

# DRAFT

## Sector Midterm Review Report



**Sector: HNSOT**

**Reporting period: January 1, 2008 – March 31, 2009**

### A) OVERALL ASSESSMENT OF PROGRESS TOWARDS UNCT OUTCOME

<b>UNCT OUTCOME(2008-2010)</b>				
<b>● Improved performance of the Iraqi health system and equal access to services, with special emphasis on vulnerable, marginalized and excluded persons.</b>				
<b>Indicators:</b>				
By 2010, health and nutrition related programmes enhanced to ensure 20% increase in access to quality health care services, with special focus on vulnerable groups (Outcome 1).	Baseline	Target		Status as of 3/2009.
		For 2008	For 2009	
1.1) % of districts reporting DPT3 coverage >80% (WHO/MoH routine data)	1.1 Baseline: 45% districts >80% (2007 routine reporting).	1.1 Target: by 2008 - 60 % of districts have DPT3 coverage >80%	1.1 Target 2009- 75 % of districts have DPTS >80%	On track
1.2) # of measles cases (WHO/MoH routine data)	1.2 Baseline: 230 cases (2007 measles surveillance)	1.2 Target 2008-200 measles cases	1.2 Target 2009- >1 measles case per mil population	Situation is getting worse
1.3) % of underweight among U5 (MICS 4 2010)	1.3 Baseline: 7.6% (MICS3 2006)	1.3 Target 2008 6.5%	1.3 Target 2009 6% underweight among U5	Was not measured in 2008.
1.4) % of skilled attendant at delivery (WHO/MoH data)	1.4 Baseline: 79.7 % (IFHS, 2006)	1.4 Target 2008 83 % of skilled birth attendant deliveries	1.4 Target 2009 90% of skilled birth attendant deliveries	Was not measured in 2008
1.5) IMR,U5 and MMR rates (MICS 4 2010).	1.5 Baseline IMR 36/1000 live births, U5 MR 41 Deaths per 1000( MICS3) MMR 84/100,000 (IFHS)	1.5 Target 2008 5% reduction in IMR, U% and MMR rates respectively ( MoH annual statistic report depending on MMR surveillance	1.5 Target 2009 5% reduction in IMR, U% and MMR rates respectively (MoPDC/ UNFPA census 2009, MoH statistics)	
1.6) Neonatal tetanus cases of less than one case/district/ year.	1.6 Baseline : 0.05 case /district /year	1.6 Target 2008 maintain baseline	1.6 Target 2009 Validation of elimination of Neonatal Tetanus (NT) by WHO and UNICEF	
1.7) % of health expenditure of GDP	1.7 Baseline 2.5% (ICI).	1.7 Target 2008 3%	1.7 Target 2009 3.5%	3%
<p><b>Narrative Analysis of progress:</b></p> <p>Overview</p> <p>Iraq has made notable progress on health and nutrition in recent years despite grave insecurity. The United Nations Country Team has been working diligently to support the Government and the people of Ira. Significant challenges remain and Iraq can benefit substantially from further close engagement with the United Nations on the priorities defined in the revised Health and Nutrition section of the UN Development Assistance Strategy 2008-2010. The UN Country Team can boost the impact of its work by more effectively using the SOT as a guiding structure for internal and external coordination, with clearly defined joint goals, indicators and mechanisms.</p>				

Despite continued improvements in the health sector, mortality statistics indicate that Iraq still has a long way to go to attain international standards. The areas of reproductive health/maternal and child health, mental health, communicable diseases, including emerging HIV/AIDS are of particular concern to the United Nations. Progress on health indicators remains slow, and the MDGs aimed at reducing child and maternal mortality and combating major diseases (TB, HIV/AIDS) may be very difficult to meet. Part of the health problems result from low access to safe water and sanitation, inadequate energy supply and from environmental pollution.

This review confirms the relevance of the United Nations' support to Iraq in the Health and Nutrition sector and documents the contributions it has made to date. It also confirms that the United Nations has valuable contributions to make to the country's further development. It shows, however, that the current UN Development Assistance Strategy for Health & Nutrition remained a document rather than becoming a living process and consequently did not serve as effectively as it could have to strengthen strategic guidance, coherence and coordination among UN Agencies and their partners, and facilitate communication.

In the remaining 18 months of the current United Nations Development Assistance Strategy, to really make a difference it needs to be operationalized by following through on sector leadership, backed by concrete commitments from UNCT Agencies, based on well-defined indicators, facilitated by light, results-driven coordination, and presented through audience-specific communication (clear, accessible, jargon-free and relevant). Toward this end, the SOT has freshly assessed current and emerging needs, defined matching sectoral strengths, identified the greatest synergy and leverage potentials and clarified specific roles, responsibilities, relationships and expected results, in a transparent, inclusive and informal process.

