IRAQ NATIONAL STRATEGY FOR WOMEN, CHILDREN AND ADOLESCENT HEALTH 2024 - 2030

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Foreword

Statement by Minister of Health

(3 Directors - DoPH / DoTA / DoP)

Statement by 3 UN agencies

(WHO / UNFPA / UNICEF)

List of Abbreviations

ANC:	Antenatal Care
CPR:	Contraceptive Prevalence Rate
CSOs/NGOs	Civil Society Organizations / Non-Governmental Organizations
DOHs	Directorate of Health (at governorate level)
DoPH	Directorate of Public Health
DoP	Directorate of Planning
DoTA	Directorate of Technical Affairs
FP:	Family Planning
GDP:	Gross Domestic Production
ICPD:	International Conference of population development
I-WISH	Iraq Women Integrated Social Health survey
LMIS:	Logistics Management Information System
MICS:	Multiple Indicator Cluster Survey
MEC:	Medical Eligibility Criteria (for using contraceptives)
MoH:	Ministry of Health
MoE	Ministry of Education
MoHE:	Ministry of Higher Education
MoLSA	Ministry of Labor & Social Affairs
MoP	Ministry of Planning
MoF	Ministry of Finance
NNC	Neo-Natal Care
PHC:	Primary Health Care
PHCC:	Primary Health Care Center
PNC:	Post Natal Care
PPP:	Private – Public Partnership
RH:	Reproductive Health
WCAH:	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDPs	Service Delivery Points
SRH	Sexual Reproductive Health
UN:	United Nations
UNFPA:	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO:	World Health Organization

Introduction

WHY A New Strategy ?

Iraq is a signatory and endorsed the ambitious 2030 SDG Agenda. In response to that SDG agenda, as well as the "UN Global Strategy for Women, Children & adolescents Health (2016 – 2030)", the Iraqi Ministry of Health formulated an updated WCAH Strategy (2016-2020). It aimed to address inequities within the country, and to help Iraq to implement the 2030 SDGs Agenda without delay.

By end of 2022, seven years since launching of previous strategy, existing data showed that some SDGs indicators / targets are on track to be achieved by 2030. Meanwhile, other SDGs indicators seem to be lagging dehind, and that significant gaps /variations exists among different governorates, and between residential zones (urban & rural).

Consequently, too many women, children and adolescents in Iraq still have little or no access to essential, good-quality health services, still suffer illnesses, and fail to reach their full potential. Moreover Out-of-Pocket health expenses are still high, that widen gap and disparity between rich & poor households.

Final evaluation of previous WCAH Strategy (2016-2020) revealed that the previous Strategy faced serious challenges, weaknesses and lessons learned (see Page .....), mainly due to : a) Defragmented efforts & resources that were mainly driven by 10-15 vertical programme; b) fragmented service delivery modality; and c) Non-optimal Accountability & Coordination mechanism (Intra-sectoral & Inter-sectoral)

Building on lessons learned, this updated *Strategy*, spanning over the next seven years of SDGs (2024-2030) provides guidance to accelerate momentum for women's, children's and adolescents' health, and to achieve SDG Indicators & targets by year 2030.

What's New ?

In order to complete the unfinished SDG work, to address inequities within the country (including the marginalized and hard-to-reach); in all places, and to help country begin implementing the 2030 SDG Agenda, country needs to set its priorities to scale-up the evidence-based cost effective interventions at different levels of health system.

- People centered: In line with the "Global Strategy for Women, Children & Adolescent Health", the new Strategy will be "People-centered" with a "Continuum of Care" approach.
- "Equity-Driven": the Strategy will target all people in all places (particularly marginalized and hard-to-reach) to ensure equal access and utilization of quality services
- Multidimensional/ Integrated approach: Addressing the health-related targets of SDG 3 cannot be achieved without addressing many of the other 16 SDGs.[1] This *Strategy* takes a life-course approach that aims for highest standards of health and well-being, at every age.
- Efficient Intra-Sectoral Accountability / responsibility: The active involvement & participation of the all entities of Ministry of Health is crucial and fundamental for successful strategy implementation, and achievement of relevant SDGs indicators and targets

- Effective Inter-sectoral Partnership: Due to the Strategy's multidimensional dimension, it is crucial to build an effective Partnership with other social sectors, as well as with Iraqi private & SCOs sectors.

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[1] Progress on Health-related SDGs and targets in the Eastern Mediterranean Region, 2020: http://www.emro.who.int/images/stories/est/documents/progress-on-health-related-sdgs-and-targets.pdf?ua=1

Methodology for Formulating new Iraq Strategy 2023 - 2030

The development of the New "Iraq Strategy for Women, Children & Adolescent Health – 2023-2030" passed through an intensive participatory process, that included participants from Main Directorates of Mini. of Health (Dir of PH / Dir of Planning / Dir of Technical Affairs), and other entities at central level and selected DoHs).

Within this perspective, the formulation passed through several phases and steps:

1) Final Review of Previous WCAH Strategy (2016-2020): Based on inputs of managers of RMNCA Dep. / Dir. of public Health, an exhaustive analysis of strategy achievement was conducted by an independent consultant team.
2) Concurrently, an exhaustive "Situational / Needs Assessment" & "SWOT Analysis" was prepared based on existing reports and publications (local and international) (see list of References). These two documents were prepared by the same independent consultants.
3) Early February 2023, a 4-days National Workshop was organized with participants from different departments and sections of all central Directorates of Min. of Health, with participants from several DoHs. The main objectives of that National workshop were;
    a. Discuss and enrich the Final review, as well as the Situational Assessment and SWOT Analysis
    b. Discuss the Overall design of the new Strategy,
    c. Develop a Ovell Logical Framework of the strategy, as well as for its 5 suggested Outcomes, including preliminary Indicators (Goal / Outcomes / Outputs)
4) Between March and June 2023, Tens of On-line meetings / Videoconferences were organized with Main partners from the Main Directorates (Dif. of PH, Dir. of Planning & Dir. of Technical affairs), and other entities within Min. of Health. The main objective was to further develop and structure the Strategy Logical Framework, and its five outcomes into clear Outpp[ppputs and Main Interventions, as well as their respective Monitoring Matrix (Indicators – Goal / Outcomes / Outputs levels).
5) Mid July 2023: Five "1-day Face-to-Face meetings" were organized with relevant partners for each of the defined 5 outcomes. Main objective was to finalize the Strategy Logical Framework, and its five outcomes, including implementation responsibility and accountability.

Acknowledgements

The World Health Organization (WHO) is grateful to the members of the Core Working Group that have contributed to the development of this guidance document, and for their participation in the guide development process, including providing review and feedback to the first and subsequent versions.

WHO is grateful to WHO regional office team & UN agency country teams who contributed to the co-development of country mini cases:

The development process was coordinated by .....

Lastly, WHO thanks ..... for their meaningful contributions.

Context & Situation Analysis

1) Global, Regional & National Context

1.1 Global Context

Following the launching of the 2030 Agenda for Sustainable Development in 2015, the Global Strategy for Women's, Children's, and Adolescents' Health – 2016-2030[2] was launched to translate the SDG Agenda into concrete action to achieve relevant SDG targets. For maternal and child health, optimism was high for future health & well-being of women, children and adolescents around the world. But halfway through the 2030 SDG Agenda, the outlook in 2022 is less promising. The COVID-19 pandemic destabilized access to & availability of health services. Yet the pandemic is not solely responsible for the delay in achieving global goals, as progress was slow or stalled. For example:

- While Global maternal mortality ratio declined by 38% between 2000 & 2017, with an average annual reduction ratio of only 2.9% (less than half the ratio of 6.4% annual reduction needed to reach SDGs target [3].
- Immunization service coverage has stalled for many years, leaving millions of children unprotected. Coverage for the 3rd dose of DTP stagnated for a decade before dropping from 86% to 81% during the pandemic[4]

1.2 Regional (EMRO) Context

In Eastern Mediterranean Region, between 1990 and 2015, maternal mortality ratio decreased by 54% and under-five mortality by 48%. Eight countries achieved MDG 4 and three achieved MDG 5. The Region has the highest newborn mortality rate (first 28 days) after the African Region, and the 2nd highest under-five & Adolescents mortality rate. The high levels of maternal, neonatal, and infant mortality in the region are mainly due to weak health systems. There are not enough well-trained human resources, essential drugs and commodities are often lacking or inadequate, referral systems do not function well, and quality of care provided to mothers and children in referral hospitals is insufficient. Strengthening health information systems remains a key factor in improving maternal and child health.

Reproductive, maternal, newborn, and child health continue to be a priority in EMRO region. The latest report on maternal and newborn health (WHO, UNICEF, 2022) committed member states to:

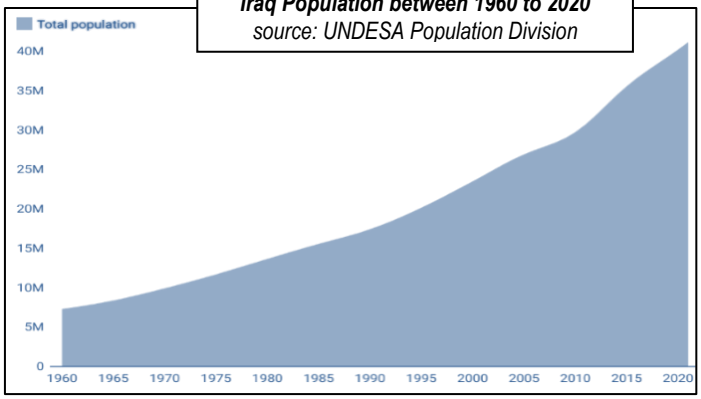
- ✓ Develop and implement plans to accelerate maternal and child health;
- ✓ Take measures to strengthen elements of health systems
- ✓ Establish sustainable financing mechanisms & mobilize domestic & international resources
- ✓ Improve coordination & accountability among all partners.

1.3 National context

➢ Demographic Context

Iraq's population has seen a significant increase over last seven decades, from 7.3 million in 1960 to around 43.3 million in 2023, and is estimated to reach 50 million by 2030 (UN DESA projections).

Iraq Population between 1960 to 2020
source: UNDESA Population Division



Over the last decades, Fertility rate in Iraq has decreased significantly from 7.4 in 1970 to 3.9 children per women in 2020. A significant difference was recorded between regions (3.8 in South/Central Iraq vs 3.1 in Kurdistan); across income (4.4 among poorest quintile vs 3 among richest quintile) and across education levels of mothers (4.7 among mothers with pre-primary or no education vs 2.8 among mothers with at least an upper secondary level of education).

Meanwhile the Iraqi population is youthful with 37% below the age of 19 years old. Women at Reproductive Age (15 - 49 years) make up almost one fourth of total population. Around 70% of the population live in urban settings.

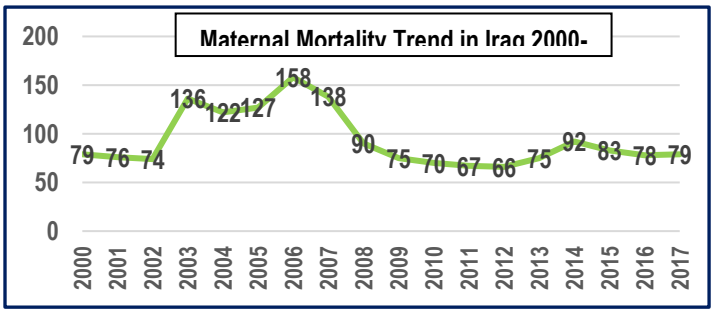
[2] Global Strategy for Women's, Children's & Adolescents' health (2016-2030):
[3] Trends in maternal mortality, 2000 to 2017 – WHO; 2019 (https://apps.who.int/iris/handle/10665/327595.
[4] WHO/UNICEF estimates of national immunization coverage, WHO (https://immunizationdata. who.int.

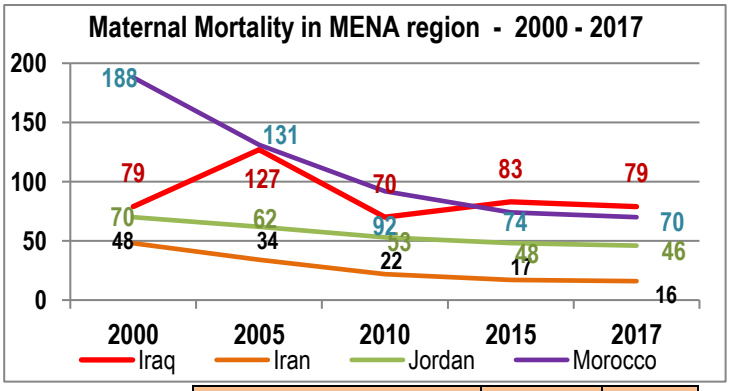
2) WCAH-related Mortality & Morbidity

1.1 Maternal Mortality & Women / Maternal Morbidity

1.1.1 Maternal Mortality

In Iraq, MMR changed significantly over last two decades. As per UN estimates [5], MMR increased between 2002 & 2006 (from 74 deaths to 158 deaths /100,000 LB). Then it witnessed a significant decline to 66 death / 100,000 LB in 2012. Since 2013, MMR had slightly increased to 79 death / 100,000 LB in 2017. In MENA region, Iraq remains among the highest countries.





Maternal Death Review

The MDSR system was initiated in Iraq since 2009. Since then, Two MDSR reports were produced for (2010-2012) & (2016-2018).

- Direct causes decreased from 69% in 2010/12 to 63% in 2016/18.
- In 2018, 3 direct causes represented 45% of maternal deaths (Pulm. Embolism, Post-Partum Hemorrhage & Hypertension).
- Indirect causes increased to 37% of Maternal deaths.
- The 2021 MOH Statistical Report showed significant differences among governorates. The highest was in Thi-Qar (75.8 /100,000 LB) & lowest was in Dohuk (18.5/100,000 LB).
- In 2018, a significant percent of maternal deaths occurs outside health facilities. Maternal death at "Home" has doubled from 13% to 28,3 % between 2012 and 2018.

Place of Death	2012	2018
Home	13 %	28.3 %
Public hospital	70.8 %	59.9 %
Private hospital	??	8.0 %

MDSR reports	2010-12	2016-18
Causes of Maternal Death	%	%
Direct Causes	**69 %**	**63 %**
Post-Partum haemorrhage	24,5 %	20 %
Pulmonary embolism	16,7 %	17 %
Hypertension	12,1 %	8 %
Sepsis	5,4 %	2 %
Rupture uterus	4,1 %	6 %
Ante-Partum Haemorrhage	4,5 %	3 %
Anesthesia	0,0 %	7 %
Indirect Causes	**31%**	**37 %**
Renal disease	2,2%	6%
Heart problems	7,6%	20%
Liver disease & Other	9.5 %	10%

1.1.2 Maternal & Women RH- Morbidity

- **Post-Partum Morbidity :** As per I-WISH survey (2011), Ever married women who had a birth during last 5 years, suffered from following Maternal morbidities :
  - 18.3 % suffered signs of Vaginal Prolapse
  - 19.6 % suffered of Urinary incontinence,
  - 22.1 % suffered of Burning urination
- **RH-related Cancers:**
  - In 2019, as per Iraqi Cancer board, Breast cancer accounted for one-third of all cancer among women, with incidence rate (36 / 100,000.
  - As per WHO Globocan (2020), Breast cancer represented 38% of all new cases of cancer among women.
- **Anemia:** Iron & folic acid deficiencies are main causes of maternal anemia, leading to adverse birth outcomes. In Iraq, anemia prevalence was 35.5% in 2006 and it drops to 19.9% in 2013
- **Gravid Diabetes Mellitus (GDM):** GDM is associated with complications during perinatal period, and causes serious risk to mother and her newborn. The prevalence in Iraq is 11.5% among pregnant women.
- **HIV**: Iraq is a country with low HIV prevalence. Between 1986 to 2014, 57% of reported cases were due to Blood transfusion, 25% were due to sexual transmission, and 6% were due to "Mother-to-Child transmission.

[5] WHO, UNICEF, UNFPA, World Bank. Trend in Maternal Mortality 2000-2017. Geneva; 2019: www.who.int/reproductivehealth

1.1.3 Violence Against Women

➢ Domestic Violence

- As per I-WISH 1 (2011), 46% of married women 15-54 years faced different types of spousal violence during last 12 months (21.4% in Kurdistan)

	Emotional	Physical	Sexual	Any Type
Urban	43	4,8	8,5	46,7
Rural	46	7,2	10,5	45,1

➢ Female Genital Mutilation / Cutting

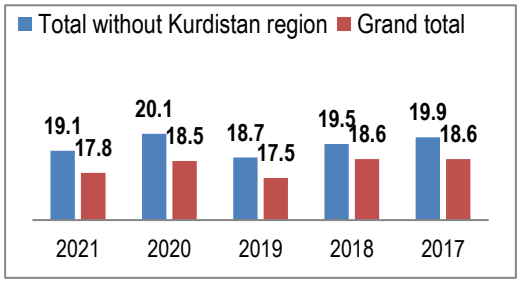
- Among women 15-49 years, as per MICS 2011, around 8.1 % of Iraqi women were victims of any form of FGM, mostly in Kurdistan region (42.8 %). In 2018, rates dropped to 7.4 % in Iraq, and 37.5% in Kurdistan region.
- Among Young daughters (0-14 years), MICS 2011 showed that 20.6% of young girls have undergone any form of FGM (25.7 % in Kurdistan region). In 2018, these rates significantly dropped to merely 0.5 % in total Iraq, and to 3.2 % in Kurdistan region.

Age group	Region	MICS 2011	MICS 2018
Women 15 - 49 years	Iraq	8.1 %	7.4 %
	Central South Iraq	1.2 %	0.4 %
	Kurdistan region	42.8 %	37.5 %
Daughters 0 - 14 years	Iraq	20.6 %	0.5 %
	Central South Iraq	4.8 %	0.0 %
	Kurdistan region	25.7 %	3.2 %

1.2 Neo-Natal, Infant & Child Mortality & Morbidity

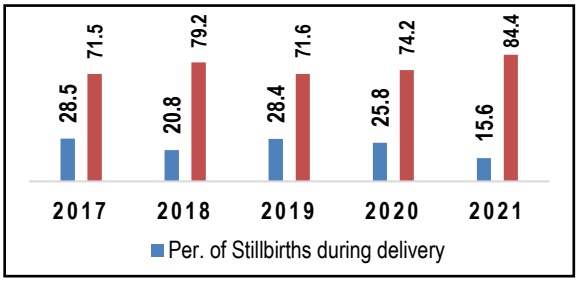
1.2.1 Neonatal Mortality

- As per MOH Statistical reports (2017-2021), Neonatal mortality showed difference among governorates: highest in Al-Najaf (18.5/1000 LB), & lowest in Al-Sulaimaniya (4 /1000 LB)
- In 2021, neonatal mortality rate was 17.8 /1000 LB with large difference among governorates; the highest rate was recorded in the Al-Najaf (18.5 /1000 LB), whereas the lowest rates was in Al-Sulaymaniyah (4 /1000 LB



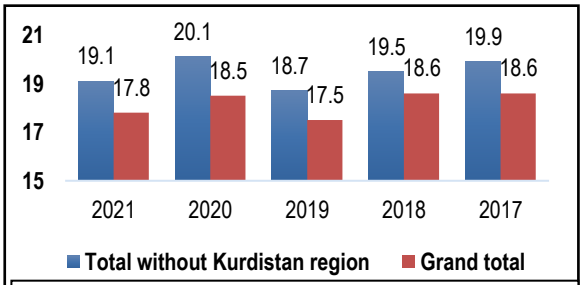
1.2.2 Still Birth

- As per MOH Statistical reports, "Still Birth" declined from 7.9 / 1000 Births in 2017 to 7.5 / 1000 Births in 2021.
- In 2017, 28.5% of still Births occurred "during delivery, but decreased to 15.6 % in 2021
- The majority of "Still Birth" occurred "Before delivery" (84.4% in 2021).



