diseases, ARI

among U5 children and nutrition programmes. Emergency preparedness and response capacity was improved by ramping up health care infrastructure and disease prevention and control.

In the area of agriculture: both technical and logistical support was provided under this project including, trainings, advocacy campaigns and supervisory farms in Al Intissar village ,distribution of fertilizers , pesticides and planting trees in Baghdad. Other support included irrigation projects, infrastructural rehabilitation of rural roads and water sanitation networks.

In the area of education: incentive system has been established for volunteers to participate as facilitators in the eradication of illiteracy programmes, it is worth mentioning that a campaign to eradicate illiteracy was initiated in three areas and secondary classes were established to create an opportunity for drop-outs especially among females to complete their education. Illiteracy is a major barrier towards written health education materials.

In the area of environment: waste collection and anti rodent campaigns were undertaken by the ministry with financial contribution of the local communities. During these events T Shirts and educational pamphlets were distributed. More support was given to the water quality control laboratories to ensure access to safe water and methods of health care waste management. In addition four water projects providing safe water in 4 areas and covering the needs of 17,000 persons were completed. Rehabilitated PHCC's contributed to improved capacity in handling health waste in various forms.

In the area of income generation: to support small businesses continued support was given to the bees' farm since the time of their establishment in 2007.

Al Intissar village training on production of Honey Al Dasem water project in Najaf governorate

a. **Report on how achieved outputs have contributed to the achievement of the outcomes and explain any variance in actual versus planned contributions to the outcomes. Highlight any institutional and/or behavioural changes amongst beneficiaries at the outcome level.**

Along with the global movement to shift into Primary Health Care, this programme 'Strengthening of PHC;' aimed to facilitate the transition of the Iraqi health care delivery system from curative and hospital bases, into a decentralised Primary Health Care (PHC) based system, with a focus on community outreach and community involvement. This is in line with the MoH target of 'establishing a robust PHC system centred on strengthening general practice in the short-term and developing a family physician and nurse practitioner model in the long term. There are clear signs of improvement of health status in Iraq over the years 2000-2006 and beyond, despite the great challenges that are still faced by the country.

For instance, the infant mortality dropped from 100.8 (Iraq Child Maternal Mortality Survey (ICMMS 1999) to 35

per 1000 live births (MICS 3 2006). The under 5 Mortality dropped from 125.9 (ICMMS 1999) to 41 per 1000 live births (MICS -3, 2006). Similarly, the maternal mortality ratio dropped from 291 per 100,000 live births (ICMMS -1999) to 84 per 100,000 live births.

Over the last few years, the UN, through the Health and Nutrition SOT, has been supporting MoH efforts to sustain basic health and nutrition services against great challenges, with several encouraging results. The progress on Infant, Under-five and Maternal Mortality were validated based on a number of surveys carried out in recent years and currently stand at 35 and 41 per 1000 live births for infant and under-five mortality (as per 2006 MICS3) and 84 per 100,000 live births (as per the 2006/7 IFHS) for maternal mortality. These indicators are 3 to 4 folds less than indicators used as a baseline in 2003-2005, but which is double of its neighbors. These new indicators recognized by the Government of Iraq in the National Development Plan (DP 2010-2014 draft) are setting new benchmarks for monitoring progress towards MDGs 4 and 5 attainments by 2015: Infant Mortality Rate (IMR) – 17/1000 live births, Under Five Mortality – 21/1000 live births and Maternal Mortality Ratio (MMR) – 42/100,000 live births.

These achievements can be attributed to improved access to and utilization of maternal and child health services and introduction of the Integrated Management of Childhood health into primary health care level.

It should be also noted that during the period under review, there were no major killer outbreak in Iraq despite national and sub-national vulnerabilities resulting from poverty and malnutrition, low coverage of vaccination of main diseases, low access to potable drinking water, sanitation, education and other social services.

Despite all these vulnerabilities, the Iraqi health system managed to keep Iraq polio free since 2000, reduced incidence of malaria (a major killer in crisis affected developing countries) into the levels of eradication, reduced prevalence of leishmanisis, and has successfully prevented/and managed measles, H5N1 and H1N1 major outbreaks.