### **Sector Outcome Indicators:**

#### **1.1 % of districts reporting DPT Coverage**

As of 31/12/2008, 61% of 115 districts achieved DPT3 coverage over 80%, which accounts for 65% targeted infants. HNSOT supported implementation (planning, social mobilization, transportation, allowances – worth of \$500,000) of the Reach Every District (RED) approach to address decline in routine coverage, resulting in improved immunization coverage. Number of districts with DPT3 coverage over 80% increased from 42 districts (37%) in 2007 to 70 districts (61%) in 2008. Number of districts with less than 50% DPT3 reduced from 25 in 2007 to just 6 in 2008. Data is based on MoH routine EPI reports.

#### **1.2 Number of Measles cases**

In 2008, a total of 8,134 measles cases were reported compared to 22023 in the first 18 weeks of 2009. The current number of cases in Iraq is nearly 3 times of 2008 and more than the number of cases in the entire Middle East and North African region.

The recent rise is due to the low immunity of the population which has resulted from the relatively low coverage of routine vaccinations from 2005-2008 due to insecurity. This can be compared to a total of 230 cases in 2007. The HNSOT supported logistics and social mobilization activities for conducting house-to-house Mop Up campaigns in 1st half of 2008 in the Anbar, Salah al-Din, Ninewa and Kirkuk Governorates vaccinating 516,684 children aged 1-5 years with Measles/MMR. These campaigns were very successful in controlling the outbreaks at these governorates as the number of Measles cases declined significantly. However, it was not sufficient to prevent spread of measles in other governorates starting from week 23 and continue through Q1 of 2009.

Despite some improvement in EPI coverage in 2008, this was not sufficient to prevent the measles outbreak which started in March 2008 and continue through out 1<sup>st</sup> quarter of 2009. In response to this ongoing outbreak, the SOT and MoH has trained and deployed 947 vaccination teams, provided logistical support including 532 vehicles which has temporarily been pooled for the response. The SOT has assisted with upgrading warehousing conditions, vaccines and overtime compensation for vaccination teams, providing experts for technical support and assisted with the cold chain. The immunization campaign is being supervised, monitored and evaluated by 270 field supervisors, monitors and experts from medical schools, WHO and Iraq Red Crescent Society. In several areas, health workers and volunteers had to hand-carry the cool boxes with vaccines from house-to-house despite the security risks.

#### **1.3 Underweight among U5 (MICS4)**

A new set of food security and nutrition data was released in November 2008 by WFP/COSIT based on their Comprehensive Food Security & Vulnerability Analyses (CFSVA) conducted in 2007. No national anthropometric indicators were collected in 2008. Based on the CFSVA report stunting remains the predominant feature of growth failure (21.8% with nearly half of them severe) in under-five children. Although national average indicator for

wasting - General Acute Malnutrition - GAM 4.7% in U5 children remains relatively low (below the cut-off level 5% for GAM), 38 (out 114 districts) have GAM over 5% ranging from 6 to 39% while Severe Acute Malnutrition (SAM) part of it in these districts ranging 1 to 13.5%. Malnutrition rates are much predominant in Southern governorates. Although anthropometric managements are not carried out annually it's very important to keep this indicator for measuring future progress of MDG1 and 4. Future surveys should assess anthropometric data by district.

**1.4 % of skilled attendant at delivery**

This indicator highlights the need to improve maternal health, to ensure skilled care before, during and after pregnancy and childbirth and strengthen national health systems in order to achieve Millennium Development Goals 4, 5 and 6. The main goal is to reduce child maternal mortality. The SOT had difficulties collecting new data on Skilled Birth Attendants. That said, the numbers are already relatively high. There is no significant difference between survey data and MOH administrative data which we consider acceptable for monitoring skilled attended deliveries yearly. IFHS 2007 figures on maternal mortality ratio at 84 per 100,000 live births are significantly high for the region.

**1.5 IMR, U5 and MM rates**

These are impact indicators which depend on a number of variables and can be only measured through a national survey every 4-5 years. Next survey which may include these indicators will be MICS4 scheduled for 2010. Annual MOH mortality data can be studied to see if it can be used for annual reporting.

Overall 2008 progress to these indicators is the following: Infant, Under-five & Maternal Mortality were validated based on a number of surveys carried out in the last 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 for maternal mortality (as per 2007 IFHS)– This sets new benchmarks for progress monitoring towards MDGs 4 and 5 attainment by 2015, which were reflected in MDGs workshops in January and March 2009. Target by 2015: IMR – 17/1000 live births, U5M – 21/1000 live births and MMR – 29/100,000 live births.