1.2.3 Infant mortality rate

- As per UN Interagency Group for Child Mortality[6], Infant mortality rate in Iraq decreased from 35.6 / 1000 LB in 2017 to 21.3 / 1000 LB in 2020.
- In 2021, 25.7% of infant deaths were attributable to respiratory & cardiovascular deaths, and 13.5% were caused by congenital malformations.

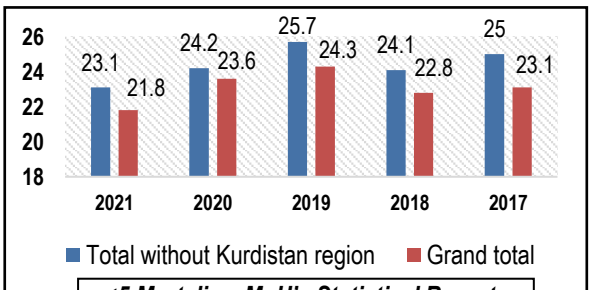


Infant Mortality – MoH ' Statistical Reports 2017-2021

1.2.4 Under-5 mortality rate

Based on estimates of UN Interagency Group for Child Mortality, under 5 mortality rates decreased from 41 / 1000 LB in 2000 to 25.2 / 1000 LB in 2020.

As per MoH national statistical reports, Under-5 mortality rate changed from 25 / 1000 LB births in 2017 to 23.1 / 1000 LB birth in 2021. Higher rates of under-5 mortality were recorded among children, with "low or no educated mothers" and among poorest quintile in 2018



<5 Mortaliy – MoH's Statistical Reports

[6] *CME Info - Child Mortality Estimates :* https://childmortality.org/data/Iraq

1.3 Neo-Natal, Infant & Child Morbidity

2.3.1 Low Birth Weight

- Weight at birth is a good indicator not only of mother's health & nutritional status but also newborn's chances for survival, growth & long-term health.

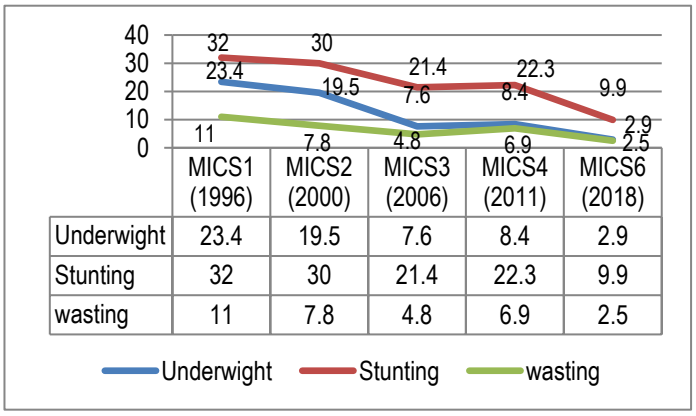
	2017	2018	2019	2020	2021
% Low birth weight	6.6	7.1	8.7	7.7	8.2

source: Annual Statistical Reports 2017-2021

- Over the last five years (2017- 2021), Low-Birth rate had increased by around 25%. Moreover, significant variations could be observed among governorates, with Diala and Anbar have 2 fold national rates in 2021

2.3.2 Nutritional Status

- As per MICS surveys in Iraq, indicators had significantly improved over last 20 years:
  - 9.9% suffer from stunting
  - 2.5% suffer from wasting.
  - 2.9% are moderately underweight.
  - 6.6% are overweight.
- These indicators are strongly correlated with mother's education, household wealth index, but weak correlation with urban & rural zones



	MICS1 (1996)	MICS2 (2000)	MICS3 (2006)	MICS4 (2011)	MICS6 (2018)
Underwight	23.4	19.5	7.6	8.4	2.9
Stunting	32	30	21.4	22.3	9.9
wasting	11	7.8	4.8	6.9	2.5

2.3.3 Children with Diarrhea

- Diarrhea is a major cause of child mortality and morbidity. Diarrhea leads to the loss of large quantities of water and nutrients from the body in the form of liquid stools.
- As per MICS survey, Percentage of under-five children who had diarrhea in 2 weeks prior to survey, was: a) Highest in Kirkuk (25.5%) & Dyala (18.5%); b) Lowest in Sulimanya (8%) & Erbil (9%)
- Percentage of diarrhea among children (0-23 months) was ➔ 21%.

	MICS 2011	MICS 2018
Iraq	15 %	12.8 %
Central South	16 %	13.4 %
Kurdistan	9 %	9.8 %

2.3.4 Children with Suspected Pneumonia

- As per MICS survey, Percentage of under-five children who had diarrhea in 2 weeks prior to survey, was Highest in Sulimanya (23.8 %) & Lowest in Baghdad (4.2).

	MICS 2011	MICS 2018
Iraq	10 %	3.4 %
Central South	8.3 %	3.3 %
Kurdistan	18.2 %	3.7 %

2.4 Adolescent Mortality & Morbidity

2.4.1 Adolescents Mortality

In 2021, accidents were the leading cause of mortality among this age group. Similarly, during previous years, accidents were the leading cause of death among adolescents

2.4.2 Adolescent Morbidity

Adolescents (10-19 years) are about 23% of Iraqi population. Often, they encounter problems, including low knowledge on reproductive health, harmful practices (FGM, early marriage & childbearing, unsafe abortion, STIs/HIV & substance abuse. As in many countries, there is scarce data about adolescents.

- the "(I-WISH 1 - 2012, revealed the following about Iraqi Adolescent Girls (10 – 14 years)
  - 46 % were exposed to violence in last month
  - Only 54% has Knowledge about Puberty
  - 82.4% were enrolled in Schools (urban 88% / Rural 71%)

Students aged 13-15 years	Total	Boys	Girls
Mental Health			
% attempted suicide in past 12 months	14.6	13.7	15.8
Violence & Unintentional Injury			
% were in a physical fight in past 1 year	37.1	49.5	22.4
% bullied in past 30 days	27.7	32.4	21.9
Protective Factors			
% whose parents understood their problems	43.9	45.4	42.1
Smoking & Tobacco			
% smoked cigarettes during past 30 days	8.7	12.1	4.6

- The Last Global School Health Survey, conducted in 2012, revealed the following
- WHO EMRO report on School health (2017) revealed that around 25.3% of adolescent (13 to 18 years) are overweight, and 85% of them had insufficient physical activity.

2.4.3 Early & Child marriage

Early marriage compromises girls'. Women who are married at early ages are likely to drop out of school, to get early pregnancy, to give birth to more children, more exposed to maternal mortality & domestic violence.

MICS Surveys	Under 15 years		Under 18 years	
	2011	2018	2011	2018
National	5.5 %	7.2 %	23.7 %	27.9
Kurdistan	4.9 %	2.6 %	22.4 %	11.8 %
South / Central Iraq	5.6 %	8.2 %	23.5 %	30.1 %

As per MICS 2018, around 28% of young women are married before age of 18 years, and 7% before age of 15 years . These rates do not vary much between urban and rural areas, but greatly influenced by educational level of girls (34% for girls with no education, and 7% among those with secondary or higher education), as well as by household wealth (19 % for richest households versus 30 % among poorest households.

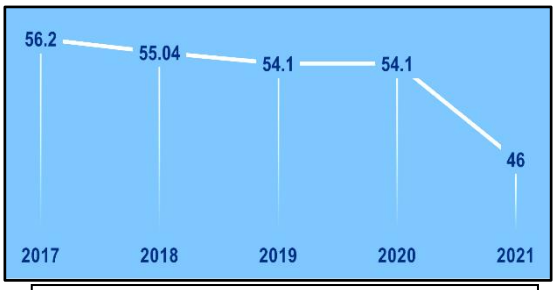
MICS 2018	< 18 years	< 15 years
Primary or Less	34	--
Upper Secondary	7	--
Poorest	30	3
Richest	19	12
Urban	28	7,4
Rural	27,6	6,2
National	25	7

2.4.4 Early Childbearing & Adolescent Fertility rate

Iraq has a high fertility rate among adolescents compared to neighboring countries.

- As per World Bank estimates in 2020, adolescent fertility rate in Iraq was 72 births / 1000 adolescent girls (15-19 years), with disparities between rural & urban areas.
- As per MICS surveys (2011 & 2018), significant differences exist among governorates. Lowest was in Duhok (3.6%), while highest was in Karbala (22.3%).
- As per MoH's statistical reports, fertility rate among girls (<19 years) decreased from 56.2 births in 2017 to 46 births /1000 girls in 2021.
- These rates may be attributed to lack of SRH knowledge among adolescents. In fact, only 22% of adolescent girls (15 - 19 years) used any contraceptive methods and only 16% used a modern method.
- These problems are further exacerbated by poor health seeking behavior, inadequate access to information and services, as well as by social problems such as poverty.

MICS survey	**2018**
Iraq	70
Poorest families	91
Richest families	39
Rural zones	75
Urban zones	68
No/Less education	123



Source: Annual Statistical Reports 2017-2021

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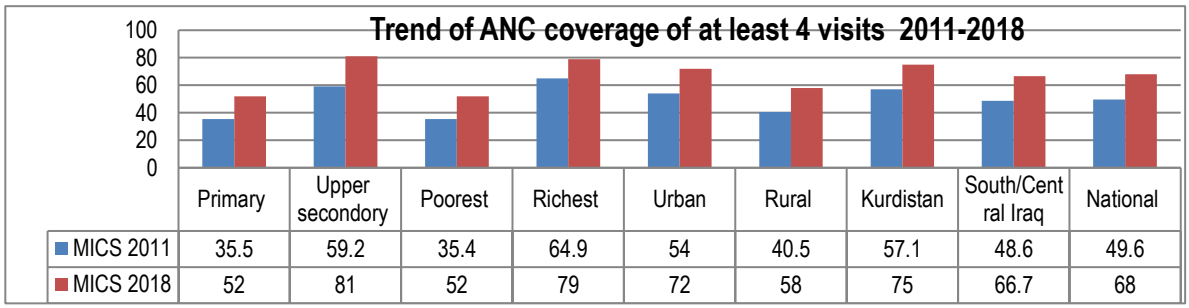
3) Trend of WCAH Service Delivery & Coverage

3.1 Women & Maternal SRH Care services

3.1.1 Maternal Care services (Ante-Natal & Post Natal Care

Main PHC centers are expected to provide all ANC elements. A low-profile package is offered in sub-PHC centers. and Health-houses provide only advice and counseling. Meanwhile hospitals provide comprehensive services for referral cases that require advanced care and support.

➢ **Coverage of ANC services by Determinants**

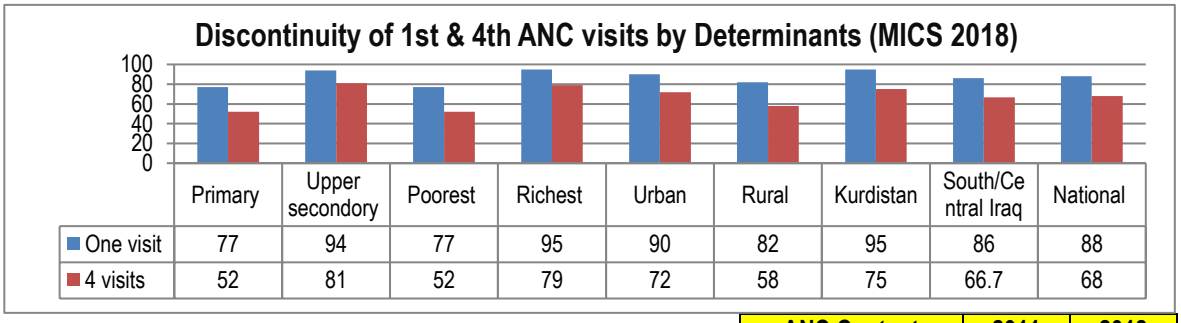


	Primary	Upper secondory	Poorest	Richest	Urban	Rural	Kurdistan	South/Central Iraq	National
MICS 2011	35.5	59.2	35.4	64.9	54	40.5	57.1	48.6	49.6
MICS 2018	52	81	52	79	72	58	75	66.7	68

- As per MICS 2011 & MICS 2018, Proportion of pregnant women who received 4 or more ANC visits increased from 50% in 2011 to 68% in 2018, with an increase of around 18 percent points.
- The same is observed for social determinants (wealth, education, urban / rural)

➢ **Discontinuation between 1st & 4th ANC visits (by Determinants)**

As per table below, there is a "Drop Out / Discontinuity" rate of around 22% between 1st & 4th visit.



	Primary	Upper secondory	Poorest	Richest	Urban	Rural	Kurdistan	South/Central Iraq	National
One visit	77	94	77	95	90	82	95	86	88
4 visits	52	81	52	79	72	58	75	66.7	68

➢ **Quality Content & Providers of ANC visits**

Based MICS 5 & MICS 6, the following could be deducted:

- Quality of ANC improved from 65% in year 2011 to 80% in 2018.
- Tetanus Vaccination remain low at merely 63%
- ➢ Rate of ANC by Qualified provider has significantly increased form 77.7 % in 2011 to 87.5 % in 2018).

ANC Content	2011	2018
Blood sample	69 %	83 %
Urine sample	68.5 %	81 %
Blood pressure	71.8%	84 %
All above	65 %	80.4 %
Tetanus Vaccine	**56.5%**	**62.8%.**

ANC Provider	2011	2018
Qualified Provider	77.7 %	87.6 %
Public Doctor	52.9 %	52.3 %
Private Doctor	24.5 %	35.2 %
Nurse / Midwife	0.3 %	0.1 %

➢ **Source / Place of ANC services**

- As per I-WISH 1 & 2, the private sector is the main provider of ANC services. It increased from 55% in 2011 to 62% in 2021.
- On other hand, coverage by PHC system for ANC had significantly decreased from 31% in 2011 to around 17% in 2021. This could be attributed COVID-related restrictions.

ANC Source	I-WISH 1		I-WISH 2	
PHC centers	31 %	44%	17 %	38%
Gov. Hospitals	13 %		17 %	
Public Clinic	---		4 %	
Private Clinic	53 %	55%	57 %	62%
NGO Clinic	3 %		5 %	
Other	1 %	1	0 %	

➢ **Trend of Post-Natal care services**

WHO recommend that pregnant women should have 3 Post Natal

- In 2011, ONLY 38 % of new mothers had at least one PNC visit. This rate had significantly decreased to 20% in 2018.
- As per data of MOH's Annual Statistical report, confirms such trend, where PNC visits coverage had decreased from 53% in 2017 to 41% in 2021. A decrease of around 22%.

At least ONE PNC visit	I-WISH 1 (2011)	MICS 6 (2018)
Iraq	38 %	20 %

➢ Source of Post-Natal Care services

PNC Source	I-WISH 2 (2021)	
PHC centers	10 %	45 %
Gov. Hospitals	32 %	
Public Local Clinics	3 %	
Private Clinic	46 %	55 %
NGO Clinic / Hospital	8 %	
Other	1 %	

- As per I-WISH 2, the private sector is a crucial provider of PNC services, with 55% of all new mothers in 2021
- Among Public sector facilities, PHC system is weakly used for PNC services, with ONLY 10% of all New Mothers, while Government Hospitals provide 32% of all PNC clients (TRIPLE coverage of PHC system). This could be attributed to COVID-related restrictions).

3.1.2 Emergency Obstetric & Neo-Natal Care Service

➢ Delivery Assistance

	Place Delivery		Type of Health Facility			% Skilled Providers
	Health Facility	Other	Public. Hospital	Private Hospital	PHC	
2017	83,5 %	16,5 %	82,5 %	14,3 %	3,2 %	93,7 %
2018	82 %	18 %	81,1 %	15,8	3,1 %	91,1 %
2019	84 %	15,9 %	80 %	19,8	0,2 %	90,1 %
2020	84 %	16 %	76 %	22,4	1,6 %	90,2 %
2021	86,1 %	13,9 %	76,9 %	21,6	1,5 %	96.0 %

MoH's Annual Statistical reports show that:

- % of Births delivered in health facilities slightly increased from 83.5 % to 86.1 %
- Deliveries in Public facilities decreased from 85.7% in 2017 to 78.4% in 2021
- Deliveries in Private sector increased from 14.3% to 21.6% ➔ ***(50% Increase!!!)***
- Deliveries in "PHC centers w/ Deliver room" is marginal & decreasing (from 3.2 % in year 2017 to 1.5% in year 2021 of Total Deliveries) ➔ *Merely 100 Deliveries / Per facility in a year (2 deliveries / week per facility).*
- "Deliveries by "Skilled Providers" is almost universal (reaching 96% of Total deliveries in 2021

➢ Trend of Caesarian Section (CS)

	Public	Private	Total
2011	27.8 %	79.7 %	33.3 %
2017	33,7 %	89,4 %	35,2 %
2019	32,9 %	85,8 %	36.0 %
2021	35.0 %	80,7 %	40,7 %

As per MoH's Annual Statistical reports,

- Delivery by CS gradually increased from 35.2% in 2017 to 41% in 2021
  - CS in Public facilities increased from 33.7 % (2017) to 35% in 2021
  - CS in Private facilities decreased from 89% in 2017 to 80.7 % in 2021.

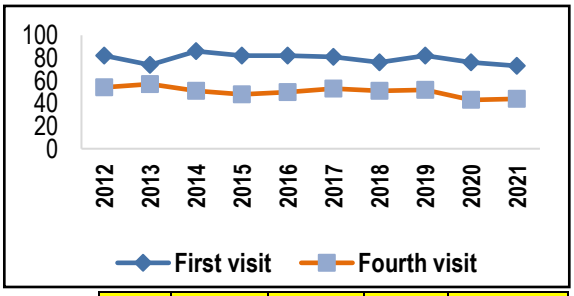
➢ Quality of New-born Health care

Percent	MICS 2018
Drying & wrapping after birth	83.7
Skin to skin	8.3
Early breastfeeding	32.4

As per MICS6 survey, the following could be deducted :

- 83.7 % of new born were dried after birth
- ONLY 8.3% were put into "Skin to Skin" contact.
- Only 32 % were "Breast fed" within one hour of birth

➢ 1st and 4th Visit by New Borns



Based on MoH's Statistical Reports

- % of infants receiving a 1st & 4th visit declined since 2012 (83% & 54%) to reach 73% and 43% in 2021
- This represents 20% decrease of Infant Monitoring.