The planned 2010 MICS 4 will be carried out in April 2010 to validate progress on Infant and U5 Mortality since last survey. Also, the Iraqi population census will provide new data both on infant and maternal mortality rates which will be then be considered by the GOI as the new baseline data. It should be mentioned also that an ongoing survey on Iraq Women Integrated Health and Social Survey (IWISH) will assist to obtain data on women in Iraq aged 15 and above.

The majority of human, technical and logistic resources used to accomplish these achievements came from the GOI. However, the investment made by the international community was decisive as the use of these resources have addressed critical gaps identified through a process of assessment and prioritization jointly carried out by the UN agencies, NGOs and aid community on one side and the Iraq MOH on the other side.

To exactly identify the role of each one of these vital contributions within the overall resources used in this time frame, would be next to impossible because of the multiplicity of actors and factors and because many outputs delivered in the field were actually inputs in the bigger aid and response machinery. However, EC funding directed to the health sector has made a difference.

Iraq has the lowest health indicators than all neighboring countries (Iran, Turkey, SAR, Jordan, KSA and Kuwait) and still considered among the countries in the Eastern Mediterranean Region with the highest maternal mortality ration (MMR). Maternal mortality for example in Iraq is three times higher than that in Arab Republic of Syria and

similar comparisons exist for other indicators in other countries.
This project contributed to the implementation of effective and efficient public health programme providing evidence in various health and socioeconomic fields through the Iraq Family Health Survey (IFHS). New health indicators which were established as a result of this survey are being used by policy makers during the preparation of various policy and strategy documents.

This programme has also contributed to the initiation of the Health Sector Reform especially in the areas of Health Care Financing, Human Resource Development, and Strengthening District Health System. It also contributed to the review and update of public Health Legislation and regulations and the improvement of health governance especially in the area of health information system.

Several health records and registers were reviewed and are now operational; this includes mother and Child Health, Communicable Diseases and Family Medicine. Currently the 19 model DoHs are connected together and with the MoH in Baghdad via the V-SAT. This activity is part of the Health Information System programme to build an internet network with MoH level and the 19 DoHs that will provide the means for quick data transfer and increase the level of coordination and information system. The establishment of an electronic HIS system is one of MoH priorities that was addressed under this project. Furthermore, school health was also supported under this programme contributing to the major outcomes.

Capacity building activities were carried out for more than 2000 health staff working in various areas of the health and nutrition sector. The capacity building activities were carried out in the form of holdings conferences/meetings, fellowships, National Training Activity (NTAs) inside Iraq, participation in workshops, conferences abroad. Most of the national training activities inside Iraq were carried out by the Trainers who were trained in TOT and other teaching methods under this project.

Additionally, during these more than 4 years of implementation this project contributed to the capacity building of a number of governmental ministries particularly Ministry of Health, Ministry of Higher Education and Ministry of Planning and Development Corporation. 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.

Several Public Health laboratories have been partially supported and coordinated with other WHO ITF projects; this includes the upgrading of National Drug Quality Control Laboratory (NDQCL), Public Health Laboratory in (Baghdad, Basrah and Erbil) and food safety laboratory, central blood bank and enhanced surveillance system. It is worth noting that the NDQCL testing capacity increased three folds compared to 2003.

The enhanced community participation in health activities was achieved in 9 localities by implementing the Community Based Initiative. The programme focused on enhancing access to basic quality health services that meet the needs of the population based on their priority needs and local decision. It was implemented in 6 villages and 2 cities where an elected Village Development Committee participated in planning implementation and evaluation of all aspects of the programme.

b. Explain the overall contribution of the programme/ project/ to the ICI, NDS, MDGs and Iraq UN Assistance Strategy.

This project has contributed to the overall goal of the ICI as well as the ICI benchmarks, this can be illustrated by the health sector reform activities that was initiated under this project, where many strategies and policies were developed or reviewed and adopted, such as the initiation of National Health Accounts; Financing options for Iraq's health sector, nursing and midwifery strategy for Iraq, IMCI, and the Basic Health Service Package. The development of such materials mostly from scratch assisted the MOH to chart the strategic direction for the Health and Nutrition Sector and initiate and streamline the process of health system reform in a more strategic way.

The rehabilitation and reconstruction of 129 Primary Health Care Centers in 19 model districts which are distributed in all governorates of Iraq contributed to improved physical infrastructure which is a crucial element in the development of a health care system and contributes to the stability and prosperity of the population. The rehabilitation of PHCCs led to increased availability of employment for the population and thus contributed to improved living conditions and ultimately improved health status. In addition, the high quality health services both preventive and curative which were provided through 129 PHCCs by focusing on both the demand and supply aspects of the system increased the access and utilization of health care services by the catchment population.