**1.6 Neonatal tetanus cases of less than one case/district/year**

This indicator should be moved to immunization indicators and become 1.3 as it linked operationally to routine immunization and RED approach. It is suggested to use this indicator in addition to TT2+ (Tetanus, Toxoid 2 vaccine; pregnant women) coverage by district as these data are part of WHO/UNICEF annual joint report.

Latest available data shows that 28 (24%) of 115 districts achieved TT2+ (pregnant women) coverage over 80% as opposed to 2 (2%) of all districts in 2007. Using these cases as baseline we can clearly demonstrate a progress in this in 2008.

**1.7 % of health expenditure of GDP**

The Total Health Expenditure (THE) is among the lowest in the region (3% of GDP), while private spending exceeds 50% of THE. Results of the Iraq Family Health Survey (IFHS, 2006) indicate a high proportion of out-of-pocket spending on health (13% of monthly household expenses), at times reaching exorbitant levels (10% of all households). GOI first priorities in the coming few years will be security and rehabilitation of the basic infrastructure, therefore, not much change in the % expenditure on Health is expected in the few years to come. The fact that the THE is tagged to the crude oil prices makes it even more difficult to project an increase in THE over the coming year.

**B) OVERALL ASSESSMENT OF PROGRESS TOWARDS SECTOR OUTCOMES**

<b>SECTOR OUTCOME 1</b>				
<b>By 2010, health and nutrition related programs enhanced to ensure 20% increase in access to quality health care services with special focus on vulnerable groups</b>				
<b>Indicators</b>	<b>Baseline</b>	<b>Target</b>		<b>Status as of 3/2009</b>
		<b>For 2008</b>	<b>For 2009</b>	
1.1) % of districts reporting DPT3 coverage >80% (WHO/MoH routine data)	1.1 Baseline: 45% districts >80% (2007 routine reporting).	1.1 Target: by 2008 - 60 % of districts have DPT3 coverage >80%	1.1 Target 2009- 75 % of districts have DPTS >80%	<b>See Separate Result Matrix</b>

1.2) # of measles cases (WHO/MoH routine data)	1.2 Baseline: 230 cases (2007 measles surveillance)	1.2 Target 2008-200 measles cases	1.2 Target 2009- >1 measles case per mil population	
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**Suggested Indicators.(new outcome and outputs)**

<i>Indicators</i>	<i>Baseline</i>	<i>Target</i>		<i>Status as of 3/2009</i>
		<i>for 2008</i>	<i>For 2009</i>	
■ Rota virus, Hib and pneumo-coccal vaccines introduced in the routine EPI program. (Output 1.1 indicators).	0	0	New vaccines introduced by 2010.	It has been adopted by the Ministry of Health.
■ # of district teams trained on management and leadership skills. (Output 1.2 indicators).	20-50	116 district teams		110
Provide regular, reliable, and safe immunization services that match demand.(output 1.5 indicator)	50% of vaccination outlets	90% of vaccination outlets	95% of vaccination outlets	70% of vaccination outlets
■ TT2+ (pregnant women) coverage by district. (Outcome 1 indicator).	In 2007 only 2 districts out 115 have TT2+ over 80%.	By the end of 2008, 33 districts out 115 have TT2+ over 80%.		
■ % of pregnant women with at least 1 ANC visit. (Outcome 1 indicator)	83.8% according to MICS 3 2006/7	90%	90%	
■ % of health facilities providing family planning services (Split PHC centers and districts hospitals)	3%	10%	3%	Baseline and targets from UNFPA. Revision?
■ Prevalence of anaemia among pregnant women (%)	37.9% (IFHS 2006/07)	35%	35%	2009 : 34% (MoH statistical report 2009)
■ % of Newborns with birth weight less than 2500gm. (outcome 1 indicator).	14.8% according to MICS 3 2006/7	10%	5%	3.89% (MoH Health Compass 2008)

■ % of pregnant women attended at least 4 ANC visits by skilled attendants	34% according to MoH/MCH annual report 2008	34%	50%	36.4%
■ # of MCH and RH related studies, assessments conducted. (Outcome 1 indicator).	0	2	1	
1. # of beneficiaries from emergency response.(output 1.2)	1 million vulnerable beneficiaries receiving aids during 2007	700,000	500,000	In 2008 - 31/03/09)Over 900,000 vulnerable beneficiaries reached (measles, cholera outbreaks, area base interventions through NGO partners) UNICEF
2. # of community volunteers/teachers etc trained.(output 1.6)		1,000 teachers on Pandemic Influenza, HIV/AIDS and hygiene promotion.		<b>1,000</b> teachers on Pandemic Influenza, HIV/AIDS and hygiene promotion.