3.1.3 Family Planning & CPR

Year	Survey	ALL methods	ALL Modern	ALL Traditional
2000	MICS 1	43.5	25.4	18.2
2006	MICS 2	49.8	32.8	17.0
2011	MICS 4	52.7	33.8	18.9
2011	IWISH 1	39.8	28.3	11.5
2018	MICS 6	52.9	35.4	17.5
2021	IWISH 2	34.3	24.0	10.3

As per MICS & I-WISH surveys, the following could be observed.

- CPR decreased from 43.5% in 2000 to 34.3% in 2021 ➔ ***20% Decrease.***
- One third of FP users prefer to use Traditional methods.

➢ Contraceptive Methods Mix (% of FP Users)

Contraceptive Methods Mix							
Year	Survey	Modern	Tradit.	Pill	IUD	Abstin.	Withdraw
2000	MICS 1	58 %	42 %	21 %	25 %	4.4%	17 %
2006	MICS 2	66 %	34 %	29 %	25 %	4.2%	15 %
2011	MICS 4	64 %	36 %	30 %	18 %	2.1%	29 %
2011	I-WISH 1	71 %	29 %	35 %	19 %	5.5%	17 %
2018	MICS 6	67 %	33 %	30 %	17 %	2.8%	28 %
2021	I-WISH 2	70 %	30 %	34 %	18 %	4.7%	24 %

- Modern methods increased from 58% of all users to 70%.
- In 2021, Pills & IUD are most used Modern methods.
- While IUD use decreased from 25% to 18%, Pills increase from 21% to 34 % of FP users
- Of traditional methods, "Withdrawal" & "Periodic Abstinence" are most used.
- "Withdrawal" is used by ONE Quarter (24%) of ALL FP users

Linkage between High use of Traditional Methods & High Rate of Un-Intended Pregnancy (24% of pregnancies) - *I-WISH survey*

➢ Source of Modern FP Services

Source of FP Method	I-WISH 1		I-WISH 2	
PHC centers	5 %	15%	3 %	10%
Gov. Hospital	8 %		5 %	
Public Local Clinic	2 %		2 %	
Private Clinic	44 %	85%	33 %	90%
Pharmacy	33 %		55 %	
NGO Clinics/Hospitals	3 %		2 %	
Other (husband, friend,	5 %		<1 %	

- Data of I-WISH 1 & 2 showed that the Private sector is the main source of FP services & contraceptive products (85 to 90%), while the public sector represents merely 15% to 10% (in 2021) of all users
- Within Public sector, Hospitals provide 50% of Public sector contribution, while the PHC system contributes just 30% of Public sector contribution
- Moreover, FP offer by Iraqi CSOs & NGOs remains modest (merely 2 - 3 % of all FP users)

➢ FP Service Delivery in Health Network

Health Facilities (HFs)	2017	2019	2021
HFs Offering FP services	**552**	**719**	**778**
ALL HFs	3,499	3,587	3,570
% of HFs offering FP	**16 %**	**20%**	**22 %**
HFs (excluding Sub-PHCs)	2,136	2,132	2,244
% of HFs offering FP	**26 %**	**34%**	**35 %**

- MoH's Statistical Reports show that Iraq health network has expanded to around 3,570 facilities over last few years.
- The offer of FP services in Iraqi Health network has increased from 552 Public Health facilities in 2017 to 778 in 2021.
- Based on these figures, it could be concluded that:
  - In 2021, only 22% of PHC facilities offer FP services.
  - If Sub-PHCs are excluded, percentage will be merely 35% of PHC facilities. ➔ ONE Third of PHC facilities

➢ Un-Met FP Needs by Modern methods

Year	Survey	% Unmet FP needs	% Satisfied Need by modern FP
2011	MICS 4	8.0	55.5
2011	I-WISH 1	24.7	??
2018	MICS 6	14.3	53.7

As per available surveys (MICS & I-WISH):

- Unmet FP needs are estimated between 14% and 25%.
  - Rate was higher within lowest wealth quintile
- Satisfied needs for modern FP methods are around 54% at national level, with significant variation among governorates

3.1.4 RH-related Cancer (Breast & Cervix cancer)

- In 2000, a National Programme for "Early Detection and Downstaging of Breast Cancer" was launched, and mainly targeting women between 40 & 69 years. It aimed to reach 10% of that group by year 2025.
- During its first few years, the programme established 4 Specialized centers (Two in Baghdad, one in each of Basra & Ninewa), then followed by 16 specialized clinics in main hospitals of other governorates.
- These clinics promote Clinical Breast exam (CBE), including Mammography, Ultrasonography (US), & "Fine Needle Aspiration Cytology" (FNAC) services, as well as educating women on Breast Self-Exam (BSE).
- By 2023, the "Breast Cancer clinics" have increased to around 49 clinics, that are located in main hospitals, with around 86 mammography machines..
- Coverage of Breast Cancer Programme has almost doubled during the last 3 years.

	# of Women examined	% of Targeted Women
Yr 2020	70,691	< 2 %
Yr 2021	120,328	< 3%
Yr 2022	158,748	~ 4.2 %

- **Challenges**
  - Programme is mainly "Hospital Based" (2ry & 3ry levels), offering Early Detection, Screening and Treatment services, as well as Counseling / Community Awareness.
  - Significant Inequity / accessibility challenges, particularly in peripheral and rural zones, as majority of centers are in main / central Hospitals (NOT in district/ Peripheral hospitals
  - Expansion of Breast Clinics in District Hospitals is mainly hampered by lack of radiologists, as well as necessary equipment.
  - Lack or limited Community based interventions at PHC level (Breast palpation, counseling/referral services), and weak integration into service delivery package at PHC services;
  - Serious cultural barriers & mis-concepts about Breast cancer among women at reproductive age.

3.1.4 Services for VAW Survivors

- In 2021, in line with "National Strategy to Combat Violence against Women & Girls - 2018 -2030", the MoH, launched a "GBV Strategy for Ministry of Health (2022 – 2026)", with WHO assistance.
- Using a Client-centered approach, the Strategy provides a framework to guide all Institutional Stakeholders,

jointly with other collaborating sectors & civil society associations, to strengthen their response & support to GBV survivors", particularly women & girls.

- By year 2026, the Strategy aims to avail the following services for GBV survivors:
  - GBV/ VAW Referral services : At annual basis, 20% of Main PHCs would integrate GBV referral services (through Mental Health units. By year 2026, 100% of Main PHC centers would be covered.
  - Twenty (20) "One-Stop Assistance Centers" (OSAC) would be established in selected Main PHCs
  - Eight (8) Centers for Clinical Management of Rape (CMR) would be setup in Main Hospitals
- By end of 2022, the following Services were established :
  - 44 Main PHCs integrated referral services for GBV / VAW survivors (excluding Kurdistan region)
  - Two OSAC centers were established in 2 Main PHCs in Kirkuk & Ninewa
  - Preliminary preparation for 3 CMR centers in Two hospitals (Baghdad & Kirkuk), as well as at General Directorate of Forensic Medicine (الطب العدلي)
- For Service coverage, the table represent number of GBV survivors provided with services:
  - Of 32,322 cases, more than Two Thirds were women & Girls
  - Psychological Violence was the most common. (> 50%)
  - Beneficiaries of GBV/VAW services have Doubled since year 2020

VAW / GBV Cases - 2022				
	Female	**Male**	**Total**	**% female**
Physical Violence	3,965	1,736	5,701	70%
Psychological Violence	11,852	4,610	16,462	72%
Economic Violence	5,793	3,993	9,786	59%
Sexual Violence	260	113	373	70%
Total	**21,870**	**10,452**	**32,322**	**68%**

Challenges

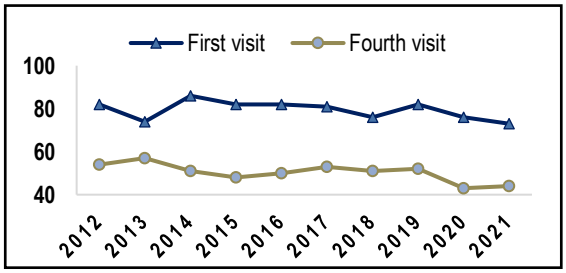
- Limited number of planned Services :
  - OSACs (20) would mean that ONLY One center per governorate (DOH), which would constitute a major challenge for GBV survivors;
  - CMR centers (8) would mean that several Governorates would not have such crucial services.
- Detection and Referral to OSACs is limited to Main PHCs (PHC-cub-centers Not included), which would limit beneficiaries that are frequenting PHC-Subcenters
- Behavior change efforts are conducted within health facilities, with limited involvement of other relevant sectors

3.2 Child Health services

3.2.1 Breastfeeding

- Breastfeeding practices are suboptimal in many parts of Iraq: Only 32% of newborn start breastfeeding early & 26% breastfeed exclusively for 6 months. .
- In Iraq, exclusive breastfeeding is the most popular breastfeeding method for infants under 6 months

MICS surveys	2011	2018
Early initiation breast feeding	42 %	32 %
Exclusive Breast-feeding (First 6 months)	19,6 %	26 %



3.2.2 Infant Visits

- As per MoH's Annual statistical reports, percentage of infants receiving 1st & 4th visits are declining since 2012 (from 83% & 54%) to reached 73% and 43% (in 2021) for 1st & 4th visits respectively.

3.2.3 Immunization Coverage

MoH's Annual Statistical reports (2018- 2021) shows that:

- Vaccination coverage has improved at different degrees, particularly 1st doses of Polio and DPT.
- Some Vaccines stagnated or even dropped, such as Measles that dropped by 10 percent points
- There is significant drop-out (Discontinuation) of 11 percent points between 1st & 3rd dose of Polio & DPT

Vaccine	MoH's Statistical Report				MICS survey	
	2018	2019	2020	2021	2011	2018
BCG	94	97	98	94	92	94,3
Polio 1	79	94	93	88	90	87,5
Polio 3	72	85	78	77	69	69,1
DPT 1	79	93	90	89	85	84,5
DPT 3	72	84	74	78	63	64,3
Measles	84	82	76	75	75	65,6
Hep B	84	89	90	88	89	74,4

Fully Vaccinated Children (at 12 & 23 months: As per MoH's rules, a child during his / her first year of life should have: 1 BCG dose, 3 DPT doses, 4 Polio doses, 3 Hep-B, & 1 Measles dose, and 1 MMR vaccine at age of 15 months

Between 2011 & 2018, Data of MICS surveys shows that:

- Fully vaccinated children (12 & 23 months) dropped by 20%
- This drop varies among different social determinants

MICS surveys	2011	2018
National	58 %	47%
Primary education	46 %	44%
Upper secondary	69 %	59%
Urban	64 %	51%
Rural	46 %	38%

3.2.4 Growth Monitoring

National surveys, between 2011 & 2018, in urban & rural areas of 18 governorates, showed the following:

- a gradual decline of under nutrition indicators for children under five years;
- an emergence of overweight and obesity.

3.2.5 Vitamin A Supplements

Year	2017	2018	2019	2020	2021
% given Vit A	80 %	76 %	78 %	63 %	67 %

- Based on MoH's Statistical reports, Percentage of children receiving "Vit. A supplementation" has declined by around 18 % (from 80% in 2017 to 67% in 2021)

3.2.6 Management of Child Illnesses

As per MICS surveys (2011 & 2018), Incidence of diarrhea & Acute Resp. Infection "ARI" (during last 2 weeks before survey) has decreased.

Meanwhile, the use of private sector is increasing.

Diarrhoea		2011	2018	Acute Resp. Infection		2011	2018
Incidence		15 %	13 %	Incidence		10 %	--
Help Seeking	Public sector	--	26 %	Help Seeking	Public sector	47 %	19 %
	Private sector	--	34 %		Private sector	44 %	37 %
ORS / ORT Received		23 %	25 %	Antibiotic Received		67 %	40 %
				Antibiotic Source	Public sector	--	28 %
					Private sector	--	75 %

3.3 School & Adolescents Health services

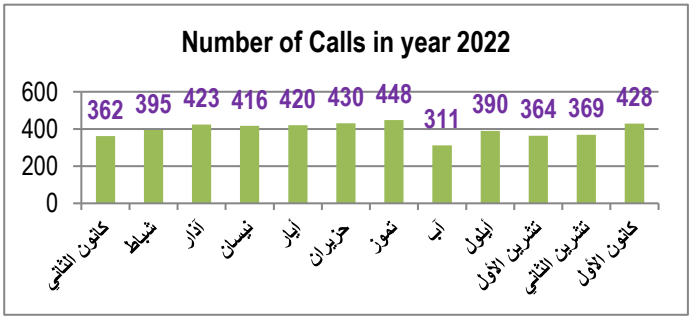
- In 2010, an experimental program was initiated in (15) health centers in 4 governorates, with UNFPA support. However, the programme was interrupted due to several challenges.
- In 2017, the program was re-designed with WHO support, and a training package on Adolescents health was developed based on WHO Guidelines, covering adolescents' relevant healthtopics.
- As of 2020, with WHO & UNFPA support, the program was integrated into 55 Main PHC centers in 8 Governorates, which were expanded to 63 health centers in 15 Governorates in 2022
- Within this context, 781 Health staff were trained, & and 817 School Health Coordinators & teachers

Beneficiaries		9,738			
	Adol. Clients	%		Adol. Clients	%
Sex & Age	Female	54%	Frequency	1st Visit	94%
	10-14 years	48%		Follow up Visit	3%
	15-19 years	52%			
	Male	47%	Motif	Curative	48%
	10-14 years	45%		Counseling	27%
	15-19 years	54%		Smokers	8%
Category	Students	88%		Alcohol Use	1%
	Working & Other	8%		Drugs Use	1%
	Married Adol.	4%		Referral	1%

Analysis of Adolescents Clients (year 2022)

- Almost Equal utilization by Sex or Age group
- Clients are mainly "Students" !!
- Very few "Follow Up" visits !!
- Minimal Referral to 2ry level !!!
- # of Clients / Center ➔ ~ 170 clients / year
  ➔ ***< FOUR Clients / Week / Center***

- **Helpline:** Concurrently to setting "Adolescent Units" at main PHCs, a ***"Helpline" (080000111)*** was launched with UNFPA support, through communication networks (Asiacell, Zain & Korek). It aims to provide health advice to adolescents & parents. Service is provided by trained health staff in weekdays except Friday
- During 2021, several posters & promotional materials were developed and disseminated among adolescents.



In 2022 : 4,756 calls ➔ ~ 400 calls / month ➔ Less than 18 Calls / Day !!!

SWOT Analysis of WCAH Programme Delivery

Based on WHO's "6 Building Blocks for Health System"

Introduction

Historically, the health care delivery system in Iraq had been a "Hospital-oriented" and "Capital-intensive" model with less emphasis on preventive measures.

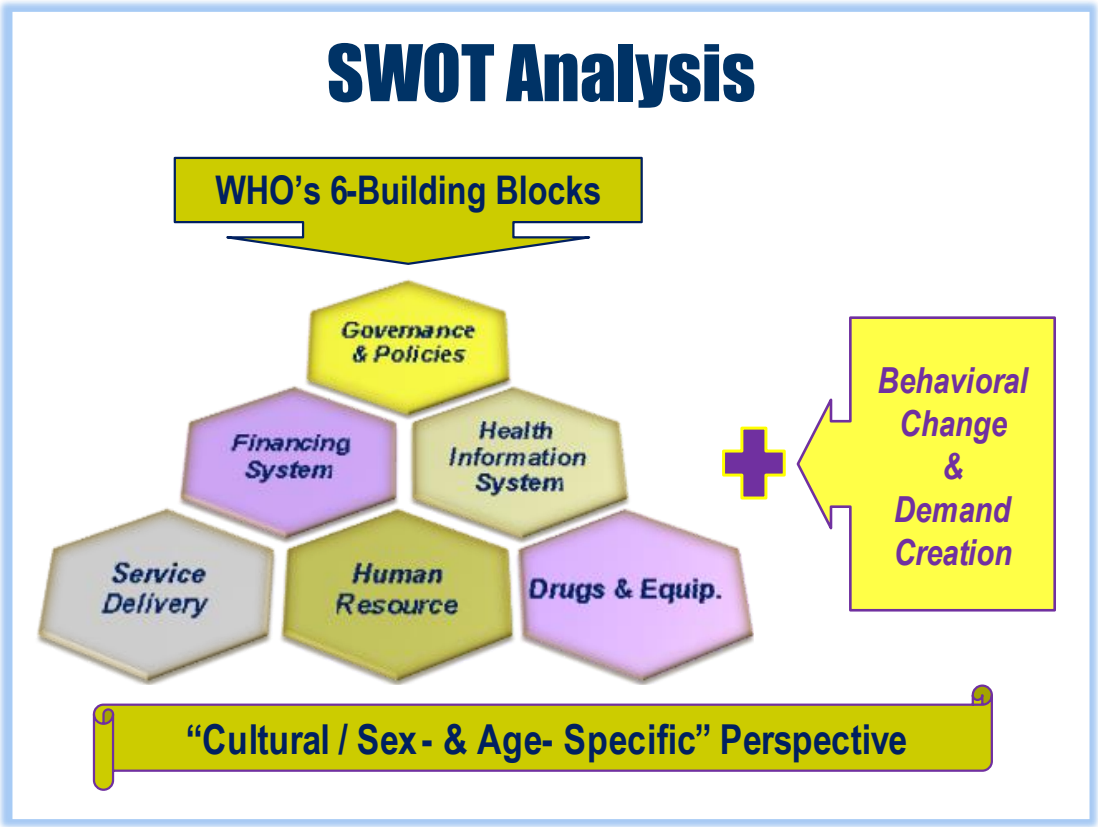
Since early seventies of the last century, Health of Iraqi citizens started to improve, when the country adopted an advanced health system and a comprehensive basic healthcare network.

Meanwhile, war and crisis has halted the improvement of health system. During the last 10 years, Iraq faced unprecedented complex security, humanitarian, and fiscal challenges while it was still recovering from long periods of conflict and political turmoil. These challenges encompass improving access to quality health services by transforming the hospital-oriented system to a PHC model, overcoming recurring shortages of essential medicines, dealing with budget deficits, and rehabilitation of infrastructure, training, and deployment of human resources.

Moreover, modernization of Public Health sector, including the effective and adequate delivery of WCAH services, should also encompass addressing integrated sector governance and its implementation in terms of provision of services and effective management of the country's resources remain major sector priorities. Within this context, for adequate analysis of challenges affecting "Availability/ Accessibility/ Utilization" of WCAH services, the following causal analysis will use WHO's 6-Building Blocks for strengthening health systems, namely:

1. Governance / Coordination
2. Health Care Financing
3. Service Delivery
4. Health Workforce (Human Resources)
5. Health Technologies & Pharmaceuticals
6. Health Information System

In addition to these "6 Building Blocks", the SWOT Analysis will include a Seventh Dimension : "Behavioral change & Demand Dimension".