A huge number of preventive measures to combat TB and Malaria were launched during this project which contributed to reduction in the prevalence of TB and eradicated malaria from the country thus leading to reduced deaths and disability in the population from such diseases. This project supported the immunization campaigns for two deadly diseases of childhood i.e. measles and polio which caused reduction in the death and disability brought by the diseases that subsequently led the country to polio free status and caused improvement in herd immunity of the population. As global experience and evidence has shown all such efforts ultimately led to reduction in MDG Goal 4 i.e. reduction of child mortality.

The initiation of family medicine approach in 3 PHCCs and the early diagnosis of risk factors associated with pregnancies, timely referral and management of at risk patients by a huge network of PHCCs in 19 districts contributed to a reduction in the maternal and neonatal morbidity and mortality. This effort was further complemented by preventive and control measures against CD and NCD which were undertaken by this project to eradicate and combat the diseases which had contributed to high rates of morbidity and mortality
e.g. TB, Malaria, Leishmaniasis, measles, mental health, diabetes, heart diseases etc.

The two huge national surveys i.e. Iraq Family Health Survey and Iraq Mental Health Survey which were conducted under this project provided policy makers and decision makers with the updated figures and indicators which will assist the planners in the formulation of evidence based strategies and plans. The information from these surveys will assist the stakeholders of the health and nutrition sector to determine progress towards the health sector MDGs and will help them in the identification of shortcomings and gaps in our current plans for the sector. Some of the indicators from this survey will serve as baseline indicators which will be used as reference for measuring the progress against those indicators.

The capacity building and training of more than 2000 health staff contributed to delivery of good quality health care services to more than 4.4 million populations who reside in the catchment population of the PHCCs. The availability of quality health services at the level of first contact of patients with the health system i.e. PHCCs enhanced the

effectiveness and efficiency of health care system and caused reduction in the flow and load of patients at the tertiary level of the health system. This change caused reduction in the out of pocket expenditure by the patients and freed resources for those patients whose conditions required the attention of specialised care at the hospital level.

Under this project out of the total who were trained 33% were female participants which has been considered a significant accomplishments in the presence of peaks of political instability and turmoil. This is considered a great stride to ensure the deployment and availability of female essential medical staff at the level of PHCCs which will make certain increased access to and utilization by women and other vulnerable groups of the population. Globally all such interventions has led to reduced level of maternal and neonatal morbidity and mortality.

This project pioneered the introduction of a successful PHC system into the health care system of the country and successfully initiated and fulfilled the commitment of transforming the hospital and curative based system into PHC system with focus on community outreach and community mobilization. Hence we could infer that this project had remarkable contribution in the achievement of the goals and targets of MOH and UN assistance strategy for Iraq which advocates for improved access to health care service based on PHC approach.

Hence, this project together with other project implemented by MOH, partners and donors may have contributed directly to the following MDGs:

Eradicate extreme poverty and hunger (MDG 1), especially in the area of child malnutrition and CBI
Reduce child mortality (MDG 4)
Improve maternal health (MDG 5)
Combat HIV/AIDS, malaria and other diseases (MDG 6)

Explain the contribution of key partnerships including national, international, inter-UN agency, CSO or others towards achievement of programme/ project results.

WHO worked closely with MOH representatives, key managers, middle managers and health professionals from the central, governorate and district levels, which directly increases levels of capacity building and long term sustainability.

The Ministry of Health and Health Cluster members (UNICEF, UNFPA, WFP and WHO) worked closely together during the implementation of the project activities and coordinate their work in order to maximize the synergy and prevent any duplication of efforts.

From its base in Amman and its national staff network in the Governorates, WHO worked closely with the MOH/district directors through teleconferencing and direct meetings in Amman and Baghdad. The flow of information was streamlined so that all partners, planners and decision makers have an easy access to it for decision making and advocacy purposes. The entire WHO network of staff, logistics and telecommunication contributed to support the MOH. Close collaboration was sustained with the UN Health Cluster throughout the implementation phase of the project.

The following governmental organizations and non governmental organisations contributed to the project achievements.