*Narrative Analysis of progress:*

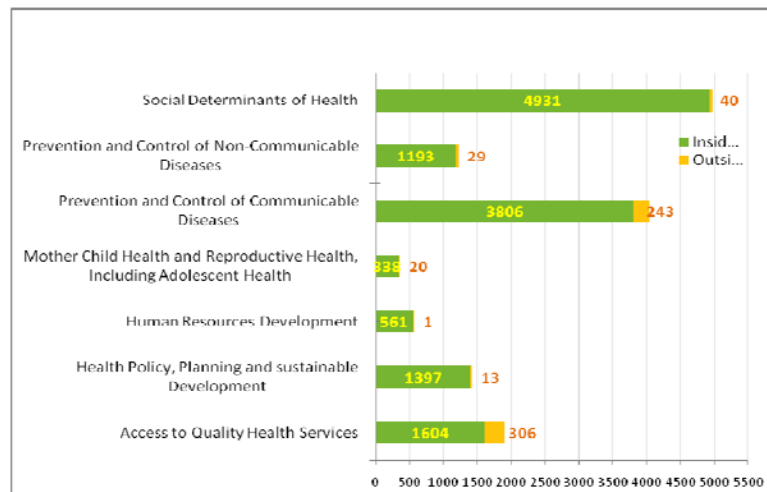
***The following are the outputs contributed to the achievements of sector outcome:***

***Output 1.1 (Policies strategies, and guidelines related to health and nutrition developed if required; review based on standard human rights and principles)***

1. Draft EPI multi year plan 2009-2013 developed and currently being finalized by MOH;
2. Contributed to MCH strategy for 2010-2014 development
3. Contributed to National Medicine Policy development
4. Provided technical inputs to MOH strategic plan for 2009-2014.
5. Provided inputs to the development of National Emergency Medicine and blood transfusion Policies
6. Contributed MOH/MO in the defining MDGs and Indicators for Iraq (MDG1, MDG4, 5 and 6)
7. Contributed to the National Development strategy for 2010-2014.

***Output 1.2 (Institutional and personnel capacity of health/nutrition and related programs strengthened for improved quality service delivery).***

1. To address quality of basic health services, the capacity of over **2,000 (1.2.1)** health workers was enhanced through trainings in essential new born and emergency obstetric care, case management (CM) of diarrhea using new low osmosis ORS & Zinc, hygiene and breastfeeding promotion and CM of ARI. In addition, **12 (1.2.1)** Health Education Managers at governorate level were trained in advancement for communication in collaboration with John Hopkins University in Beirut and MOHP Egypt, Further, more than **1,000 (1.2.1)** health workers capacity was enhanced in areas of communication for different priority areas and **1,000** teachers on Pandemic Influenza, HIV/AIDS and hygiene promotion.
2. Some 1400 staff of selected district hospitals countrywide was capacitated to enhance the provision of Emergency Obstetric Care services, and a team of master trainers was established to conduct continuous training programmes inside the country. The training covers reproductive health issues in general with focus on emergency obstetric care. Improvement of service delivery prompted expanding the cascade training to include additional numbers of service providers as well as covering additional topics such as referral and surveillance.
3. The HNSOT trained 658 master trainers (ToT) outside the country. These master trainers in turn trained 13460 staff during 2008 inside Iraq. In addition to the above; special training programs have been designed for policy makers at the central level in MoH, MO education, environment and other line ministries. Similar programs for midlevel and district teams to improve the technical, managerial and leadership capacities were also implemented and around 30% of targeted staff was reached by these training activities.



(Figure 1, Cumulative, number of people trained in each area inside and outside Iraq per area of operations (WHO 1 January 2009))

- More than 85 training workshops have been conducted in Iraq in the area of Pandemic Influenza preparedness. The aim of the workshops was to develop qualified teams of professionals who will be responsible for investigation of outbreaks of human Avian Influenza cases and provide immediate response to the outbreak.