1 Health Governance System

Governance is the highest of the 6 pillars of any health system. Without some form of governance, the other pillars would operate within silos rather than within a well-managed and "governed" system. "Governance" includes: a) policies, regulation & Planning processes; b) Monitoring Process ; c) Coordination mechanism & Process.

Building on lessons learned of the final review of previous WCAH Strategy (2016 – 2022) (see Page 35), the following is a SWOT analysis of the "Governance" Pillar

1.1 Strength

a) Policy, Strategies & Planning processes:

- National Health Policy is moving towards "Universal Health Coverage" & Strengthening PHC system.
- During last ten years, the Iraqi MoH approved several strategies related to maternal and child health.
- MoH's commitment to decentralization to facilitate management, & monitoring of programmes & services.

b) Monitoring Implementation Process

- Sub-national health authorities (in 19 governorates) are main implementers of all strategies,

c) Coordination Mechanism & Process

- Existence of Intra-sectoral & Inter-sectoral Coordination Committees

1.2 Weakness

a) Policy, Strategies & Planning Process

- Some legal frameworks need review to be more favorable for PHC system and WCAH issues
- Existence of more than 15 "Vertical" Strategies & Action Plans, within a "Limited Resources" context !!
- Detailed / costed WCAH 3-year Action Plan was not reviewed or updated at Yearly-basis.

b) Monitoring Implementation Process

- Limited coordination between PHC system & the Curative System (2ry & 3ry Hospitals
- Unclear Monitoring System and Lack of Standard Reporting Format / Tools (Annual & Semi-Annual)
- Lack of Semi-Annual or Annual Progress reports produced by central or DoHs Levels

c) Coordination Mechanism & Process

- Unclear Operational modalities of Coordination mechanism (membership, functions, periodicity, ……..)
- High Turnover of Programme managers, particularly at DoH and Health sectors,
- Multiplicity of Stakeholders, with Overlapping mandates (Culture of Departmentalism)

1.3 Opportunity

a) Policy, Strategies & Planning Processes

- Commitment of Government & MoH for a decentralized Planning & Implementation
- MoH's current efforts for a National Humanitarian Preparedness and Response plan
- Significant Support by UN agencies and other Bi-lateral donors

b) Monitoring Implementation Process

- Monitoring process of "National Health Policy", as well as "Medicines Policy"

c) Coordination Mechanism & Process

- Existing Coordination Mechanism for "Health Insurance Initiative"

1.4 Threat / Risks

d) Policy, Strategies & Planning Process

- Wide Institutional organogram at central & DoH levels, creating challenges for planning & management

e) Monitoring Implementation Process

- Donors favoring Vertical programming & reporting

f) Coordination Mechanism & Process

- Multiplicity of agendas by Stakeholders and Donors, including UN agencies
- Limited Coordination with Private sector, professional Associations and National NGOs
- Existing "Culture of Departmentalism" could jeopardise future efforts.

2 Health Financing System

Health Financing Indicators

Based on MoH's Statistical reports 2017-2021, government's budget varied over years. Health budget has "Doubled" between 2017 & 2021, reaching around 7% of the total government budget. "Per capita health allocations" increased by 75% between 2017 & 2021

	2017	2018	2019	2020	2021
Gov. budget (Billions IqD)	100,671	104,158	133,107	76,082	102,849
Health Budget (Billions IqD	3,834	4,302	6,306	5,757	7,485
% Health budget	**3.8 %**	**4.1 %**	**4.7 %**	**7.6 %**	**7 %**
% Capital Budget	1.1 %	1.5 %	4.4 %	1.8 %	2 %
Health Exp. / Capita (IqD)	120,000	112,859	187,247	166,607	211,126

Recurrent Categories of MoH budget

The largest share of health funding goes towards employee salaries & purchase of commodities. Budget for PH programs remains limited (~ 1% of health budget, knowing that this budget is then divided among 12-15 health programs..

The increase in funding for PH programs in 2021 is mainly due to COVID-19 crisis.

Item	2017	2018	2019	2020	2021
Employees' Salaries	72%	70.5%	58.5%	65,3%	60,6%
Services	2.2%	2.1%	1.3%	1,6%	1,3%
Commodities	22%	24.7%	28.7%	28,9%	21,7%
Maintenance	1.6%	1.4%	4.5%	1,5%	1,6%
Health programs	***1.2%***	***0.7%***	***1.1%***	***0,7%***	***12,5%***
Non-monetary	0.4%	0.4%	5.9%	2,1%	2,6%
Other expenditures	0.13%	0.1%	0.1%	0,01%	0,04%
Contributions	0.3%	0.1%	0.03%	0,01%	0,01%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**

Projects & Financial expenditures

As per the 2017 Statistical Report, the budget execution rate is low, indicating some structural factors impacting on budget management. These may include cumbersome administrative procedures, slow transfer of funds, non-optimized sharing of responsibilities, etc.

in billion IqD	2017
Annual allocation	292.7
Expenditure for year-1	91
Spent	89.5
Operational installment	1.6
% of financial expenditure	**31%**
Large differences among DOHs	

Challenges facing Iraq Health sector Financing system

Based on report of World bank group [7], the following could be concluded :

- Budget decentralization process was poorly executed with several constraints, including DoH capacity to fulfill their roles;
- There is a persistent under-execution of the investment budget, which is likely related to fiscal rigidities limiting managers' flexibility in adjusting budgets in short term, and weak public financial management capacity.
- Iraq suffers from weak financial management capacity at all stages of budget formulation and execution, as well as lack of a medium-term expenditure framework.
- Iraq could engage actions including rethinking decentralization, improving fund flexibility, strengthening public financial management, emphasizing PHC service delivery, institutionalize health package efficiency analyses).

Out of Pocket Health Expenditure [8]

- Recent WHO updates (2018) indicate that out-of-pocket expenditure is 78.5% (this was 46% in 2012.
- As per MoH's data, "Out-Of-Pocket Health expenditure has "Doubled" between 2012 (25%) & 2019 (~ 51%).
- Out-of-Pocket spending remains high, which is mainly due to lack of "Health Insurance or "Prepaid schemes",
- Main Components of "Out-of-Pocket" are
  - Costs of private sector (where costs increases from year to year.
  - While hospital services are "Free" in public facilities, many patients have to buy medicines due to stock-outs

[7] "Addressing Human Capital Crisis: A Public Expenditure Review for Human Dev. Sectors in Iraq"

[8] "Addressing Human Capital Crisis – a Public Expenditure Review for Human Dev. sectors in Iraq" World Bank 2020"

SWOT Analysis

2.1 Strengths

A. Budget Setting

- Budgets allocated to "Min. of Health/" are increasing.
- MOH is gradually moving from "Items Budget Policy" to "Programs and Performance budget" policy.

B. Budget Execution

- Cost Accounting with costing for program budgeting is implemented.

2.2 Weaknesses

A. **Budget Setting**

- Low health budget for "Preventive Public Health programmes"
- Competition & defragmented allocation among PH programs
- Inequitable Budget allocation among DoHs ➔ "Population Dispersion" weakly considered.

B. **Budget Execution**

- Low health budget execution rate due to unclear Financial execution SOPs & weak capacities of managers (central & Local level)
- Rigidity & non-flexibility of budget execution SOPs (by Min. of Finance)
- Lack of Financial execution reporting for costed action Plan
- Limited involvement of program managers and other partners

2.3 Opportunities

A. Budget Setting

- "Client-Centered" & "Decentralized Annual Planning" would favor Mobilization of Non-Cash funding from other Ministries & Partners
- Current MoH's Efforts for "Health Insurance System" & "Health Financing regulations"

B. Budget Execution

- Implementation of "Cost Accounting" (Nat. Health Account) would enhance resource allocation and improve efficiency.
- Decentralization is an opportunity to adapt health budgets to local realities/ needs, and to mobilize resources (cash & Non-cash contribution) from local partners
- Annual action plans are better for budget management & mobilizing support from partner & UN agencies.

2.4 Threats / Risks

A. **Budget Setting**

- Limited available resources & Competition among programmes
- Centralized planning and Budget allocation processes
- Donors' funding is Favoring specific "Vertical Programmes"

B. **Budget Execution**

- Rigidity & non-flexibility of budget executions SOPs (by MoF)

3 Health Information System (Statistic / Surveillance / Surveys / Research

Improving the collection, processing, analysis, dissemination of health information WCAH is a key step to achieving better health outcomes in Iraq. A comprehensive assessment of Iraq's health information system was undertaken in 2019 at request of Ministry of Health and Environment.

1.1 Strengths

- Existence of a national health and vital statistics department in Dir. of Planning & Resource Dev.
- Current Iraq HIS is well developed, & Iraq MoH is in process of a new HIS to improve quality of data.
- % of core health indicators reported to WHO increased from 71% in 2014 to 78% in 2018.
- Access to health information is secured through online and new technologies.
- Presence of reporting system from Health facilities, including data collection tools & Integrated monthly report to Health district, DOH and Central levels.
- MoH statistical reports are published annually, with various tabulations of majority of WCAH services
- Existence of several Dashboards, such as EmONC / PHC centers / Health Human Resources Dashboards
- MDSR is implemented since 2012, and PNDSR is newly initiated 3 years ago

3.2 Weaknesses

- Data of PH programmes operate concurrently with a vertical information system, and fragmented approach.
- Paper-based Data collection tools (registries), with risk of Transfer of Data from registries
- Descriptive Statistic reports with limited in-depth analysis / tabulations (central & DoH levels)
- Lack of institutional collaboration among different directorates & departments (even among units of same department), leading to duplication of data collection at facility level ;
- Lack of standardization of data to be shared with other departments.
- Lack of regular analysis & reporting on progress towards national & global targets.
- "Equity" not reflected in tabulations of Statistical reports (no Data disaggregation by SDP types & levels)
- HIS across all its components fulfils only about 24% of attributes of a functional HIS
- Lack of regular and independent data quality assessments.
- Annual statistical reports are published a year after the reporting year,
- Household surveys are irregular, limiting effective monitoring of key health-related indicators.
- MDSR & PNDSR :
  - Mainly managed by RMNCA Dep., with limited involvement of Curative dep. /DoTA
  - Serious operational challenges at facility and DoH levels, exacerbated by irregular data auditing.
  - Wide variation among DoHs regarding MDSR & PNDSR implementation: a) Poor Inpatient file record; b) Biased classification of cause of deaths at death certificate; c) Poor commitment of Health Providers

3.3 Opportunity

- Iraqi MoH prioritized strengthening routine system for data collection in WCAH components
- Current piloting of DHIS2
- Current Initiative of sharing data between Stat. dep & DGPH
- HIS could benefit from new technologies.
- Availability of HIS assessment conducted by MOH
- National Surveys conducted by MoP with UN agencies and MoH

3.4 Threats

- Lack of national strategy for e-health, and delay in implementing a web-based (DHIS-2).
- Data security measures
- Resistance by vertical programmes, exacerbated by limited funding
- Lack of technical expertise could hinder the successful implementation.
- Poor internet connection at all levels DOH, District and HFs
- Cost implementation for scaling-up DHIS2, and use other IT technologies

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4 Health Service Delivery System

Definition & Characteristics

Services are designed so that all people are covered with "Equitable" & "Quality" services, across the life course & continuum of care, for healthy & sick groups, without financial hardship ..... (UHC context)

1. **Client – Centered Package:**
   - ✓ Comprehensiveness ➔ Promotive, Preventive, & Curative,
   - ✓ integrated within Continuum of Care (along Life Cycle)
   - ✓ Right-based (respect and dignity) with Positive Experience of care (Acceptability & Convenience to Clients)
2. **Quality Basic Essential Health:**
   - ✓ Given in a timely fashion
   - ✓ Provided at different levels of health care system
   - ✓ Functional Referral pathways (whenever necessary
3. **Equitable Accessibility**: ➔ Geographic, Gender & Age specific, with Minimal Financial Barrier

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WCAH-related services in "Basic Health Service Package" ➔ at PHC system

WCAH Services		Main PHC	Sub-Center		Health Houses
			Physician	Paramedic	
ANC	Pregnancy Diagnosis & Test	Yes	Yes	Yes	No
	Basic Exam	Yes	Yes	Yes	No
	Detection of Risk Pregnancy	Yes	Yes	Yes /Refer	Yes/ Refer
	Anti-Tetanus & Ferro Folic	Yes	Yes	Yes	No
PNC	Basic exam	Yes	Yes	Yes	None
	Detect complications	Yes	Yes	Yes/ Refer	Yes/ Refer
FP	Services & Counseling	All	All	All	None
	Commodities	All	(No IUD)	Condom	Condom
Delivery Ass.	Only PHC / Delivery Room	~ 125	No	No	No
Infant & Child	Growth Monitoring	Yes	Yes	Yes	Yes
	Vaccination **(See below)**	Yes	Yes	No	No
	IMCI (ORS & Zinc)	Yes	Yes	Yes	Yes
	Nutrition / Vit A	Yes	Yes	Yes	No
Vaccination	**(See above)**	Yes	Yes	Yes	No
Nutrition	Growth Monitoring	Yes	Yes	Yes	No
	Vit A & Ferro-Folic (***See below)***	Yes	Yes	No	No
School Health	Basic Package	Yes	Yes	Limited	No
Laboratory Tests	Pregnancy Test	Yes	Yes		No
	Hemoglobin	Yes	Yes		No
	Blood Group / Rhesus	Yes	Yes		No
	Blood Glucose	Yes	Yes		No
	Albumin in Urine	??	??		??
	HIV Test for pregnant women	Few	No		No
Medicines	Ferro Folic / Vit A (***see above)***	Yes	No ?		No
	FP Commodities (***see above)***	Yes	No ?		No
	Other Curative medicines	Yes	??		No
Equipment	Basic Equipment	Yes	Reduced	7 Basic	7 Basic
	Glucometer	Yes	Yes	Yes	Yes
	Sonic Aid	Yes	Yes	No ?	No
	SONAR	Few	No	No	No
Few Main Centers	HIV Test for pregnant women	➔ Only in Centers with HIV VTC centers			
	SONAR	➔ Only in "Family Health Center"			

Guideline covers several aspects of Services

- Basic Services to be provided.
- Minimum Equipment
- Medicines
- Laboratory Testing

Minimum Staffing / PHC Categories ➔ Not Addressed

Basic services

- Some Basic services are ONLY available at Main PHC (HIV testing of Pregnant women / Breast Cancer Screening / GBV Detection & Referral)
- Child Vaccination are offered in ALL PHC/Sub-centers & Health Houses ?

Basic Laboratory Tests

- Majority of WCAH testing are available at Main PHCs & PHC / SC (is it True?)
- No difference between PHC/SC run by Doctor & PHC/SC run by Paramedics.
- HIV testing of Pregnant women is limited to few "Main PHCs" ➔ via VTC centers

Medicines

- While ANC & FP services are available at PHC-SC (run by Doctor or Paramedics), related Basic Medicines are NOT available / provided (Vit A / Ferro-Folic, & FP Commodities (Pills, injectables or IUD)

Equipment

- List of Basic equipment : Same list for "PHC/SC with Paramedics" & "Heath Houses"
- Sonic Aid ➔ Not available at PHC-SC with Paramedic ➔ Rational ?
- SONAR ➔ ONLY at Family Health centers ➔ Rational ?

Health Houses ➔ WCAH service package is VERY Limited :

- Child health ➔ ONLY Growth Monitoring & IMCI
- Health Education / counseling for Women / Child & Adolescents
- WCAH Medicines ➔ None is available (Neither Preventive Nor Curative)

Trend of Health Delivery System in Iraq (2017 – 2021)

Overall Increase of Total Health Facilities

By around 8 to 13 %

Health Infrastructure	2017	2019	2021
Main PHC centers	1.295	1.353	1.367
PHCs / Sub-centers	1.363	1.455	1.326
Total PHCs (Main & SCs)	**2.658**	**2.808**	**2.693**
PHC run by Physicians	1.221	1.181	1.272
Family Medicine centers	117	118	197
PHC offering FP services	554	719	778
PHC with Delivery room	120 to 125		
Health Houses	502	553	580
Public Clinics	314	297	358
Health Insurance Clinics	254	196	207
General Hospital	161	162	174
Teaching Hospitals	77	80	78

Trend of Outpatients (2017 to 2022) of "PHC system"

- Outpatients at PHC System decreased from 49% to 45% of ALL Outpatients of Iraq Health System
- 2ry & 3ry level facilities are overwhelmed with Out-patients (46% of Total Outpatient

Under Utilization of PHC Services

Average Outpatients / PHC facility ➔ merely 206 / week.

(40 users / working day / PHC)

South Central Iraq	2017		2022	
Health Infrastructure	# of HFs	# of Outpatients	# of HFs	# of Outpatients
ALL PHC Facilities	**2,348**	**24,187,297**	**2405**	**25,790,645**
Public Clinics	314	2,594,834	326	2,664,528
Health Insurance Clinics	254	486,852	217	486,509
ALL 2ry & 3ry level	**273**	**20,870,440**	**312**	**26,202,827**
Specialized Centers		1,418,845		1,509,874
Total Out-Patients		**49,558,268**		**56,654,383**
% Outpatients at PHC centers		***49 %***		***45 %***
% Outpatients (2ry & 3ry system		***42 %***		***46 %***

A) Maternal & Women RH service

a) Maternal Care Ante-Natal & Post Natal Care

Coverage of ANC & PNC:

As per data of MOH's Annual Statistical report

Maternal Care	2017	2019	2021
% ANC - 1st Visit	56 %	56 %	45 %
% ANC - 4th Visit	35 %	39 %	23 %
% "ONE" PNC visit	53 %	49 %	41 %

- ***ANC :*** Between 2017 & 2021, Coverage of ANC care by PHC system has significantly decreased, by more than 20%
- ***PNC :*** PNC visits coverage decreased from 53% in 2017 to 41% in 2021.

As per existing surveys (MICS & I-WISH),

- ✓ PNC visits significantly decreased from 38% in 2011 to 20% in 2018

At least ONE PNC visit	I-WISH 1 (2011)	MICS 6 (2018)
Iraq	38 %	20 %

Source / Place of ANC & PNC :

As per I-WISH surveys,

- ANC coverage by PHC system had decreased from 31% in 2011 to around 17% pregnant women in 2021.
- PNC services at PHC system are weakly used (10% of all New Mothers), while Government Hospitals provide 32% of all PNC clients ➔ ***TRIPLE coverage of PHC system***).

ANC Source	I-WISH 1		I-WISH 2	
PHC centers	31 %	44%	17 %	38%
Gov. Hospitals	13 %		17 %	
Public Clinic	---		4 %	
Private Clinic	53 %	55%	57 %	62%
NGO Clinic	3 %		5 %	
Other	1 %	1	0 %	

> Up 62 % of Pregnant Women get ANC or PNC services from Private sector !!!