1. Government of Iraq:

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

1.3. Ministry of Education: MoE main contribution focused on sending key messages to community and strengthening basic education in terms of improved quality of life. In addition, close coordination was maintained with MOE on the school health component of this project.

1 **Ministry of Environment**: The MoEn supported healthy living conditions and prevented environmental degradation. This programme included activities addressing 'Water and Health Care Waste Management' to limit its adverse impact on the public health.
2 **Ministry of Municipalities**: The ministry major contribution to this project was promoting the Healthy Cities Initiative in two cities along with MoH and other line ministries.
3 **Ministry of Agriculture**: Has contributed to many components of this project, however, the significant contribution was implementation of the Community Based initiative in 6 villages located in 6 different governorates.
4 **Ministry of Planning and Development Corporation**: The MoPDC supported the MoH in strategizing and putting health on the political agenda.
5 **Ministry of Finance**: MoF supported the MoH in adequately financing health priorities and in launching strategic initiatives like national health accounts. MoF colleagues provided valuable inputs to the various technical working groups of MoH.
6 **Ministry of Human Rights**: The MoHR assisted this programme by sending key messages to the public, media and government authorities that access to health is a basic human right and it is the responsibility of everyone. The health system should provide the quality services but the public is responsible to seek the health care when they need it.
7 **Parliament**: The Parliamentarians supported the MoH in revising the health legislation and ratifying health related policies and strategies; it also advocated for MoH in order to enhance financial support for priority health problems which affects the majority of the population.

International Community

It is worth noting that several areas of this project were implemented in close coordination and cooperation with the International Community including UN agencies, members of the Health and Nutrition Sector Outcome Team (SOT), donor agencies and International NGOs.

Donors Support

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

USAID on Strengthening the PHC System, during the first 24 months of this project implementation.

Inter-Agency Collaboration

WHO has worked closely with members of the HNSOT i.e. UNICEF and UNFPA on the Primary Health Care Programme in order to avoid overlapping of activities and ensure complimentarily. The major activities that were coordinated under this project with UNICEF were: **a**) Integrated Management of Childhood Illnesses (IMCI), **b**) Family Physician Practice initiation, **c**) Expanded Programme on Immunization (EPI) and nationwide MMR immunization campaign. Collaboration with UNFPA for Emergency Obstetric Care has also been an important and consistent resource.

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

Others

International NGOs: MERLIN (INGO) was involved in the implementation of this project by conducting a series of Trainings of Trainers (ToT) at the Communicable Disease Centre in Baghdad.

Civil Society: Participation of Civil Society including religious community leaders and leaders of women groups in the design and implementation of this project especially its community based Initiative part, ensured successful implementation of this project and created a supportive environment for future health related projects.

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

Other additional resources were used during the project implementation and which are not mentioned in the above budget. These resources included:

1 **MoH contributions** as the lead ministry has co-funded many activities under this project, especially under the community based initiative (CBI) project and basic health package project;
2 **WHO core funds** were used to compliment some of the activities funded under this programme such as Iraq Family Health Survey that was funded from this programme and WHO core funds.
3 **Logistics and administrative resources**. WHO facilities were used for video/teleconferencing, which were vital during the project implementation given the security situation in Iraq, where regular interactions with MoH officials and other partners were ensured. The WHO Iraq office in Amman, Jordan was critical in assuring access to, and movement of, project support equipment.
4 **Technical support and backstopping** received from WHO regional office and head quarter offices, outside the agency management support framework.
5 Additional MoH and WHO personnel involved in the programme implementation, monitoring, evaluation and reporting.

b. Highlight the contribution of the programme/project on cross-cutting issues:

This project was executed at the national level, contributing to the primary health care needs of the country at the central, regional and local levels.

Besides geographical balance gender balance has been considered as a decisive factor in planning and implementation of capacity building activities. Efforts have been instituted by this project to mainstream the gender in all polices and strategies of the MoH and other relevant Ministries. WHO has always ensured that gender equality be considered in the execution of various activities supported by this project e.g. in recruitment and training activities, rehabilitation and reconstruction works etc. This project has also ensured that the collection of all data pertaining to this project be segregated on the basis of gender as shown by the chart below. This programme has trained around 2,000 persons, out of which around 33% were females and 67% were males with participants from the 19 governorates.