***Output 1.3 (Enhanced functional capacity of health and health related facilities and institutions (services) in low coverage areas (rehabilitation and procurement))***

- The HNSOT worked to boost access to health services for the most under-served groups. Access to primary health services for 210,000 people (including 45,000 women and 35,000 children under-five) living in remote areas was increased through the construction/rehabilitation of 15 PHCCs and maternity hospitals in Diyala, Wasit, Dohuk, Suleimaniyah and Erbil during 2008. In early 2009 additional 50,000 people have got better access to PHC services through the completion of construction/ rehabilitation of 6 PHCCs in Dohuk, Erbil and Ninewa, Muthana and Babil Governorates.
- Polio National Immunization Day (PNID) were implemented in October/November, reaching nearly 5 million children under five (96.8 per cent of the target in the 1st round and 99.5 per cent in the 2nd round). UN support for these campaigns included provision of incentives for PNIDs trainings, mobile/outreach teams and support of social mobilization activities. For the first time, MoH/DoHs supported transportation for over 5,300 mobile teams in addition to their regular commitment to providing all required Oral Polio Vaccine (OPV) from the MoH budget. Similarly, UN supported logistics and social mobilization activities for conducting house-to-house Mop Up campaigns in the 1st half of 2008 in Anbar, Salaheldin, Nineveh and Kirkuk Governorates vaccinating 516,684 children aged 1-5 years with Measles, Mumps and Rubella (MMR).
- With regard to upgrading health facility infrastructure, in 2008, the UN, through 95 different projects with a total cost of about \$15.4 million has supported the Iraqi health system with physical and functional rehabilitation of health facilities and training to enhance laboratory analytical capacity. These projects are contributing specifically to MDG 4,5 and 6, but also 7 as the environment has been a spotlight issue with regard to health waste management and water quality control and MDG 8 as priority has been given to access to affordable medicines in cooperation with private sector. Functional capacities of selected 24 district hospitals were enhanced through physical rehabilitation and provision of medical equipment and supplies. Coupled with enhanced capacities of service providers, EmOC services at the targeted project sites were substantially improved, this situation has prompted MoH to request expanding the geographical coverage of the project to include additional sites in the three northern governorates of Iraq in an attempt to reduce caseloads in the new project sites, 6 selected peripheral PHCCs were included in the rehabilitation process with the additional of delivery rooms and associated annexes.
- Provision of health services in PHCCs located in remote underserved areas (such as the marshlands in Missan, Thi-Qar and Basrah), was also enhanced through another support to a RH services project implemented by an international NGO. Underserved areas in other locations within the country such as the northern region, will also be addressed through a new project during the forthcoming second term.
- The HNSOT completed the rehabilitation of two Food Quality Control Laboratories in Basra and Mosul while the completion of Erbil Laboratory is expected for the month of May 2009. The total amount of above

rehabilitation is over \$ 1million. Moreover, in order to increase the capacity of the Ministry of health to integrate and use essential health technologies, the SOT supported the rehabilitation of six Biomedical Equipment Repair workshops valued about \$ 1 million in Medical City, Mosul, Basra, Erbil and Kimadia, the State company for medicines and medical appliances in Dabbash and the new construction of one Biomedical Workshop in Muthana. Also under Avian and Pandemic Influenza preparedness, the HNSOT supported the rehabilitation of one Avian Influenza isolation unit in Erbil with a cost of circa \$ 240,000. A new unit valued at about 0.7 million is currently being constructed in Basrah. In the same context, water quality monitoring has been improved with the support provided to the MOEv's Central Water Quality Control Laboratory in Baghdad now fully equipped with more sophisticated and advanced devices.

6. Under community based initiative also known as local area development programme (LADP), the SOT is supporting the rehabilitation of eight PHC projects with an estimated cost of \$0.6 million in the governorates of Basra (Al Hosh and Bahilla) and Missan (Al Haddam and Al Maimona). Similar rehabilitation work in Hilla (Al Murjan) in Qadissiya (Al Chebaish) and Suleimaniyah (Said Sadiq) is ongoing.

**Output 1.4 (Empowered and engaged local communities and private sector to enhance equitable access to health and nutrition services with special focus on missed opportunities in access to health).**

1. Social mobilization campaign during PNIDs (Oct/Nov 2008) reaching nearly 5 million U5 children and social mobilization activities for conducting house-to-house Mop Up campaigns in the 1st half of 2008 in Anbar, Salaheldin, Nineveh and Kirkuk Governorates vaccinating 516,684 children aged 1-5 years with Measles, Mumps and Rubella (MMR).
2. In 2008, national health education and media campaigns for diarrhea /cholera and avian influenza prevention and control were conducted and social mobilization for PNIDs in late March 2009 allowed to reach about 5.1 million (97%) of U5 children.
3. Increasing outreach and access to reproductive health services in remote areas is being handled through community based activities such as the Women Health Volunteers (WHV) programme implemented in the southern marshlands involving 500 women. Community and religious leaders are also involved in this process. Revitalization of local health committees and tapping from local government resources to support health projects is also being considered.