PNC Source	I-WISH 2 (2021)	
PHC centers	10 %	45 %
Gov. Hospitals	32 %	
Public Clinics	3 %	
Private Clinic	46 %	55 %
NGO Clinic	8 %	
Other	1 %	

b) Emergency Obstetric & Neo-Natal Care Service

Delivery in Public sector (hospitals & selected PHC) decreased from 86 % in 2017 to 78 % in 2021 ➔ ***a 9% decrease)***

	Em. Obstetric / Neo-Natal Care		
	Public Hosp	Private Hosp	PHC
2017	82,5 %	14,3 %	3,2 %
2019	80.0 %	19,8	0,2 %
2021	76,9 %	21,6	1,5 %

➢ Trend of Caesarian Section (CS)

As per MoH's Statistical reports, Delivery by CS gradually increased from 33% in 2011 to 41% in 2021

- ○ CS in Public facilities increased from 28 % (2011) to 35% in 2021

WHO recommend that Caesarian Section should be up to 15%

	Public	Private	Total
2011	28 %	80 %	33 %
2017	34 %	89 %	35 %
2019	34 %	86 %	36 %
2021	35 %	81 %	41 %

- **Basic EmONC at PHC centers**

Around 125 Main PHC centers were equipped with staffing, equipment & supplies to deliver Basic EmONC services. However, number of deliveries is very limited, and decreasing from 3% in 2011 to merely 1% of All Institutional deliveries.

Significant variations exist among governorates. Highest is in Thi-Qar, reaching 9% in 2017.

Causes could be attributed to current regulations & restrictions governing these facilities.

South & Central Iraq		All Births in HFs	at PHC	%	Birth / Week /HF
2017	All Iraq	889,659	14,465	1.6%	2.1 / wk
	Thi-Qar	63,091	5,658	9.0%	
2019	All Iraq	909,605	9,533	1.0%	1.4 / Wk
	Thi-Qar	59,731	4,308	7.2%	
2021	All Iraq	911,414	11,162	1.2%	1.7 / Wk
	Thi-Qar	57,251	3,434	6.0%	
2022	All Iraq	903,016	10,244	1.1%	1.5 / Wk
	Thi-Qar	58,660	2,962	5.0%	

27 Cases could NOT be delivered at PHC Delivery Room ("Guidelines on Nursing Functions" ➔ P 49)

c) Family Planning services

➢ FP Service Delivery in Public Health Network

- Offer of FP services in Iraqi Health network increased from 552 Health facilities in 2017 to 778 HFs in 2021.

	2017	2019	2021
HFs Offering FP services	552	719	778
Total Main PHC & Sub-Center	2,136	2,132	2,244
% of HFs offering FP	26 %	34 %	35 %

ONE Third (35%) of PHCs (Main & Sub-centers) to deliver FP services &

➢ Source of Modern FP Services/ Methods

- I-WISH surveys showed that Private sector is the main source of FP services & products (up to 90% in 2021), while the entire Public Sector provides services to merely 10% of all FP users.
- In 2021, PHC centers provide FP to merely 3% of all FP users, while Public Hospitals provide for 5%

Source of FP	I-WISH 1		I-WISH 2	
PHC centers	5 %	15%	3 %	10%
Gov. Hospital	8 %		5 %	
Public Clinic	2 %		2 %	
Private Clinic	44 %	85%	33 %	90%
Pharmacy	33 %		55 %	
NGO Clinics	3 %		2 %	
Other	5 %		<1 %	

d) RH-related Cancer ➔ (Breast cancer)

- By 2022, 49 Specialized clinics were established, mainly in Main hospitals of 19 DoHs, with 72 Breast Screening equipment (ONE Third in Baghdad!!). In 2022, around 158,748 women were examined
- **Challenges**
  - Programme is mainly "Hospital Based", leading to accessibility challenges for peripheral and rural women.
  - Lack of Community-based Screening interventions at PHC level (Breast palpation, referral services

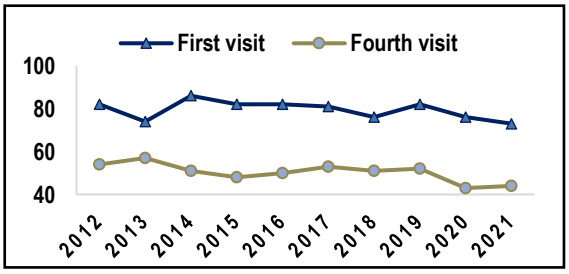
e) Services for GBV Survivors

- By end of 2022, the following Services were established :
  - 2 OSAC centers established in 2 Main PHCs in Kirkuk & Ninewa,
  - 2 CMR centers are being setup in 2 Hospitals (Baghdad & Kirkuk)
  - 44 Main PHCs integrated referral services for GBV survivors.
  - Merely 32,322 cases were provided necessary services (Two Thirds were women & girls)
- **Challenges :** Limited number of GBV services, and Detection/Referral is limited to Main PHCs

B) Child Health services

a) Infant Visits (Growth Monitoring)

As per MoH's Statistical reports, % of infants receiving 1st & 4th visits had declined since 2012 (from 83% & 54%) to reach 73% and 43% (in 2021) for 1st & 4th visits respectively



b) Fully Vaccinated Children (12 & 23 months

Between 2011 & 2018, Data of MICS surveys shows that:

- Fully vaccinated children (12 & 23 months) dropped by 20% .
- This drop varies among different socio-economic determinants

MICS	2011	2018
National	58 %	47%
Poorest	45 %	32%
Richest	67 %	63%
Urban	64 %	51%
Rural	46 %	38%

c) Vitamin A Supplements

Based on MoH's Statistical reports, Percentage of children receiving "Vit. A supplement" has declined from 80% in 2017 to 67% in 2021 ➔ 18% decrease!!

Year	2017	2018	2019	2020	2021
% given Vit A	80 %	76 %	78 %	63 %	

d) Management of Child Illnesses

As per MICS surveys (2011 & 2018), The Incidence rates of diarrhea & Acute Respiratory Infection "ARI" has decreased.

Acute Resp. Infection		2011	2018
Help Seeking	Public sector	47 %	19 %
	Private sector	44 %	37 %
Antibiotic Received		67 %	40 %

C) Adolescents Health services

As of 2020, the program was integrated into 63 PHC centers in 15 Governorates (except KRG).

Adolescents Units Statistics (year 2022)

- Almost Equal utilization by Sex or Age group
- Clients are mainly "Students" !!
- Very few "Follow Up" visits !!
- Minimal Referral to 2ry level !!!
- # of Clients / Center ➔~ 170 clients / year ➔ ***< FOUR Clients / Week / Center***

SWOT Analysis

Based on the above, SWOT Analysis will be structured around Two main Topics:

1) Service Delivery Package & Delivery Modality
2) Supervision & Quality Monitoring of WCAH services

4.1 Strength

1. Service Delivery Package & Delivery Modality

- ✓ National Health Policy reflects MoH's Commitment to strengthen PHC system, and ensure availability of WCAH services at different health system levels
- ✓ Existence of wide health network, including PHCCs , hospitals, public clinics & health insurance clinics
- ✓ Presence of Several Guidelines including : a) Detailed Guideline on "Basic Health Service Package" at PHC system; b) Clinical WCAH Protocols, including SOPs and effective Referral System

2. Supervision & Quality Monitoring

- ✓ Existence of Supportive Supervision system & plans at all levels, with qualified supervisors
- ✓ Existence of supervision tools and checklists
- ✓ Existence of quality improvement structure at central & DoH levels (Technical & Administrative)

4.2 Weaknesses

1. Service Package & Delivery modality

- ✓ Vertical program implementation / Delivery at PHC centers ➔ Non-client centered
- ✓ Complex WCAH service delivery Modality, by type of health facility (main PHCC, PHC/SC, H. Post)
- ✓ Poor infrastructure with Limited equipment & supplies, leading to serious challenges for compliance with technical guidelines & protocols, particularly in peripheral & rural Zones.
- ✓ Complex SD modality (THREE different PHC levels) ➔ serious Inequity between Rural & Urban zones,
- ✓ Existence of Multiplicity & Non-friendly SOP at PHC centers ➔ Leading to serious barriers for clients
- ✓ Huge clients referral to 2ry HFs (at district & governorate levels) ➔ significant service discontinuity;
- ✓ Some of cost-effective interventions are only offered in Main PHCs or even hospital-Based (FP, Early detection of Breast Cancer, Detection/ referral of GBV survivors, ...
- ✓ Under-utilization of PHC service package, particularly at PHC/Sub-centers and Health Houses

2. Supervision & Quality of Care

- ✓ Fragmented supervision by different WCAH vertical programs & other dep. of PH Dir.
- ✓ Multiple tools & Plans & reporting systems for each level
- ✓ Paper- based supervision reporting systems, with limited feedback to SDPs
- ✓ Limited conduct of operational & quality of care research
- ✓ Limited support to Private sector (For-Profit & Non-Profit)

4.3 Opportunities

➢ **Service Package & Delivery modality**

- ✓ Wide network of "Public Clinics" and "Health Insurance clinics"
- ✓ Wide expansion private service network, reaching rural areas and villages.
- ✓ Presence of health services by other ministries (MOLSA's Juvenile centers / Min. of Justice's Prisons Health centers)
- ✓ Existence of other stakeholders at national & governorate levels (Medical & professional associations, Non-Profit Local associations & NGOs)

➢ **Supervision & Monitoring**

- ✓ Existence of University Research centers for independent Operational research

4.4 Threats

➢ **Service package & Delivery Modality**

- ✓ Predominance of Hospital-Based care model, with much focus on Curative services
- ✓ Resistance among different MoH stakeholders at central & DoH levels
- ✓ Donor driven funding with preference to vertical programs

➢ **Supervision & Monitoring**

- ✓ Resistance & competition among different stakeholders at central, & possibly at DoH levels

5 Health Human Resources System

Introduction

National Health Policy" (2013-23) ➔ ***"Human Resources are Backbone of Health Service Delivery***. As such, Ministry of Health will

a) Collaborate with MoHESR for Medical / Health Education programs
b) Oversee registration & re-certification.
c) Recruit & deploy of health workforce;
d) Review service conditions (salary, contracts, ….);
a) Strengthen professional associations.

1) Trend of Human Resources

Between 2017 & 2021 (South & central Iraq)

- MoH's Workforce reached 343,979 (increase of 49 %
- Physicians increased by 13%, and 50% were female;
- Nurses/ Midwives / Paramedics : Total number had almost "Doubled" (around 50% were female)

MoH Stat. Reports	2017	2022	% Increase	Female
Total Workforce	252,723	343,427	48 %	49%
Physicians	31,451	35,159	13 %	52 %
Nursing/Midwives	64,297	95,999	49 %	59 %
Paramedics	59,961	110,761	85 %	44 %

2) Human Resources at PHC system

(in South Central Iraq – 16 DoHs in 2021)

As per 2021 MoH's Statistical report:

- Only 1,072 PHCs (Main & SC) have doctors ➔ ONLY 54 % of All PHCs (out of 1,906 PHCs)
- Deployment of Physicians to PHC system is NOT limited to Main PHCs !!! Some are posted in PHC/SC & even at Health Posts
- Large disparity among governorates (94% in Baghdad & 21% in Wassit)

South – Central Iraq	PHC System			PHC with Doctor		Doctors at PHC system
	Main	S C	Total	#	%	
Baghdad	214	49	263	246	94 %	1,413
Basrah	97	47	134	60	44 %	374
Nineveh	105	101	206	134	68 %	552
Maysan	35	40	75	26	31 %	54
Al-Dewaniya	43	41	84	44	52 %	195
Diala	66	39	105	63	61 %	206
Al-Anbar	79	109	188	79	42 %	167
Babylon	50	74	124	61	50 %	296
Kerbela	36	27	63	39	62 %	278
Kirkuk	62	64	126	67	53 %	200
Wasit	47	34	81	17	21 %	182
Thi-Qar	83	85	168	81	47 %	151
Al-Muthanna	31	45	76	25	35 %	30
Salah El-Deen	62	60	122	54	42 %	172
Al-Najaf	51	30	81	27	33 %	211
Total SCI	**1,061**	**845**	**1,906**	**1,072**	**54 %**	**4,481**

As per UNICEF Facility survey (2019), Most of PHC system (Main & Sub-Centers), particularly in Rural and Peripheral zones, faces Shortage & High Turn-Over of skilled staff to provide WCAH package.

3) Trend of Nursing & Midwifery Workforce (2011 – 2021)

- Nurses & Midwives ➔ Doubled
- Nursing Profile ➔ Upgraded (Institutes/ Colleges

Qualified Nurses (above Sec. School) increased from **27 %** to **50 %** of all Nursing worksforce

Nurses & Midwives	Yr 2011	% of Total		Yr 2022	% of Total	
Bachelor holder nurses	2,441	5%	**27%**	13,969	15 %	50 %
Technical nurses (Institute)	10,268	20%		26,191	27 %	
Midwives	934	2%		7,894	8 %	
Skilled nurses (2ry School)	24,768	50%	**73%**	43,096	45 %	**50 %**
Ass. nurses (< 2ry school)	11,316	23%		4.773	5 %	
Total	**49,727**			**95,893**		

"Supply of More Health workers may NOT be as Effective as Better "Development & Management" of existing Human Resources

Determinants of Efficient "Development & Utilization" of Human Resources

1) **Policies, Functions & Tasks** : ➔ should consider / be based on:
   a. Level of Education (College / Institutes / Secondary level
   b. Knowledge & Skills acquired (Pre- & In-Service Training).
2) **Pre- Service Education / Training :**
   a. Academic curriculum
   b. Internship Period (Practicum) ➔ Rotation & Residency **(الإقامة و التدرج)**

3) **In-Service Training**
   a. Content : ➔ Right Mix of ***"Knowledge"*** & ***"Competency/ Skills"***
   b. Relevance ➔ Staff Pre-Service education & Current Functions & Tasks

4) **Management of Human Resources**
   a. Deployment / Distribution
   b. Retention / Motivation ➔ Particularly in PHC system

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1) HR Policies ➔ Functions & Tasks in PHC System

a. Nurses/Midwives ➔ limited to "Caring for wounds, provide injections & Administrative tasks
b. Para-medicals ➔ Counseling & Administrative tasks
c. Physicians ➔ Main provider of WCAH package

No Doctor ➔ No Services

Functions & Tasks of Nurses/ Midwives at PHC centers

Same set of "Functions /Tasks" for ALL Categories, irrespective to : a) Education level (College/ Institutes/Sec. school); b) Acquired Skills & Knowledge through "In-Service Training".

Consequences

1. RMNCA Package ➔ Partially/ Minimally delivered in 1400 PHC centers
2. 2ry Care level ➔ Overwhelmed by Unsatisfied Clients
3. Private Sector ➔ secure 50 to 85 % of RMNCA package
4. Nurses/Midwives ➔ Under-Utilized ➔ *Frustrated / Non-motivated to work in PHCs*
5. Physicians ➔ Overwhelmed ➔ *Low Quality of Care*

2) Pre- Service Training

- Training Institutions" ➔ increased 4 Folds.
- Medium & High-level Institutions ➔ 98%
- Phasing Out of "Sec. Nursing/ Midwifery Schools"

Training Institutions	2011	2017	2021
Medical Colleges	23	28	36
Nursing Colleges	??	16	41
Hlth Tech. Colleges	??	53	67
Hlth & Tech. Institutes	13	28	49
2ry Nursing Schools	8	59	2
2ry Midwifery School	??	18	1
Total	44	202	196

A) Pre-service Curricula

- Physicians ➔ Mainly "Curative Medicine"
  - Limited Skill-based PHC / Preventive Medicine
  - Limited communication /Counseling Skills
- Nurses / Midwives ➔ "Hospital-based" curricula
  - Fair content on Ob/Gyn & Pediatric Health
  - Limited / NO skills on R/MNCAH service, as well as communication /Counseling Skills
- Paramedic / "Public Health Workers":
  - Focused on Community Health, Counseling, health promotion, ……..

B) Pre-Service "Rotation / Residency"

B.1) Newly Graduated Physicians

- Length: 3 years for physicians, nurses & Midwives
- Deployment Law / Regulation
  - 1st year (Rotation" - إقامة دورية) ➔ in "Teaching or Selected Hospitals"
  - 2nd year (Graduation - تدرج) ➔ in Peripheral facilities ➔ mainly Hospitals
  - 3rd year "Senior Resident" (مقيم اقدم) ➔ Mainly hospitals ➔ to select Specialization
- Deployment decision: a) 1st Rotation year by DGP & DOHs ;
  b) 2nd & 3rd Rotation Year by relevant DOHs ?
- Orientation Course :
  - At start of 1st year ➔ 3 weeks ➔ By Dep. of PHC / DGPH & & relevant DoH ?
  - At start of 2nd year ➔ 1 week?? ➔ By ????

Very Few Graduate Physicians are Ever posted in PHCs

B.2) Newly Graduated Nurses / Midwives

- Length ➔ 3 years
- Deployment Process
  - 1st year ➔ in "Teaching or Large Hospitals"

- 2nd & 3rd year ➔ Peripheral facilities ➔ Mostly to District hospitals?

➢ Deployment Decision
- 1st Rotation year ➔ by …….???
- 2nd & 3rd Rotation Year ➔ by …….???

➢ Orientation Courses:
- At start of 1st year ➔ 3 weeks ➔ By Nursing Dep / Nat Training Center / DoHs ?
- At start of 2nd year ➔ 1 week ➔ By ????

3) In- Service Training

Yearly, thousands of "In-service Medical courses" are organized (centrally & DOHs) : > 3,000 in yr 2021

➢ Generic TOT courses ➔ "Nat. Training Center ➔ for DOHs' teams

➢ WCAH courses: ➔ supported by PH programmes (DGPH). Each Programme :
- Develop training package, with Short TOT component.
- Train trainers (Focal points at DoH & district levels)

Each DOH has several "Teams of Trainers"

4) Human Resources Management

1) Deployment & Distribution

		Yr 2017	Yr 2018	Yr 2019	Yr 2020	Yr 2021
توزيعات	أطباء التدرج	1,505	2,030	2,130	2,818	4,889
تعيينات	مقيم دوري	1,648	2,140	2,940	2,450	2,660
	كلية تمريض	1,279	1,275	1,413	1,663	2,215

➢ Despite a Large Recruitment/ Deployment process ➔ *Newly Graduate Physicians / Nurses are* ***rarely Posted in PHCs***

➢ As exposed earlier, and based on other reports, the following could be concluded :
- ONLY 25% of Total MoH's Human resources are assigned to PHC System (85,391 out of 343,979)
- While 4,118 physicians are deployed to PHC system, 45% of PHC centers remain without doctors
- ~ 22,400 Nurses (54% are Females) are posted in PHCs

South Central Iraq				
HR Categories	PHC center	Health Post	Health Sector	Total
Doctors	4,118	20	343	4,481
Female Nurse	11,879	144	516	12,539
Male Nurse	10,101	285	788	11,174
Med. Assistants	14,596	205	2,446	17,247
Bachelor Tech.	4,545	28	624	5,197
Bachelor Science	2,263	25	377	2,665
Laboratory Ass.	7,692	84	753	8,529
Admin. Staff	12,487	259	4,227	16,973
TOTAL	**85,391**	**1,133**	**11,933**	**98,457**

B) Motivation & Retention in PHC system

➢ **Newly Graduated Physicians :**
- Senior Residents are requested / expected to be posted in Hospitals (start Specialization)
- Monetary Allowance ➔ Only Physician posted in Hospitals.
- In-Service WCAH Training: ➔ New graduates NOT prioritized

➢ **Nurses & Midwives:**
- Allowances for working in PHC …….????