Table #7

PHC Participants			
Area	F	M	Total
Access to Quality Health Services	274	744	1018
Health Policy, Planning and sustainable Development	81	159	240
Human Resources Development	9	10	19
Mother Child Health and Reproductive Health, Including Adolescent Health	102	66	168
Prevention and Control of Communicable Diseases	51	144	195
Prevention and Control of Non-Communicable Diseases	82	113	195
Social Determinants of Health	64	99	163
Total	663	1,335	1,998

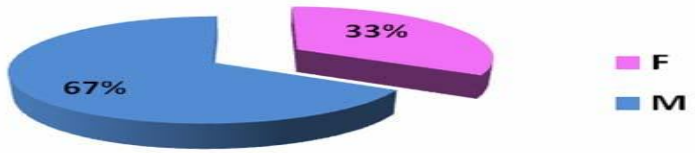


Figure #8 Distribution by sex

Moreover, the planning and implementation of this programme always focused on the most vulnerable areas. Many of the rehabilitated PHCCs are located in the central and south parts of the country that is based on the assessment conducted in the beginning of this programme which identified needs and priority areas to ensure enhanced access to quality health care to the most vulnerable and deprived population in line with health as a human right.

It is worth noting that most of the construction/rehabilitation work was done through the MoH. The rehabilitation work was done by at least one engineer and two skilled staff along with 20 semi skilled people. Hence, in total, the construction of the training centres and the PHCCs in Iraq created 2,032 jobs (in 148 projects) per day. On average, each project lasted for 80 days, hence, this programme created a total of 162,400 job opportunities.

Environmental improvement remained a key focus area of this project during all phases of its implementation. The rehabilitation of 129 PHCCs contributed to not only an improved physical structure but it contributed equally to an enhanced environment through upgrading the infrastructural elements of facilities e.g. improved management of water supply and drainage of the health facilities and careful handling of the health facility waste management. A huge number of campaigns and sessions to enhance personal and environmental hygiene were carried out by the reconstructed facilities to the populations in their catchment areas, which contributed to reduction in the level of environmental pollution. The development and successful implementation of guidelines on infection prevention and health education contributed either directly or indirectly through creation of sanitary and healthy surroundings to reduction in the level of health hazardous practices and consequently improved and clean environment.
Moreover, community integration and participation in the programme execution was ensured by implementing the CBI project which is a community based intervention that targets the empowerment of deprived communities and rehabilitation of their local economic and social institutions. The aim of the CBI is to improve people's quality of life (with a special emphasis on high risk groups such as women, children and youths). This is achieved through health development, building of people's capacities, fulfilment of their basic development needs, promoting peaceful coexistence and promotion of a collective work spirit. This approach promotes self reliance by enabling community development ownership.

e. Provide an assessment of the programme/project based on performance indicators as per approved project document using the template in Section IV

See section IV

III. EVALUATION & LESSONS LEARNED

a. **Report on any assessments, evaluations or studies undertaken relating to the programme/project and how they were used during implementation. Has there been a final project evaluation and what are the key findings? Provide reasons if no evaluation of the programme/project have been done yet?**

A thorough assessment of the situation was done in the following areas in order to come up with the gaps and short comings prior to implementation of the project activities.

Physical rehabilitation and new constructions: at the onset of the programme in November 2004 a rapid assessment was conducted in close coordination with the MoH. 128 PHCCs and 144 sub-centers were assessed in the selected 19 districts. This process included assessing the physical conditions, manpower needs and assessment of services provided and equipments available and needed. In accordance with the assessment outcome 129

PHCCs were selected in 19 districts, comprising 7% of the total centers and 56% of the total number of PHCCs in the 19 selected districts, 2 centres are located in Baghdad and the rest are located in Tilkeif, Dakok, Beiji, Khalis, Heet, Mahmoudia, Madaen, Swera, Amarah, Zubair, Suk Al Shyouk, Alurmaitha, Diwania, Manathera, Hindia, Al Musaiab, Akra, Shaklawa, Shamshama.

CBI project: the implementation started by undertaking a baseline assessment with the aim of identifying the gaps and priority areas of work. Based on the results of this assessment the areas of implementation were identified.

BHSP Development: the process started with a review of the health status of the Iraqi population to determine major health problems and to identify health services essential for addressing these problems. The PHC network was also assessed in terms of its infrastructure and human resources so as to determine the scope and type of services it is capable of delivering. Results from the situational analysis were concluded into suggestions for a range of basic health care services to be delivered as a standardized package along a "continuum of care" that links communities, local PHCCs and hospitals.