**Output 1.5 (Enhanced monitoring and evaluation mechanisms in place to track progress and identify gaps in the provision of health and nutrition services with special emphasis on the unreached).**

1. EPI coverage survey in Kirkuk carried out in November (reflecting the situation in 2007) have provided updated indicators which continue to be used for monitoring and evaluation of immunization campaigns (i.e. Diphtheria, Pertussis and Tetanus (DPT3) –at 70.6 per cent, and measles 75.3 per cent with dropout rate at about 20 per cent)
2. CFSVA report launched in November 2008 led by WFP has permitted to release a new set of food security and nutrition data/indicators.
3. KAP assessment for preventive practices for Avian influenza has permitted to have indicators to measures gaps. The results reflected 33% gaps in hand washing practices among care givers, 35% gap in correct cooking practices, and 60% gap in hand washing practices after contact with poultries among school children. Additional significant gaps were reflected in food handling and reporting process on sick poultries. These results directed 2008 communication plans to specifically target the behavioral gaps.
4. Need assessments and identification of gaps in the provision of health and other social services to women and adolescents/youth are being addressed. In this respect, a survey on women health and social status is planned to be conducted during the second term (09-10), the questionnaire for which has already been finalized but conduction in the field delayed due to involvement of COSIT in the 2009 Census. An Adolescent/youth survey is currently being conducted in the field, results of which will be used among other programming for youth, to assist the Ministry of Youth and Sports (MoYS) in drawing a National Youth Strategy. Both interventions are multi-dimensional/multi-sectoral that involve a wide spectrum of partners, both UN and governmental
5. The major emerging priority would be to ensure the good management of health services particularly at the local level in remote underserved areas, including provision of medical equipment, supplies and medication, and staff properly trained and given sufficient incentives to render the services at the required quality.
6. Cross-cutting issues that UNFPA interventions address are Gender and human rights, in particular the right of

women to access appropriate RH services including maternal health.

7. ICI benchmarks as well as MDGs indicators for health will continue to be used as a guide to assess the progress made towards their attainments. However, these cannot be assessed at present due to the rather short duration of the support strategy that does not enable measurement of the impact.

***Output 1.6 (Emergency preparedness and response. Access to basic health services to the most vulnerable people affected by the ongoing humanitarian crisis assured).***

1. Emergency interventions in health increased in 2008. The SOT supported MOH/DOH efforts to control the cholera outbreak, contributing promptly to the overall response through the provision of 3 million ORS sachets and 4 million Zinc tablets. In addition, the SOT provided hygiene materials and purification tablets, supported mobile teams for conducting active surveillance and hygiene promotion.
2. The SOT team has been prompt in providing the required emergency assistance to the populations affected by insecurity and ongoing violence, especially in Basra, Baghdad, Tela'afar, Kirkuk, Mosul and Diyala. Over 720,000 people benefited from emergency supplies (surgical/medical supplies for victims of violence, basic health kits, and obstetric emergency kits). As part of the IMPACT project, assessments of the situation of the most vulnerable sub-districts including those with IDP camps and IDP-affected areas was done and the required basic health and nutrition services were provided.
3. In response to acute shortages of medicines, the UN has supplied emergency medicines worth of over US\$ 2.5 million during 2008 and 2009 (up to March 2009) and also trained over 820 people related to emergency response
4. For over three years, the HNSOT are providing full technical and logistic support to reduce opportunities for a pandemic influenza (caused by human H5N1 infections) and to strengthen early warning system in Iraq. Committees have been established to implement the national preparedness plan. During the H9 N outbreak in Basrah, the response included communication and social mobilization activities at different levels.
5. Regarding Pandemic Influenza preparedness, many missions have been conducted during 2007, 2008 and 2009 by WHO International staff to Baghdad to support the national technical committee in updating the Pandemic Influenza Strategic Plan. - Between 24-26 February 2009, WHO Iraq focal point for Avian and Pandemic Influenza has organized a meeting in Baghdad with Iraq AI technical committee. Operational plans for the 8 Pandemic Influenza strategies were completed and then endorsed by the technical and high level committees.
6. UN has been supported the government of Iraq, particularly the Ministry of health to develop its capacity of emergency preparedness and response planning and in disaster management and mitigation

### **C) RECOMMENDED ADJUSTMENTS IN UNCT AND/ OR SECTOR OUTCOMES (WITH RATIONALE)**

Previously, the UNCT outcomes for the health sector did not have linked indicators. There was a need to update the current set of outcomes and indicators. These updates are more thoroughly described in the attached logframe (excel).