"HIGH Turnover" & "Short Retention" of New Graduates at PHC system

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SWOT Analysis

Strength

1. **Pre-Service Training:**
   - ➢ Increased Training Entities (~ 200 Public & Private entities), mainly colleges and Institutes)
   - ➢ Phasing out of "Secondary Nursing / Paramedical Training Entities
2. **In Service Training:**
   - ➢ "Nat. Center for Training & Human Dev. supports capacity building of trainers at all DoHs
3. **Policies, Management & Retention**
   - ➢ National Health Policy : High Commitment to all HRH categories
   - ➢ Existence of National Guidelines on Functions & Tasks of Nurses & Midwives (by Nursing Dep.)
   - ➢ Existence of Graduation Law (3-year Obligatory service) for physicians, Nurses & midwives
   - ➢ HR information system (2 Initiatives ➔ By HR Dep. & MCH dep.)

Weaknesses

1. **Pre-Service Training (Physician & Nurses)**
   - Academic Curricula: mainly Curative content, with Limited skills on RMNCA components.
   - Graduation / Internship period (3 years) (physicians / Nurses / Midwoves)
     - Mainly Hospital-Based, with Limited opportunities to gain RMNCA-related Skills;
     - At start 3rd Rotation year, new physicians are posted to hospitals to start specialization !!
2. **WCAH In-Service Training** ➔ *mainly Driven by Vertical PH Programmes*
   - Content: Not Client-centered / Large Focus on "Knowledge" / Risk of duplicated content
   - Trainers: Each PH programme has its own Trainers team (programme Focal Point)
     High Turnover of DOH trainers
     Limited coordination with "Nat. Center Training"
   - Beneficiaries: Physicians on Graduation period are rarely targeted
     High costs with High Turnover of trained Staff
     Paper based monitoring system with Risk Repetitive training of same beneficiaries.
3. **Policies, Management & Retention**
   - Current "Rotation/Residency" law (Graduated physicians, nurses/ midwives) create major Barrier for their deployment to PHC system during the entire 3-years Graduation period
   - Unclear Deployment criteria & system of new graduates to PHC system (after Rotation)
   - Existing Guidelines on "Functions & Tasks of Nurses/Midwives" face challenges:
     - ✓ Functions does NOT consider "Education level" (College / Institute / 2ry school)
     - ✓ Functions at PHC system shows weak role of nurses in delivering WCAH package.
   - Inequity of Staff Deployment between 1ry & 2ry Care System
   - Limited "Motivation" for physicians or nurses to be posted at PHCs (during or after Rotation period)
   - Limited utilization of Human Resource Dash-board by DoH managers
   - Limited research on satisfaction of physicians & nurses for working at PHC system

Opportunities

1. **Pre-Service Training**
   - Community Medicine Course in Pre-Service Curricula
   - Orientation courses for Newly graduated physicians, nurses & paramedics", at start of 1st year
   - Short training courses for new graduates after 1st year of Graduation
   - Existence of "Training Health centers" & "Family Health centers"
2. **In-Service Training**
   - Existence of Nat. Center for Training & Hum. Development
   - UN agencies support for TOTs & Cascade training (at DOH levels)
3. **Policies, Management & Retention**
   - Existence of "Guidelines of Functions of Nurses & Midwives" at Public facilities (1ry & 2ry)
   - Draft Revised Job-Description prepared (not yet approved)
   - Existence of HR Dash Board at HR Department
   - Thousands of new Graduates (physicians & Nurses) at yearly Basis
   - HR deployment decentralized to DoH level ?? (of Graduate

Threats / Risks

1. **In-Service Training**
   - Competition among Public Health programmes
   - Donors & UN agencies prioritizing Vertical programmes
2. **Policies, Management & Retention**
   - Preoccupation for "Private-Practices" (Mal-practices, ….
   - High focus on "Quality of Care" than "Equity & Access"
   - Pressure by Medical Syndicate & Medical professional Associations
   - Staff Satisfaction for Deployment & Working at PHC System Prioritization of 2ry Care & Curative System
   - External Lobby influencing Adequate deployment of Human resources

Achieving SDGs will not occur unless there is:
- ***Right mix of Health Workforce,***
- ***Skilled with the Right Skills***
- ***Deployed In the Right Place at the Right Time.***

Window of Hope:
Investing & Empowering Newly Graduated Physicians & Nurses

6. Health Technologies and Pharmaceuticals System

A) Governance of Medical Supplies System:

- Iraqi National Regulatory Authority (NRA): it ensures safe & effective medicinal products and has 2 committees: a) Medicines Policy Committee; b) National Board for Selection of Drugs which enlist medicines in two lists: "Essential Medicine List (EML) & "Comprehensive Medicine List" (CML).
- Dir. of Technical Affairs (DOTA): It grants marketing authorization, quality control, inspection duties, pharmaceutical licenses. It has several departments & sections.
- KIMADIA is the procurement arm of MoH of all EML products, vaccines & equipment for public health facilities.
- National Center for Drug Control & Research (NCDCR) is responsible for Quality control of all Medicines.
- Dir. of Inspection: It oversees adherence of all stakeholders to rules and regulations.
- Dir. of Public Health: it ensures development of related national guidelines, including the required medicines.

B) Procurement System & Process

- The EML & CML are established based on "National Guidelines", as well as "Lists of Registered Products".
- Any medicinal product must be approved & registered by NBSD.
- Until recently, Iraqi Essential Medicines List (EML) was subdivided into three levels (L1, L2, and L3).
- Medicines on "List 1" is procured and distributed by KIMADIA
- Procurement of List 1 medicines starts by a "Forecasting of needs", within a "Bottom-Up" approach, jointly with DOHs, with overall guidance of Directorate of Technical Affairs (DOTA), using Forecasting Tools.

C) Distribution & Management System of EML (List 1)

- **Warehousing:** KIMADIA manages central & regional warehouses, that distribute medicines to DOHs'
- **Management & Distribution**: a "*Management & Logistic Information System (MLIS)* is crucial for adequate & Timely distribution system (to avoid "Overstock" or "Out-of-stock" of medicines at all levels.

As the Iraqi MoH is facing challenges to secure safe and effective "Essential Medicines" for PH programmes, , the Iraqi MoH, with WHO support, assessed the SRH commodities, that revealed the following findings:

1) **National SRH Guidelines:** Only 68% of WHO EML items are mentioned on National Guidelines. This could be attributed to absence of few Guidelines (Abortion care & Pre-conception), and the need to update other national guidelines.
2) **National EML - List 1**:
   a. "Contraception" is the lowest (15 % of National guidelines – 2 out of 13 items)
   b. While "Abortion & Preconception" have NO National Guidelines, they are fairly covered by EML / List1.
3) **SRH Registered Products**: Majority of SRH categories of are "Well-Registered", however "Contraception" has ONLY 3 registered products
4) **SRH Items procured**: "Contraception" was the least procured (15 % of National

SRH Categories	Global EML	National Guide	% of G. EML	List 1	% of Nat. Guidelines
Contraception	14	13	93%	2	15 %
Ante-Natal care	39	31	79%	35	113 %
Intra-Partum care	22	14	64%	16	114 %
Post-Natal Care	8	8	100%	5	63 %
Abortion Care	10	0	0%	8	??
Preconception	8	0	0%	7	??
Newborn Care	16	14	88%	11	79 %
TOTAL	**117**	**80**	**68%**	**84**	72 %

SRH Categories	National Guide	List 1	Registered products	Procured in 2019	% Nat Guide	Forecast tools
Contraception	13	2	3	1	8 %	3
Ante-Natal care	31	35	190	25	81 %	31
Intra-Partum care	14	16	48	11	79 %	16
Post-Natal Care	8	5	86	4	50 %	5
Abortion Care	0	8	38	6	??	8
Preconception	0	7	21	4	??	7
Newborn Care	14	11	23	5	36 %	9

Right for Basic Essential Medicines

- Due to Stock-Outs, many patients have to refer to private market for these medications
- Pharmaceuticals are the largest driver of "Out-of-Pocket Health spending ➔ 36% in 2017

Guidelines) ➔ *ONLY Pills)*

SWOT Analysis

A) Strengths

- A well structure Governance system that ensure accountability and fair decision-making process
- In 2015, A 5-years National Medicines Policy was developed, by Medicines Policy Committee and Pharmaceutical dep. / DOTA;
- KIMADIA has a flexible procurement system (tendering or by direct procurement), and ability to procure SRH products, not "Non-included in National guidelines, if necessary.
- Overall situation of SRH medicines looks better in 2019, compared to previous years (in 2018, only 12% of SRH medicines included in national EML, were procured).
- Budget allocation for KIMADIA varies between 20 to 22% of MoH's Budget (1.5 to 2 Billion US$).

B) Weaknesses

- National WCAH Guidelines:
  - Some items on WHO Global EML are missing / omitted
  - Two Categories have no National guidelines
- Limited advocacy with NBSD & Nat. Regulatory Authority
- Only 2 FP products (out of 13 on National Guidelines) are included in Iraq EML
  - Some FP methods are registered under "Commodities"
- Several crucial SRH items have limited registered Products / Producers
  - Registration should be done by Producers/ Scientific Bureaus ➔ Procedures constitutes major barriers
- Some RMNCA commodities are not procured, mainly due to lack of bidding by "Scientific Bureaus", possibly due to Low Profit Margin
- Limited involvement of RMNCA managers (central level) in Forecasting & Procurement processes
- Forecasting process are based on "Past consumption", which *does NOT consider Periods of "Out-of-Stock" or Increased Demand / Clientele*
- Existing Commodities M&LIS tools is "Paper-based" & lack data on Consumption & Existing Stock", which may lead to High risk of "Out-of-Stock" or "Overstock" at all levels
- Distribution system is favoring "Push System" leading to 'Over-stock" or "Out-of-Stock" of products in health facilities. Meanwhile "Vaccines" are distributed using the "Pull System".

C) Opportunities

- High commitment of MOH's leadership for well-being of mother, women, children & adolescents.
- Increased financial allocation to KIMADIA for procurement of EML (List1)

D) Threat

- Competition among vertical programmes, leading to defragmentation of available financial resources
- Increase "Household Out-of-Pocket Health Expenditures", due to Non-Availability or Out-of-stock of essential WCAH medicines;
- High DOH's tendency to use their limited financial resources to procure Curative medicines, rather for Health Preventive medicines (WCAH)

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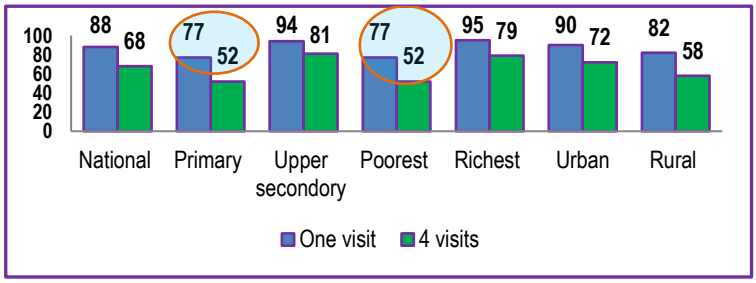
7 Behavioral Change & Demand Creation

1) **ANC – 1st & 4th visits** As per MICS 2018, "Discontinuity" (drop Out) between 1st & 4th ANC visits is significant (20 to 25%). largest Drop Out are in rural areas & among poorest or Low educated women)



2) **Post-Natal Care (PNC) / Mothers:**

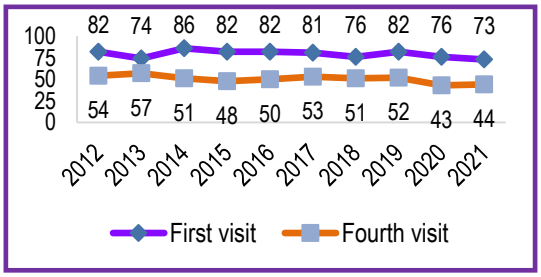
MoH's Statistical reports shows that PNC visits are decreasing since 2017 (from 53% to 41%). The same is confirmed by I-WISH & MICS surveys

Year	% PNC
2017	53 %
2019	49 %
2021	41 %

At least ONE PNC visit	
I-WISH 1 (2011)	38 %
MICS 6 (2018)	20 %

3) **1st & 4th Visit for New Borns (2012 to 2021)**

- Decline of Coverage for Infant Visit
  - 1st Visit by 10% (82% in 2012 to 73% in 2021
  - 4th visit by 20% (54% in 2012 to 44% in 2021.
- Discontinuation (Drop-out) between 1st & 4th Visits
  - In 2021: ➔ 40% Drop-Out / Discontinuation !! (from 73% for 1st Visit) to 44% for 4th Visit.



4) **Family Planning / Birth Spacing services**

- CPR declined from 43.5% in 2000 to 34.3% in 2021
- Low Acceptance / Utlization of Modern FP methods
- 30% of FP users are using ➔ "Traditional Methods"

Ineffective methods ➔ Un-Planned pregnancies ➔ 24% (I-WISH 1 & 2)

Contraceptive Prevalence Rate				
Year	Survey	ALL methods	Modern	Traditional
2000	MICS 1	43.5 %	25.4 %	18.2 %
2006	MICS 2	49.8 %	32.8 %	17.0 %
2011	MICS 4	52.7 %	33.8 %	18.9 %
2011	IWISH 1	39.8 %	28.3 %	11.5 %
2018	MICS 6	52.9 %	35.4 %	17.5 %
2021	IWISH 2	34.3 %	24.0 %	10.3 %

5) **Gender Based Violence - Domestic Violence**

- As per I-WISH 1 survey, 45% of Women (15-49 years were exposed to Domestic Violence
- Weak / Low Help Seeking Behavior !!!

	Emotional	Physical	Sexual	Any Type
Iraq	44,5	5,5	9,3	46
Urban	43	4,8	8,5	46,7
Rural	46	7,2	10,5	45,1

6) **Breastfeeding :**

As per MICS surveys, Breastfeeding is "NOT Optimal" ➔ as **Low as 32% & 26% !!!**

MICS Survey	2011	2018
Early initiation Breastfeeding	42 %	**32 %**
Exclusive Breastfeeding	20 %	**26 %**

7) **Child Health Services (Diarrhea, ARI, ….)**

- **~ 40 % ➔ Did Not seek Treatment.**

	Public	Private	Other	None
Diarrhea	26 %	34 %	1.5 %	38 %
ARI	19 %	36 %	3 %	41 %

8) **Adolescent Morbidity (10-19 yrs)**

I-WISH-1 Survey (2012), Girls (10 – 14 years):

- 46% suffered violence in last month (parents, brothers,
- 54 % had Knowledge about Puberty signs.

WHO EMRO report on School health (2017)

- 25 % of adolescents (13-18 years) were "Over-weight".

% Students aged 13-15 years	Boys	Girls
Attempted suicide in last year	14 %	16 %
Were bullied in last month	32 %	22 %
Had a physical fight in past year	50 %	22 %
Seriously injured in past year	38 %	29 %
Smoked cigarette in past 30 days	12 %	5 %

Teenage / Early Pregnancy / 1000 girls (MICS 6 – 2018)			
Iraq	70	Rural zones	75
Poorest families	91	Urban zones	68
Richest families	39	No Education	123

Child & Early Marriage				
MICS Survey	< 15 years		< 18 years	
	2011	2018	2011	2018
National	5.5 %	7 %	24 %	28 %

Health Promotion Activities

- Activities ae Mainly through :
  - Mass comm. events (Radio & TV)
  - PHC-based activities.
- PHC-based activities are :
  - "Printed materials"
  - Meetings !! Health Committee !!
  - "Lectures"
- Lectures : ~ 2 events / PHC / month
  - Attended by existing clients
  - RMNCA promotional package ➔ Topic-based ➔ Delivered in fragmented manner
- Meetings at PHC facilities ➔ Health Committee with community leaders
  - Average : 2 meetings / year / Health facility

Number of	2017	2019	2021	2022
Radio Interviews	242	734	394	208
TV Meeting	111	269	438	288
Health Campaigns	96	76	24,654	165
PHC-Based activities				
Promotion Materials	1 million	½ million	~ 5 million	5 million
Meetings at PHC centers	3,911	4,609	16,596	5,711
Meetings / PHC / Year	*< 2 / year*	*~ 3 / year*	*~ 6 / year*	*~ 3 / year*
Lectures at PHC centers	42,409	42,604	40,340	50,519
Lectures / PHC center	*~ 16/ year*	*~ 22 /year*	*~ 20/ year*	*~ 25 /year*

SWOT Analysis

Strengths

- Existence of Health Promotion Dep. at all levels (Central to PHC centersty
- Existence of Media Dep. at Central & DOHs levels
- Existence of Large Network of PHC Facilities that conduct promotional activities (pamphlet & lectures)
- Existence of "Community Leaders Health committees" at PHC level, that meet regularly (Twice /year)
- Existence of SBCC Strategy & FP Demand Creation Plan
- National Multi-sectoral Strategies on "School Health" & "Combating Violence Against Women"

Weaknesses

- Majority of Promotional activities are :
  - conducted within Health facilities, among existing clients.
  - Topic-Based (not Client-centered)
  - Delivered in fragmented manner
- Some Promotional activities are missing "Interactivity" with Targeted groups (pamphlets & lectures)
- Defragmentation of behavioral changes efforts & funding by Programs (by Thematic area)
- Limited promotional activities targeting adolescents & youth
- Weak Outreach / Community-based promotional interventions
- Limited Joint promotional programmes with other Social sectors (ministries & Local CSOs).
- Lack of social research on health knowledge, attitudes & practices (Commmunity & Individual level}.
- Limited Communication skills of HCPs (those conducting "lectures" at health facilities

Opportunities

- Large network of Family & Women Support centers at local level (MoLSA & Women CSOs)
- Existence of VERY Large Religious structures
- Existence of Frame of Collaboration & Coordination with MoE & MoHESR on School Health issues
- Health coordinators in all School levels & Universities & Institutes
- Existence of Large Network of Youth Centers (MoYS)
- Existence of Large Network of TV / Radio Channels and social medias.

Threat / Risks

- Limited financial resources for behavioral change programs.
- Weak commitment of TV channels to cover production/ dissemination of health promotional activities.
- Culture & False Belief
- Only 33% of Adolescents are enrolled in Upper Secondary Education & Higher.