IFHS: the principle objective is to provide policy, decision makers and researchers with a reliable, useful and relevant database for the development of health and population policy. For further information *please refer to 'Iraq Family Health Survey section 1.7.'*

School Health: WHO supported the study proposal on the second assessment of the AOSHC, submitted by the MoH/Health Education Unit at the directorate of Public Health and Primary Health Care, which was conducted in December 2005 in cooperation with the School Health Unit/MoH. *For further details please refer to section 1.5.*

Stocktaking review of the International Reconstruction Facility Fund for Iraq (IRFFI)-Project Performance Review (January 2009): *(kindly refer to annex X for all the assessment details.)*

This evaluation included sites visited during the field study. The field study was originally scheduled for the Mosul area during May 2008. Military activity and difficult humanitarian circumstances resulted in the study being postponed, and later moved to the Southern region. It took place during June 2008 and included site visits to eight project locations in Basra and ThiQuar; seven Primary Health Care centres and one hospital facility.

This project has undergone another national level Independent Final Evaluation with the purpose: to provide an Independent Evaluation to assess the project's relevance, efficiency, effectiveness and sustainability and to examine the lessons learned as well as to measure the short and long term impact and develop conclusions and recommendations that could be of use when implementing similar projects in the future. The final report of this evaluation is expected to be produced by the end of April 2010.

b. Indicate key constraints including delays (if any) during programme/ project implementation.

Constraints

The military conflict of March/April 2003 was followed by looting of the public facilities and civil unrest that resulted in disruption in the whole infrastructure of the country, where the health sector was severely affected. This situation has continued through 2004 where the Coalition Provincial Authority was formulated as a transitional phase until the first legislative elections took place in January 2005. The newly-elected transitional Assembly was tasked to write a new permanent Constitution for Iraq and exercise legislative functions until the new Constitution comes into effect.

Since March/April 2003, Iraq has gone through several phases of crisis and emergencies, and the incidence of bombing Al Askari Mosque in Samarra in Feb 2006, was the start of the sectarian violence, where the security situation has drastically deteriorated through the years of 2006, 2007 and early 2008. The health sector was highly affected by the violence, especially killing and kidnapping of the health personnel that led to the brain drain of the qualified and well trained health professionals.

The implementation of this nationwide project was also impeded by insecurity and frequent changes in the leadership of MOH. Several Ministers of health were appointed during the implementation period of this project, 4 project focal points were changed, and several members of the Steering Committee Management Teams were changed, in addition to the high turnover of the senior focal points. Since MOH was the main partners for WHO, these changes have negatively affected the implementation of the project. This has also led to changing the ministry priorities to cope with the evolving security situation, losing the ministerial institutional memory with regards to the implementation of this project. It is worth mentioning that the years of 2005, 2006 and 2007 witnessed the peak for the implementation of this project and the peak of the conflict during which WHO has lost three support and security staff in the period 2004-2009.

In 2005 WHO received a letter from the MoH[1] requesting that 5 million USD be shifted from procuring of equipment to do rehabilitation of PHCs in the 19 model districts. The reason for that was in the initial stage of planning it was estimated that 24 million USD will be needed to procure equipment to be used in the 19 model PHC districts in addition to having other international partners working in this area such as ABT associates who were supposed to complete the rehabilitation works and have changed their plan to procure equipment instead of rehabilitation work. Concerning the target districts, three changes were introduced for security reasons upon request from MOH at national/Governorate levels.

WHO reallocated 8% of budget line in June 2006 concerning contracts to the budget line concerned with training. That is due to the fact that all the work intended under contracts was completed. Moreover, there was a possibility to provide more capacity building during the forthcoming six months and to improve the efficiency of service delivery in the 19 model districts.

a) Constructions in Baghdad_Karkh were impossible for security reasons. No contractor was ready to undertake this work. This Districtwas then removed from the list.
b) In stead, Numania district in Wasit Governorate was introduced in 2007 upon request of MOH and consent of WHO. With this, two districts were supported in Wasit: Swera and Numania.
c) Dokan replaced Chamchamal in Suleimania Governorate.
d) Baqouba was chosen instead of Al Khalis.
e) All remaining 16 districts remained unchanged. All Governorates were targeted (with the

exception of Baghdad-Karkh (see annex showing final list of districts targeted).