#### **REFORMULATION OF OUTCOMES AND OUTPUTS**

- **Outcome 1:** Families and communities, with specific emphasis on vulnerable groups and those affected by ongoing humanitarian emergencies, have improved access to and utilization of quality health and nutrition services
  1. **Output 1.1:** Service providers at health and health-related institutions, particularly in low coverage areas, have functional facilities and adequate supplies for improved service delivery
  2. **Output 1.2:** More Iraqis demonstrate improved health and nutrition practices and are empowered to promote participatory approaches and demand quality services
  3. **Output 1.3:** All Iraqis, with an emphasis on the most at-risk population have improved access to quality communicable and non communicable diseases prevention and control, including care, treatment, and support services
  4. **Output 1.4:** People most affected by emergencies and vulnerable groups have access to quality basic health and nutritional services, including psychosocial support
- **Outcome 2:** Health and nutrition policy makers and service providers at all levels are better able to effectively develop, manage, and implement quality and equitable policies, strategies, plans, and programmes
  1. **Output 2.1:** Policy makers and other relevant stakeholders develop, review, and update policies, strategies, plans, and guidelines to conform to international norms and standards

2. **Output 2.2:** National, district, and governorate officials have enhanced capacities in planning, implementation, and monitoring and evaluation in health and nutrition programmes
3. **Output 2.3:** Civil society and community members are engaged and empowered to effectively participate in planning, implementation, and monitoring and evaluation of health and nutrition programmes

#### **D) KEY ASSUMPTIONS, RISKS AND OPPORTUNITIES**

##### **Assumptions:**

1. Adequate allocation of funds to the sector;
2. Adequate allocation of funds for recurrent and operational costs including training, transportation, DSA for outreach and campaigns;
3. Security situation improve;
4. Stability of health professionals and support staff (no rotation) in MOH with the regard to senior/mid level managers;
5. International staff is deployed back to Iraq or spending significant time inside Iraq on mission status.
6. Commitment of the government and other stakeholders at all levels

##### **Risks/challenges:**

1. Insecurity remained an issue. Remote mode of operation using local contractors was used, Insufficient or lack of presence in Baghdad (or inside Iraq) for some UN agencies, access to red zone and UN visibility remains a challenge.
2. Frequent turnover of key government staff – impossible addressing promptly as it requires time and substantial briefing/capacity building of new appointed staff. Often they were reluctant to support earlier agreed activities. Difficulties in implementation of long term strategies.
3. Rebuilding of confidence with the Government needed, especially on technical support for the health reform process
4. Global financial crisis and donor fatigue
5. End of Trust Fund and move to bilateral funding
6. Brain drain/limited professional capacities even within United Nations
7. Corruption in social services
8. Imbalance in the humanitarian vs. political/development arm of United Nations in Iraq

##### **Opportunities:**

1. Political will: MOH has embarked in major initiatives to reform the health systems and major conferences on health system reforms took place in 2008.
2. High demand by line ministries and the population as well for evidence-based, effective, high-impact health and nutrition interventions and appropriate policy options. , national and sub-national and institutional frameworks leading to the attainment of MDGs 4, 5 and elements of 1, 6 and 7 by 2015. This will involve presenting the policy options and their implications in user-friendly ways and maintain vigorous monitoring of the progress towards MDGs through Iraq Info and Countdown 2015 initiative.
3. The need for countrywide equitable and sustained coverage for selected evidence-based preventive and case-management interventions, which can achieve major reductions in maternal, newborn and child mortality.
4. Strengthened decentralized planning, budgeting and delivery mechanisms.
5. Government's self-sufficiency and sustainability of basic health and nutrition supplies.
6. The assumption that the security situation would improve and hence facilitate the implementation of project/programme activities was to a large extent invalid as the risks resulting from continued unfavorable security situation, particularly at project sites located within so called "hot" or hostile zones, were substantially high. Implementation of rehabilitation activities had to be stopped or postponed for long periods of time and local contractors and their staff as well as UNFPA and UNOPS national project staffs were at high security risk. This situation also restricted selecting the locations to conduct the in-country cascade training of service providers.
7. Availability of information that can enable us to build evidence-based interventions
8. More investment in capacity building for national staff
9. Having NDP 2010-2014, nationalized MDGs that can be used as advocacy tool