Summary Final Review of WCAH Strategy 2018 – 2020

1 Overall Achievements.

Based on Self-Assessment by team of R/MCH Dep. / Dir. of PH, the implementation of Strategy's Main Interventions by 2018 (Mid-term) & by 2022 (Final) were as follows:

- ✓ Only 40% of Strategy interventions were fully achieved.
- ✓ Around 17% of Interventions were never initiated.
- ✓ 3rd Goal was highest "Fully achieved" (54% of interventions), while 1st Goal was lowest "Fully Achieved" with merely 14%

Goals	Fully		NONE	
	2018	2022	2018	2022
Coordination	14	14	0	0
Maternal / Neo-Natal	13	37	35	23
Child health	46	54	11	11
Adolescents	0	40	30	10
HIV / AIDS	22	22	44	33
Women RH Concerns	22	44	37	12
Overall Strategy	***21***	***40***	***30***	***17***

2 SWOT Analysis for Implementation of WCAH Strategy

2.1 Structure of Logical Framework Matrix

- ✓ Strategy had 6 Goals, 15 Outcomes, 38 Outputs, 180 Interventions.
- ✓ Action Plan (2018-20) had 438 activities.

Previous Strategy (2013 – 2017) had same 6 Goals, 24 Outcomes, 58 Outputs & 218 Main Interventions

Strength

- 4 Goals are " Client - Centered"
- Strategy focused on "Providers capacity building", "Data collection", and "Behavior Change" interventions

Weakness

- Two Goals (1st & 5Th) were NOT Client-Centered, but rather on issues (HIV/AIDS & Coordination)
- Wide Logical Frame / Action Plan, with Un-Balanced Structure (2nd & 3rd Goals have 75 % of ALL activities).
- Defragmentation of efforts & serious operational challenges among 10-15 Programmes
- Limited or NO interventions addressing Three of WHO's 6-Building Blocs

Opportunity

- "Client-Centered" with "Continuum of Care" approaches would : a) Enhance service integration & equity between Rural / Urban zones; b) Create synergies among different vertical programmes.

Threat / Risk

- Strategy is mainly Driven by around 15 "Specific Programmes"
- Limited available financial resources & Donors are favoring some specific vertical progrmmes

2.2 Strategy Monitoring Matrix (Indicators)

Strengths

- Indicators are defined for ALL Results (Goals / Outcomes / Outputs), with 94 indicators

Weaknesses

- ~ 50% of Indicators are not SMART to assess results, and lacking Baseline, Targets, or Data source

Threats / Risks

- Weakened commitment of Government & donors due to Inability to assess Strategy achievements.

1.3. Implementation Modality (Accountability, Coordination & Partnership

Strength

- Strategy Logical Framework defined implementing & collaborating entities
- National committee established at central level, with several stakeholders, including other ministries & donors.

Weakness

- Accountability was ambiguous, with multiple partners at intervention level, & mainly driven by RMNCA Dep./DoPH.
- Action Plan was developed two years after Strategy launching, and lacked "implementation responsibilities".
- Unclear Operations of Coordination mechanism, exacerbated by Multiplicity of Technical committees.
- Limited contribution by other ministries, Private sector, Iraqi NGOs & University Research
- DOH Action Plans were not Systematic prepared at Annual or Bi-annual basis

Opportunities

- Decentralization & partnership with other ministries, private sector & NGOs would favor "Non-Cash Financing"
- Partnership with University would encourage Research on Health Social determinants

Threats / Risk

- Multitude of stakeholders exacerbated by Competition among different progarmmes

1.4. Implementation Monitoring Process & System

Strength :

- MoH launched a Mid-term review in 2018, and a Final Evaluation in Nov. 2022.

Weaknesses :

- Monitoring Process was not implemented as defined (Annual Plan / Periodic review / Yearly Report);
- Lack of reporting guidelines & tools to track Strategy implementation (programmatic & financial).
- MTR & Final Evaluation was Not based on facts and data

Opportunities

- Annual Action Planning & reporting would enhance monitoring system

Threat / Risks

- Donor driven funding is favoring specific Programmes.

2.5 Financial Analysis

Strengths

- Detailed Costed implementation / Action Plan (2018 – 2020) for 440 Types of activities
- Funding source is mainly Gov / MoH Budget at Central & DOH levels, with support from UN agencies

Weaknesses

- Significant Budget Imbalance among 6 Goals (2nd & 3rd Goals have 95 % of Total budget),
- Absence of Financial Monitoring tools & annual reports
- Limited resources for DoHs Action Plans

Opportunities

- Decentralized Action Plans would favor fund mobilization by local government & CSOs, private sector, & donors

Risks / Threats

- Centrally driven budgeting & funding by vertical programmes
- Funding by UN agencies & Donors are mainly driven by vertical programmes

Summary Lessons Learned & Challenges / Opportunities

Lessons Learned

1. *Wide Logical Framework Matrix Driven by Vertical Programmes led to*: a) Defragmented efforts; b) "People-/Client-Centered" & "Continuum of Care" principle were NOT integrated .
2. *Monitoring Matrix/ Indicators*: Smart Indicators, with Baseline, Targets and source, are essential for monitoring process, as well as for Mid-term & Final Evaluation.
3. *Accountability / Responsibility*: Ownership was mainly assumed by RMNCA Dep./DoPH, sometimes with other directorates & departments
4. *Coordination & Partnership:* a) Intra-Sectoral (within MoH) was limited & sporadic; b) Multi-Sectorial partnership (beyond Min. Health) was timidly or weakly operationalized.
5. *Monitoring Process & System:* None of yearly monitoring process were implemented, leading to Inability to track Strategy implementation (programmatically or financially).
6. *Financial Allocations*: "A 5-years Costed Action Plan is NOT ideal neither for Government or UN financial process Annual Programmatic & Financial reports are crucial to ensure Financial sustainability.
7. Root Causes of Health System weaknesses was addressed sporadically and in fragmented approach.

B. Challenges

1. Centralized planning and Budget allocation processes
2. Limited available resources & Competition among programmes.
3. Funding from UN Agencies & donors are driven by "Specific Programmes"

C. Opportunities

1. Client-centered & Decentralized planning would favor non-Cash contribution & harmonize efforts with partners

Iraq WCAH Strategy 2023 – 2030

Guiding Principles

In line with "Global Strategy on Women's Children & Adolescents Health (2015 – 2030), and its "action areas, the Iraq WCAH strategy (2023 – 2030) will adopt the following guiding principles:

1. **People / Client-Centered services** :
   - Continuum of Care within a Life-Cycle / Integrated Service Delivery
   - Innovative Service Delivery Modalities & Interventions, that enhance client utilization & acceptability.
2. **Human Rights-based / Equity-driven to Quality of Care**: The strategy should be Equity-Driven and adopt all relevant measures to minimize gaps and disparities between governorates, and particularly between rural & urban zones.

> *"As we embark on the new agenda, due consideration must be given to make sure that **"Nobody is Left Behind"***

3. **Cultural/Gender Sensitivity & Age-responsive:** Recognizing the critical impact of cultural barriers on women and girls to seek services they need, it is crucial to remove un-necessary SOPs in health-care settings, and to ensure women and girls have access to "Culturally-sensitive, Age-responsive & Discrimination-free services.
4. **Health System Resilience ("Building Bocks") :** National health strategies should aim to strengthen all the building blocks of the health system to deliver universalhealth coverage**.....**
5. **Multi-Stakeholder Accountability & Responsibility & Sustainability**
   - Intra-sectoral Accountability: To address root causes & challenges facing Health System', and to ensure sustainability of efforts, it is crucial to engage different directorate / departments within Ministry of Health
   - Multisectoral Partnership & Collaboration: Considering the multi-dimensional nature and challenges, requiring an enabling environment to ensure greater engagement of non-health partners, including other relevant government sectors, local authorities, as well as Iraqi CSOs and Private health sector.
   - Effective Public-Private Partnership : On same line, it is crucial to build a stronger Partnership with local CSOs as well as the private health sector.
   - Decentralized Implementation: A decentralized approach must be pursued in strategy management, which lends itself to high efficiency & ownership at governorate level, while taking into account local cultural context, challenges and opportunities[9]
6. **Enhanced Monitoring & Evaluation:** it is crucial that the Strategy design, plans and implementation would be "Evidence-Based" and guided by reliable data, generated through existing health information system, as well as national surveys with in-depth analysis & research. Operational research can lead to stronger systems and to improved service quality, efficiency and effectiveness[10]
7. **Individual Potential & Community engagement :** Women, children & adolescents are the most powerful agents for improving their own health and achieving prosperous and sustainable societies. Social, behavioral, and community research helps to increase understanding of how to promote positive behavior for health.

Target Population

- ✓ Women 15 – 49 years (married and Non-Married
- ✓ Children under 5 years
- ✓ Children 5 – 10 years & Adolescents (10- 19 years) - Boys and Girls
- ✓ Adult male and Community at large

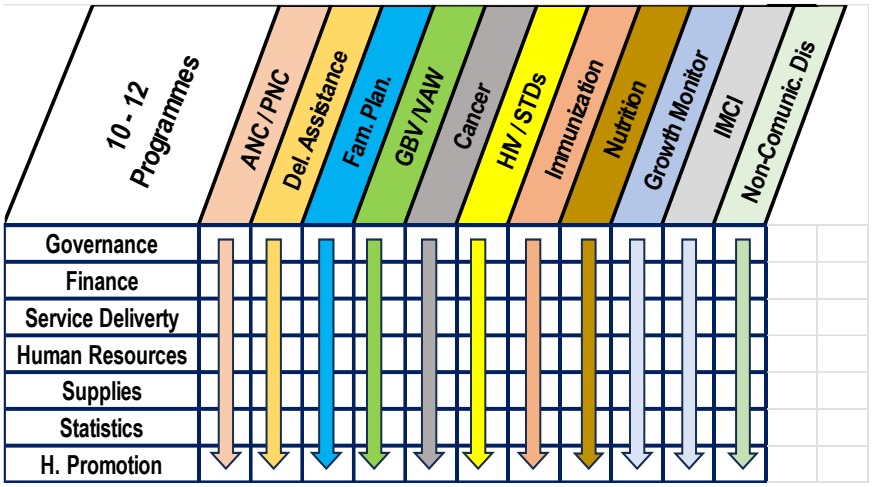
[9] Global Strategy for Women, Children & Adolescents (2016 – 2030), page 60 & 66

[10] Idem

New Approach

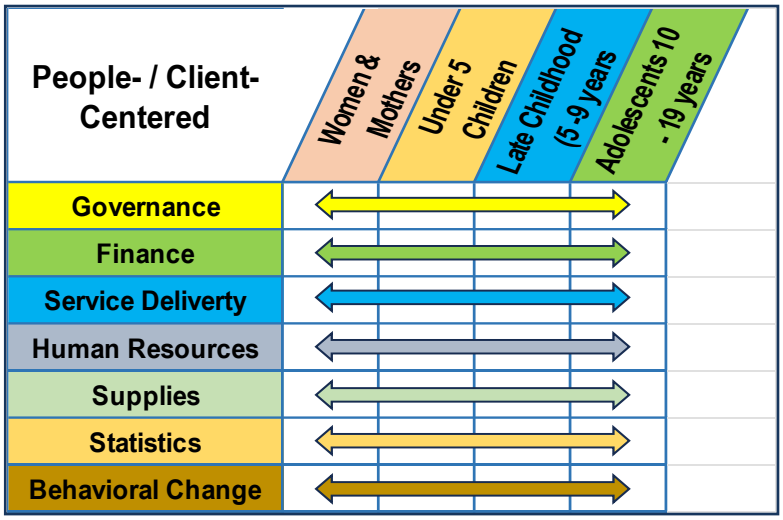
The design of previous Two WCAH strategies (2013-17 & 2016-2020) were mainly:

- Driven by 10 – 12 Vertical Programmes,
- Several roots causes of "Health System" were not addressed (Finance/ Service Delivery / Supply systems)



Building on *lessons learned of previous WCAH Strategy 2016-2020, and guided by above mentioned "Guiding Principles", the new "*Iraq WCAH Strategy (2023 – 30) will adopt the following approach & Structure:

- **Goal :** will be "People- / Client-centered" ➔ (Women/ Children/ Adolescents
- **Outcomes:** Will focus on "Strengthening Health System" (**The 6-Building Blocks)**, will be based on *Seven SWOT Analysis*



To simplify the "Strategy Logical Framework", The following will be adopted

- "Financing system" will be integrated with "Health Governance system"
- To ensure systematic use of Health Statistics". " Health Information System" will tackled as follows :
  - ✓ *Service Statistics* ➔ "Service Delivery System"
  - ✓ *Hum. Res. Statistics* ➔ "Hum. Resource System
  - ✓ *Supply Statistics* ➔ "Pharm. System

Outputs

Based on SWOT Causal Analysis, Each Outcome was operationalized into 2-3 Outputs

Main Interventions

- Each Output was operationalized into 3 – 4 Main Interventions, that should expand over 3 – 5 years)
- Responsibility / Accountability : Each Intervention will have : 1 – 2 Main Implementing Parties, and 1- 3 Collaborators

Iraq RMNCAH Strategy 2023 - 2030

Goal / Vision

"By 2030, every Iraqi Woman, Child & Adolescent, in every setting, enjoys their rights to Physical, Mental & Social health and well-being, and able to participate in shaping sustainable Iraqi society"

5 Outcomes	Gouvernance & Financing System	Service Delivery System	Human Resource System	Pharmaceutical System	Demand Creation & Behavior Change
14 Outputs	3 outputs	3 outputs	3 outputs	3 outputs	2 outputs
	• Costed Bi-Annual Planning • Monitoring System & Mecanism • Intra-sectoral & Multi-sectoral Coordination	• Client-centered RMNCA Health Package • Supervision & Quality Control • Service delivery Statistics	• Pre-service training of HCPs (All Categories) • In-service Training of HCPs • Human Resource Information System	• Essential Medicine list for RMNCAH services • Forecasting & Procurement of RMNCAH EML • Management of RMNCA Medicines (including Electronic L&MIS)	• Community-Based Outreach / Awareness with Men & Women • Out-reach & Communication for Adolescents & youth
50 Main Interventions	12 Main Interventions	11 Main Interventions	11 Main Interventions	8 Main Interventions	8 Main Interventions

Outcome 1 : Health Governance & Financing Systems

Summary Challenges & Opportunities

Weaknesses & challenges	Opportunities
Policy, Strategies & Planning	
• Some legal frameworks need review to favor PHC system & WCAH issues • Existence of more than 15 "Vertical" Strategies, within a "Limited Resources" context !! • Detailed Costed Action Plan was formulated two years after Strategy launching; • Costed Action Plan was not reviewed or updated on a Yearly-basis. • Wide Institutional Organogram at central and DoH levels	• MoH's commitment to UHC & Decentralized Planning • Significant Support by UN agencies and other Bi-lateral donors • Annual action plans are better for budget management & mobilizing support from partners & UN agencies
Monitoring Implementation	
• Unclear Monitoring System and Annual Reporting Format / Tools • Lack of Annual Progress reports produced by central or DoHs Levels	• Existence of Sub-national health authorities (in 19 DoHs) • Monitoring process of "National Health Policy", & "Medicines Policy"
Coordination Mechanism & Process	
• Unclear Operational modalities of Coordination mechanism (functions, periodicity, ……..) • Repetitive change of Programme managers, particularly at DoH and Health sectors, • Multiplicity of Stakeholders, with Overlapping mandates ("Culture of Departmentalism) • Limited coordination / involvement of Curative System (2ry & 3ry Hospitals". • Limited Coordination with Private sector, professional Associations and National NGOs	• Existing Coordination Mechanism for "Health Insurance Initiative"
Budget Setting & Execution	
• Low budget allocated for PH programmes, with defragmentation of financial resources. • Inequitable Budget allocation among DoHs, as "Population Dispersion" is weakly considered. • Low budget execution rate due to unclear Financial SOPs & weak managers capacities • Rigidity & non-flexibility of budget executions SOPs (by MoF) • Lack of Financial execution reporting for costed action Plan • Donors' funding is favoring specific "Vertical Programmes"	• Budgets allocated to "Min. of Health/" are increasing. • "Client-Centered" & "Decentralized Annual Planning" would enhance Mobilization of Non-Cash funding from other Ministries & Partners • MoH's efforts for "Health Financing regulations" & "Cost Accounting" to enhance resource allocation and improve efficiency.

Logical Framework

Outcome 1: ***" By Year 2030, Enhanced Programmatic & Financial Management of WCAH Strategy (policy, planning, monitoring/ evaluation & coordination "***

Outputs	Main Interventions	Main Responsible	Partners
Output 1.1: Enhanced PH policies, plans & financial resources in favor of WCAH at central & DoHs levels	1.1.1 Ensuring adequate integration of equitable accessibility for WCAH elements into national Health Policy, laws & regulations, national Disasters Preparedness, & Health Insurance law /system (including normative costs of WCAH services)	Policy dep / PH Dir / Legal dep / Health Insurance Committee	
	1.1.2 Developing 3-year Integrated budgeted action plans, at central & DoHs levels within an equity approach, & in line with timetable set by Min. of Finance	Policy Dep / Finance dep	RMNC Dep, Othre DoPH Dep / DoHs
	1.1.3 Advocating among MOH decision makers, and Min. of Finance for increasing & sustaining financial allocation for evidence-based WCAH action plans, and to PHC system in general	Finance Dep	DoPH / DOHs
	1.1.4 Promoting & advocating financial partnership with other governmental sectors, local NGOs, private sector & International partners for client-centered WCAH packages, at central & governorate levels	Planning Dep / DoPH	Dir of Int. Health / DoHs
Output 1.2: Operationalized Efficient monitoring mechanism /system, for programmatic & Financial management of WCAH strategy at central & DoHs levels	1.2.1 Implementing a standardized monitoring plan, tools, with regular review & reporting of budgeted / costed Action Plans	Policy Dep. / Finance Dep	DoPH / DoHs
	1.2.2 Enhancing Financial execution of WCAH Action Plans, at central & local levels, including monitoring cash flow	Finance Dep	DoPH / DOHs
	1.2.3 Ensuring Periodic review & evaluation (mid-term & Final) of WCAH Strategy	Policy Dep. / RMNC Dep	Other DoPH Dep.
Output 1.3: Operationalized intra-ministerial & multi-sectoral coordination mechanisms.	1.3.1 Strengthen functional intra-ministerial coordination mechanism & tools (SOPs), including relevant ministries, NGOs, private sector, & UN agencies/ Donor, at central & local levels	Policy dep	RMNC Dep / Other DoPH Dep.
	1.3.2 Ensuring harmonization of responsibilities & Plans among DoPH's Departments & Sections	DoPH	DoP / Admin Dir.