The implementation of this project has been significant given the complex situation in Iraq. Many factors have contributed to this end result and below are the major constrains that we have categorised as general or specifically related to the health sector or the UN context in addition to the ways of handling these constraints.

General Constraints

Violence and insurgency in the whole country.

The security situation in Amman was constrained in relation to bringing people across borders from Iraq for training and communication. Hence getting visas was an issue in many occasions.

Price inflation, fluctuations in $ US value.

Health Sector Constraints.

Absence of formally appointed Minister of Health for a period, and high turnover of senior officials at all levels.

The high turn over of the senior focal points and the ministerial focal points at all levels that caused the loss of institutional memory and hence, delay in the implementation process.

High friction among the different departments in the MoH.

Lack of MoH operational running cost expenses.

Government bureaucracy.

Attacks against health professionals.

Migration of skilled health professionals.

UN system Constraints.

Relatively high turnover of UN staff, loss of institutional memory.

Security constraints upon the movement of national staff in-city and inter-city have also been a major issue as well as lack of international staff presence in the country.

The security implication has affected the staff ceiling in the UN premises in Iraq, which limits the number of international staff and personnel deployed and the movement within the country and which impedes monitoring and implementation.

Remote management mode; Most WHO international staff were based in Amman due to the security situation.

Bureaucracy within the UN.

1
(MOH March 2005, reference number 1232)

c. Report key lessons learned that would facilitate future programme design and implementation.

During the implementation and in order to overcome these constraints the following lessons learnt were taken into consideration and /or applied at different points of implementation:

Rebuilding the PHC infrastructure should continue and this helps in shifting emphasis of health system from curative to preventive health care.

Rebuilding health is an inter-sectoral effort where UN partners and many different parts of the government needs to be involved.

Public and silent advocacy should always be applied to advocate for health in general and public health threats in particular.

Always be prepared with more than one scenario for any activity. Due to the uncertainty of the situation, it is unlikely that activities will

be conducted exactly according to plans.

Engage Iraqi counterparts at every stage of planning and implementation to ensure ownership with their future vision.
Build the capacity of MoH at different levels of the hierarchy, to ensure efficient and effective implementation of the programme.
Community participation is both feasible and useful in rebuilding of health infrastructure.
Establish a clearing house of information in the MoH, in order to verify some of the information transmitted by different stakeholders.
Ensure further exchange of information with different stakeholders including the donors and NGOs;
Integrate human rights notions and peace-building approaches into programme strategies.
A referral system is only effective in areas where the security situation allows patients to travel between health facilities.
The use of the HIS requires a stable security situation which allows for connected offices to remain in the same location.

Abbreviations and Acronyms

List the main abbreviations and acronyms that are used in the report.

GoI: Government of Iraq MoH: Ministry of Health MoE: Ministry of Education MoHE: Ministry of Higher Education MoA: Ministry of Agriculture MoEn: Ministry of Environment MoPDC: Ministry of Planning and Development Corporation MoF: Ministry of Finance MoHR: Ministry of Human Rights MOHK: Ministry of Health in Kurdistan DoH: Directorate of Health COSIT: Central Organization for Statistics and Information Technology SPHCS: Strengthening Primary Health Care System PHC: Primary Health Care PHCC: Primary Health Care Centers CD: Communicable Diseases EPI: Expanded Programme on Immunization NCD: Non Communicable Diseases CBI: Community Based Initiative BDN: Basic Development Needs HIS: Health Information System HAC: Health Action in Crisis AOSHC: Action Oriented School Health Curriculum IMCI: Integrated Management of Childhood Illnesses NDQCL: National Drug Quality Control Lab BHSP: Basic Health Service Package CCCUs: Community Child Care Units MDGs: Millennium Development Goals IFHS: Iraq Family Health Survey MICS: Multi Indicator Cluster Survey UNCT: UN Country Team IRFFI: International Reconstruction Facility Fund for Iraq SOT: Sector Outcome Team ICI: International Compact with Iraq NGO: Non Governmental Organizations INGO: International Non Governmental Organization WB: World Bank WHO: World Health Organization UNICEF: United Nation Children's Fund UNFPA: United Nations Population Fund WFP: World Food Programme UNOPS: Unites Nations Office for Project Services UNIDO: United Nations Industrial Development Organization UNDP: United Nations Development Programme