#### **E) JOINT PROGRAMMES, UN CONVERGENCE AND SYNERGIES**

- SOT shows capacity for networking, share goals. However, while internal synergy exists, there is no formalized joint programmes as per UNDG guidelines (limited capacity for joint programmes)
- All SOT initiatives are linked with National Development Strategy 2007-2010 and the International Compact with Iraq (ICI). They are also linked to individual agencies cooperation strategies such as the WHO Country Cooperation Strategy (CCA). The assistance framework is thus linked to several strategic agreements and processes which makes the joint effort robust.
- WFP Survey (CFSVA) was conducted in close collaboration with UNICEF, MOP and MOH in addition to technical contribution provided by WHO and FAO.
- Under food safety programmes, WHO, FAO and UNIDO have been working jointly to support the Government of Iraq in general and in particular, the three ministries of Health, Agriculture and Industry to increase the capacity and quality of food control mechanisms.
- UNICEF currently has no joint programmes as per the UNDG definition of joint programming. However, UNICEF's joint projects WHO through the Iraq Trust Fund reflect the spirit of joint programming, even though these projects do not strictly meet all conditions spelt out under the joint programming guidelines.
- Although substantive efforts have been made to ensure active participation of NGOs, there is still limited integration of NGOs into the sector
- UNFPA continues to implement an ITF funded project to support EmOC services in collaboration with WHO and UNICEF, however not under a joint programme modality.
- A joint programme addressing HIV/AIDS is being initiated for funding from UNDG ITF, where UNFPA will focus on the support areas as described by the agreed division of labor. Partnerships within the Sector Outcome Teams and outside including international NGOs were forged to facilitate implementation of projects on NEX (National Execution) modality. Women health and youth surveys are/will be undertaken in direct involvement and collaboration with UN agencies (UNICEF, WHO, UNHCR, UNIFEM, UNESCO, UNDP, ILO, ESCWA) and national counterparts (MoYS, MOH, MoE, MoHD, MoLSA, COSIT, etc.)
- Agencies have not yet fully developed their comparative advantages instead of "trying to do everything," mainly as a result of competition for funding

## F) LESSONS LEARNED

1. The current UN coordination mechanism (SOTs) has been instrumental in sharing information on various health and nutrition issues, on lessons learned, provision of up to date information during emergencies, formulation of joint programmes, and a platform for conceiving humanitarian projects for funding from ITF or under CAP. Further enhancement of bilateral and multilateral coordination is required to avoid duplication and explore areas of joint programming.
2. Innovative contracting and monitoring procedures ensured minimal exposure of staff to risk, while safe-guarding the integrity of processes. This mode of operations continued to provide much needed human resources for programme implementation during reporting period. In 2009, this system shall be revised and strengthened to fulfill the needs of the changing context.
3. The area-based programming approach employed since early 2008 (known as ICIC for developmental action and IMPACT for humanitarian action) is a useful foundation upon which to build future downstream programming. Enhanced engagement with counterparts at the Governorate and District level is key to the achievement of programme results.
4. Community/social mobilization was the basis of success of some programmes (i.e. NIDs, cholera) and should be expanded to other programmes. Also, community involvement is essential to increase awareness on health issues and enhance demand and accessibility to health services among communities with particular focus on women and adolescent/young girls. It should be noted that the main factor that has limited the expected wide spread of community mobilization was insecurity.
5. Self-sufficiency and financial sustainability is critical in sustaining basic health and nutrition services. National ownership of projects should be stressed on as this will ensure higher commitment of the national counterparts and hence better quality and timeliness of project implementation. Most of the reporting was undertaken at the agency level and based on information as received from the project coordinators located in the center and north and from UNOPS with regards to the rehabilitation activities. Reporting on project progress for projects implemented by international NGOs has by comparison been much more efficient and timely.
6. SOT structure allowed good coordination among members. However, coordination with national counterparts has remained weak in many instances. For instance limited use of coordination mechanisms, decentralization by national partners highlights the need for bottom-up planning/clear responsibilities. In the same context,

insufficient national capacity building highlighted the need for stressing on programme management at district level. Also, more involvement of line ministries in leading the project formulation and implementation is needed. In this regard, SOT has to move to Government-led Sector Working Group, based in Baghdad.

7. Focus should be on capacitating the national counterparts to implement facility rehabilitation activities rather than implement these activities on their behalf especially that funds are available. Managers at the district and PHC level should be trained on health management. Health authorities have been encouraged to control the high turnover of trained staff and provide incentives proportional to the remoteness of the facilities they work in.
8. A programme for training nurses to become skilled birth attendants is required to ensure minimizing unattended deliveries, particularly in remote areas. Also availability of data on women's health and social status will enable identification of needs and gaps, thereby facilitating a more concerted approach to programming as needed to enhance their health and wellbeing.
9. Need to enhance the capacity of MOH to implement HACT to facilitate implementation of UN funded projects/programmes as well as National Execution Modality (NEX). At present, NEX can be implemented by national NGOs only through channeling funds through international NGOs.
10. There is a need to strengthen programme monitoring and evaluation (M&E) process. M&E activities were greatly hampered by the security situation coupled with the limited number of field staff with no restricted movement. Outsourcing such activities was also affected due to limited the accessibility to sites within security compromised zones. The improved security would allow more freedom of movement and higher possibility of recruiting field staff to undertake such activities. Monitoring of training activities has relatively been possible; particularly for TOT training that was conducted outside the country.