Outcome 2 : Health Service Delivery System

Summary Challenges & Opportunities

Weaknesses & challenges	Opportunities
Service package & Delivery Modality	
• Vertical program implementation / Delivery at PHC centers (Non-Client centered) • Complex WCAH service delivery modality that is non friendly for clients & rural zones • Some interventions are only offered in Main PHCs or even hospital-based. • Poor infrastructure with Limited equipment & supplies • Non-friendly SOP at PHC facilities, with large clients' referral to 2ry Facilities • Donor preference to vertical programs	• MoH's Commitment to PHC system & availability of WCAH services • Wide health network (PHCCs, Public clinics, Health Insurance clinics • Existing guidelines on "Basic Health Service Package at PHC" • Wide expansion private service network, reaching rural areas • Existence of health services by other ministries
Supervision & Monitoring	
• Fragmented supervision by WCAH vertical programs & other dep. of PH Dir. • Multiple tools & Plans & reporting systems for each level • Paper- based supervision reporting systems, with limited feedback to SDPs • Limited operational research on Quality of care • Limited support to Private sector (For-Profit & Non-Profit)	• Existence of quality improvement structure at central & DoH levels • Existence of University Research centers
Service Delivery Statistics & Surveillance Information system	
• Complex Data collection at PHC system (vertical fragmented approach). • Paper-based Data collection tools (registries) • Lack of standardization of data to be shared with other departments. • Lack of regular "Data quality" assessments. • Limited in-depth analysis of statistical reports to monitor "Equity" of service delivery • Implementation costs for scaling up DHIS2 & use IT technologies	• Iraq HIS is in process to implement DHIS 2 • Existence of several Dashboards (EmONC/ PHC centers/ Human resource) • Current Initiative of sharing data between Stat. dep & other Directorates • Existing advances in new IT technologies.
• National surveys : Limited in-depth Analysis	• National Surveys conducted by MoP, jointly MoH and UN agencies
• MPDSR mainly managed by RMNCA Dep. (limited involvement of Curative dep. /DoTA) • MPDSR faces Operational challenges with poor commitment of Health Providers	• MDSR implemented since 2012, & PNDSR was initiated 3 years ago

Logical Framework

Outcome 2 : **" *By Year 2030, Enhanced equitable availability & accessibility to quality, Cultural/Gender-sensitive & client centered WCAH package at all levels including in humanitarian settings ".***

Outputs	Main Interventions	Main Responsible	Collaborator
Outputs 2.1: Strengthen & scaling up delivery of equitable, convenient, Client-centered WCAH service packages for women, children and adolescents, across PHC system & district hospitals, with particular focus on Rural zones	2.1.1 Develop & advocate for 3 (Women Children / Adolescents) equitable Client-centered Essential WCAH services packages for all PHC levels & District Hospitals, & building on WHO Family Health Modality & Social justice principles	PHC Dep / Curative Dep - DoTA	Other DoPH deps, Cancer council
	2.1.2 Develop, Pilot & Scale up Service Delivery modalities (staffing, equipment, supplies & lab. Tests) for WCA service packages, within a continuum of Care approach, for PHC system & district hospitals, including an efficient Client-friendly referral system	PHC Dep / Curative Dep - DoTA	cancer council
	2.1.3 Integrating selected WCAH services in other existing Heath settings (public clinics / health insurance clinics)	PHC & RMNCA Dep / Pub Clinic Dir	MoLSA / MoYS/ Min of Justice
	2.1.4 Strengthening innovative service delivery modalities of selected WCAH package (mobile clinics, Telemedicine, Hotline, ……	RMNCA Dep. & PHC dep	Other dep. of DoPH Cancer council,
	2.1.5 Establishing / strengthening partnership with "Profit / Non-Profit Private sector"	RMNCA Dep / Private Sector Dep.	Medical Assoc. / Health Ins. Council
	2.1.6 Stregthen Coordination mechanism with relevant partners, UN agencies & Donors	RMNCA Dep	PHC Dep.
Output 2.2: Enhanced Supervision & monitoring of WCAH service delivery, with particular focus on rural / peripheral zones	2.2.1 Ensuring regular & unified "Monitoring /Supportive Supervision" for PHC centers & District hospitals (Tools, Multi-disciplinary Team, Plans, ...), at central & DOH levels,	PHC Dep / Quality Control Dep.	DoPH relevant Dep. Cancer council
	2.2.2 Initiating & Scaling up of digitalized monitoring tools & dashboards (such as EmONC & PHC dashboards), including PHC with Maternities, for evidence-based management at central & DoH	PHC Dep / Curative Dep.	RMNCA Dep. / IT section
Output 2.3: Improve WCAH Service Delivery Statistics & Surveillance Information system	2.3.1 Supporting simplified & digitalized Client-centered data collection tools of WCAH services statistics, building on current DHIS2 implementation efforts,	Statistical Dep	Relevant Dep. of DoPH
	2.3.2 Strengthening & scaling up of MPDSR & transfer of client data between PHC system & District hospitals	Curative dep / DoTA, RMNCA Dep	Statistical Dep./ Univ. Centers

Outcome 3 Human Resources System

Summary Challenges & Opportunities

Weaknesses & challenges	Opportunities
Pre-Service Training	

• Academic Curricula: mainly Curative content, with Limited skills on RMNCA components.
• Graduation / Internship period (3 years) (physicians / Nurses / Midwoves)
  ○ Mainly Hospital-Based, with Limited opportunities to gain RMNCA-related Skills;
  ○ At start 3rd Rotation year, new physicians are posted to hospitals to start specialization
	• Increased Training Entities (~ 200 Public & Private entities
	• Phasing out of "Secondary Nursing / Paramedical Training Entities
	• Community Medicine Course in Pre-Service Curricula
	• Orientation courses for Newly graduated at start of 1st year
	• Short training courses for new graduates after 1st year of Graduation
	• Existence of "Training Health centers" & "Family Health centers"

In Service Training	
• Mainly Driven by Vertical PH Programmes, high competition among programmes • Content: Not Client-centered / Large Focus on "Knowledge" / Risk of duplicated content • Trainers: Each PH programme has its own Trainers team (Focal Point), with High Turnover of DOH trainers, and Limited coordination with "Nat. Center Training" • Beneficiaries: High Turnover of trained Staff / Newly graduates are rarely targeted • Monitoring system : Paper-based with Risk Repetitive training of same beneficiaries. • Donors & UN agencies prioritizing Vertical programmes	• Existence of "Nat. Center for Training & Human Dev. supports capacity building of trainers at all DoHs • UN agencies support for TOTs & Cascade training (at DOH levels)
Policies, Management & Retention	

• Current "Rotation/Residency" law (Graduated physicians, nurses/ midwives) create major Barrier for their deployment to PHC system during the entire 3-years Graduation period
• Unclear Deployment criteria & system of new graduates to PHC system (after Rotation)
• Existing Guidelines on "Functions & Tasks of Nurses/Midwives" face challenges:
  ✓ Functions does NOT consider "Education level" (College / Institute / 2ry school)
  ✓ Functions at PHC system : Weak role of nurses in delivering WCAH package.
• Inequity of Staff Deployment between 1ry & 2ry Care System
• Limited "Motivation" for physicians or nurses to be posted at PHCs (during or after Rotation
• Limited utilization of Human Resource Dash-board by DoH managers
• Limited research on satisfaction of physicians & nurses for working at PHC system
• Pressure by Medical Syndicate & Medical professional Associations
	• National Health Policy ➔ High Commitment to all HRH categories
	• Existence of National Guidelines on Functions & Tasks of Nurses & Midwives at Public facilities (1ry & 2ry) (by Nursing Dep.)
	• Existence of Graduation Law (3-year Obligatory service) for physicians, Nurses & midwives
	• HR information Dash Boards (2 Initiatives ➔ By HR Dep. & MCH dep.)
	• Thousands of new Graduates (physicians & Nurses) at yearly Basis
	• HR deployment decentralized to DoH level ??

Logical Framework

Outcome 3 : ***"By Year 2030, Enhanced Availability & Distribution of Skilled Human Resources for adequate delivery of WCAH services, with particular focus on PHC system, and Peripheral / Rural zones for Equity concern "***

Outputs	Main Interventions	Main Responsible	Collaborator
Output 3.1: Newly Graduated physicians, nurses/ midwives, public health workers have WCAH service delivery skills	3.1.1 Integrating of "Skill-Based Preventive WCAH care, including counseling skills, into relevant academic curriculum of all health professionals (Medical/ Nursing/ Midwifery/ Pub. Health Worker), in partnership with public & private health universities & institutes	Hum Resource Dep.	Dep of DoPH, Min. of High Ed.
	3.1.2 Reviewing & updating implementation procedures & regulations of "Graduation Law" for HCPs (physicians/ nurses & Midwives / Public Health Workers) and its implementation modalities by DOHs, to ensure adequate skill development on WCAH issues	Human Resource Dep	DoPH Deps. / DoTA Deps. / Policy Dep./ DoP
	3.1.3 Providing condensed Skill-based WCAH courses for all graduates (physicians / nurses & Midwives / Pub. Health Workers), during their "3-weeks Orientation" courses, and prior to deployment to peripheral facilities (Graduation" (التدرج) periods	Nat. Training Center Emergency Dep.	DoPH / curative Dep.
Output 3.2: Client-centered, Skills-based in-Service training provided to All HCPs categories, with priority for newly recruited	3.2.1 Developing necessary tools & skilled trainers at central & DoHs levels to deliver a Client-centered & Skilled-based in-service training package for HCPs, at PHC system, including e-Learning component, based on newly defined HCPs functions & roles, & jointly with local universities	Nat. Training Center RMNCA Dep,	Other Dep of DoPH
	3.2.2 Setup an efficient E-monitoring system for beneficiaries of In-service training efforts, for better management & equity among all HCPs	Nat. Center of Training / DoHs	DoPH / Local Universities
Output 3.3: Enhanced management of existing HRs deployed to PHC system & district hospitals , with priority to peripheral & Rural zones & Humanitarian Settings	3.3.1 Revising "Function/Tasks particularly for nurses, midwives & PH workers, posted at PHC system (Main & Sub-centers), to ensure full delivery of essential WCAH services	Nursing Dep., Paramed. Dep	RMNCA Dep & other DoPH Deps,
	3.3.2 Strengthening & operationalize HR information system, including a user-friendly Dashboard, to support DOH's Managers to monitor HR deployment.	Human Resource Dep.	PHC centers Dep, RMNCA Dep, DoHs
	3.3.3 Developing & Implementing HR regulations &/or motivation system (monetary & Non-monetary) for HCPs posted at peripheral health facilities, particularly PHC system	Hum. Resource Dep	DoPH, DoP, DoHs
	3.3.4 Strengthening Coordination mechanism with relevant partners & UN agencies / Donors	Hum. Resource Dep	Univ. Centers

Outcome 4 : Health Technologies & Pharmaceuticals System

Summary Challenges & Opportunities

Weaknesses & challenges	Opportunities
Iraq EML / EDL & RMNCA Essential Medecines	
• National WCAH Guidelines: Some items on WHO Global EML are missing / omitted ○ Two Categories have no National guidelines • Limited advocacy with NBSD & Nat. Regulatory Authority	• A well structure Governance system that ensure accountability and fair decision-making process • In 2015, A 5-years National Medicines Policy was developed, by Medicines Policy Committee and Pharmaceutical dep. / DOTA;
Forecasting & procurement of RMNCA Essential Medicines	
• Several crucial SRH items have limited registered Products / Producers: Procedures constitutes major barriers • Some RMNCA commodities are not procured, due to lack of bidding by "Scientific Bureaus" • Forecasting process is based on "Past consumption" (*does NOT consider Periods of "Out-of-Stock" or Increased Demand / Clientele)* • Limited involvement of RMNCA managers in Forecasting & Procurement processes • High tendency of DoHs to procure Curative medicines, rather for RMNCA essential medicines • Competition among vertical programmes, led to defragmentation of financial resources	• Increased financial allocation to KIMADIA for procurement of EML: ○ 20 to 22% of MoH's Budget ➔ 1.5 to 2 Billion US$ / year). • KIMADIA has a flexible procurement system, and ability to procure SRH products, not "Non-included in National guidelines, if necessary.
Distribution & Management of RMNCA Essential Medicines	
• Existing Commodities M&LIS tools is "Paper-based" & lack data on Consumption & Existing Stock", which may lead to High risk of "Out-of-Stock" or "Overstock" at all levels • Distribution system is favoring "Push System" leading to 'Over-stock" or "Out-of-Stock" of products in health facilities. Meanwhile "Vaccines" are distributed using the "Pull System".	• Increase "Household Out-of-Pocket Health Expenditures", due to Non-Availability or Out-of-stock of essential WCAH medicines;

Logical Framework

Outcome 4: " By Year 2030, Enhanced sustainable availability & accessibility of Essential WCA commodities and equipment "

Outputs	Main Interventions	Main Responsible	Collaborator
Outputs 4.1: Basic WCAH commodities are adequately included into Iraqi EDL, respecting rights & needs of women, children & adolescents	4.1.1 Regularly updating national Pharmaceutical Policies & Iraqi Essential Drug lists, to ensure adequate inclusion of Basic WCAH commodities, based on updated national WCAH guidelines, as well as WHO Global EML	Pharmacy Dep, NCSD section	Deps of DoPH
	4.1.2 Continuously Streamlining registration of large choices of Basic WCAH products & producers, to facilitate procurement process	Registration Dep., Pharmacy Dep.	Deps of DoPH
Output 4.2: Forecasting & Procurement systems are updated to secure adequate stocks of WCAH essential commodities, & equipment for all levels of PHC system	4.2.1 Improving existing Forecasting process & system of Basic WCA commodities & equipment	Need Estimation Dep	Deps of DoPH
	4.2.2 Ensuring that forecasted "Basic Essential WCA commodities & Equipment, are fully procured by KIMADIA	Pharmacy Dep., RMNCA Dep	Deps of DoPH
	4.2.3 Negotiating and gradual Piloting of Social Marketing system of selected WCAH commodities (such as FP commodities), on cost recovery basis, within Public Clinics, Iraqi Health CSOs, private pharmacies and clinics, particularly in rural & poor zones	Pharmacy Dep. Pub.Clinic Dir.	Med. & Pharmac. Assoc. & NGOs, RMNCA Dep.
Output 4.3: Enhanced management & distribution of WCAH Basic supplies at all levels to minimize over or under-stocking at SDPs	4.3.1 Develop, implement & adjust a robust E-LMIS to ensure regular & timely reporting of distribution and consumption data of commodities at all levels (local warehouses & SDPs levels)	Pharmacy Dep	DoPH, KIMADIA, DoHs
	4.3.2 Develop & implement a functional, supportive supervisory system & Checklist to monitor WCA commodities at all levels (from SDPs to central warehouses).	Pharmacy Dep.	DoPH, DoHs

Outcome 5: Demand Creation – Behavioral Change

Summary Challenges & Opportunities

Weaknesses & challenges	Opportunities

• Defragmented efforts & financial resources driven by different PH programmes
• Lack of cross ministerial/ inter sectoral coordination for SBC interventions
• Excessive dependency on TV/ radio & IEC materials causing limited direct community engagement and interaction.
• Majority of promotional activities lacking "Interactivity" with Targeted groups, to tackle attitudes & beliefs (TV & radio emissions & pamphlets).
• Lectures (Face-to-Face activities) are :
  ○ Conducted within Health facilities, among existing clients.
  ○ Top-down communication approaches adopted at PHC level e.g lectures
  ○ Scarcely organized (average One or Twice / month / PHC center)
  ○ Mostly Thematic-Based in defragmented manner
• Scarce Meetings of "Health Committees" at PHC centers (1-2 / year / PHC center)
• Lack of two-way engagement with communities and community feedback & voices
• Weak or lack of Outreach / Community-based promotional interventions
• Limited promotional activities targeting adolescents & youth, mainly through schools
• Limited research on effectiveness of different health promotion interventions.
• Weak commitment of TV / Radio channels to produce & disseminate promotional products.
• Limited Joint promotional programmes with other Social sectors (ministries & Local CSOs).
• Significant percentage of Adolescents not enrolled in Intermediate or Secondary schools
• Lack of evidence generation and behavioural insights – a Human centered design approach to guide program planning & implementation
• Limited utilization of behavioural data generated and lack of impact assessments.
• Limited trust in health care providers & government. Limited interpersonal communication with MOH community advocates
• Limited Adolescent and YP participation for in school & out of school youth.
• Lack of individual resilience towards harmful social and cultural norms
	• Large network of Family & Women Support centers (MoLSA & CSOs)
	• Existence of Large network of Mosques, with Imams and Female religious educators
	• Existence of Large Network of Youth Centers (MoYS)
	• Existence of Large Network of TV / Radio Channels and social medias.
	• Existence of relevant entities
	  ○ Health Promotion Dep. at all levels (Central to PHC centers)
	  ○ Media Dep. at Central & DOHs levels
	  ○ "Community Leaders Health committees" at PHC level
	• Existence of collaboration frame
	  ○ RMNCA SBCC Strategy & FP Demand Creation Plan
	  ○ National Multi-sectoral Strategies on "School Health" with MoE & MoHESR, as well as Health coordinators in all School levels

Logical Framework

Outcome 5: ***" By Year 2030, Improved Demand & Utilization of Preventive WCAH services, including adoption of healthy lifestyle among men, women, children, adolescents & Young people, particularly in vulnerable areas (rural & poor urban zones, & in humanitarian settings "***

Output	Main interventions	Main Responsible	Collaborator
Output 5.1: Expanded evidence-based community & Mass media interventions on women & child health issues, among women and men, particularly in poor urban & rural zones, & in humanitarian settings	5.1.1 Develop & review a comprehensive Multi-dimensional human centered SBCC Framework on Women & Child Health & Well Being, based on results of existing research & surveys, including its adoption & adaptation by different government social sectors & CBOs	Health Promo. Dep. / Media Dep	Relevant Social sectors, RMNCA Dep / Soc. Dev. Dep / UN agencies
	5.1.2 Integrating & piloting SBCC framework on Women & Child Health /Well Being, into MOLSA's & NGOs' Community-based behavioral change interventions	Health Promo. Dep. / MoLSA / NGOs	RMNCA Dep / Soc. Dev. Dep
	5.1.3 Integrating & piloting SBCC framework on Women & Child health issues, including domestic violence issues into "Adult Literacy programme in rural & poor urban zones	Health Promo. Dept. Min. of Education	RMNCA dep / Soc. Dev. Dep
	5.1.4 Promoting & delivering "Premarital Education" courses for *engaged/ newly married couples*, that address RMNC health & harmful practices, using an Interactive/ Participatory approach & Group Counseling Modalities	Health Promo. Dep / RMNCA Dep	MoLSA / MoYS / Sunni & Shiite Endowments / Social Dev. Dep.
	5.1.5 Engaging & supporting "Community-based Religious leaders / educators (male & female) to address cultural mis-concepts & awareness on Women & child health, within their current educational activities for men & women	Health Promo. Dep. / Sunni endowment / Shiite endowment	RMNCA dep / Soc. Dev. Dep / Women NGO
	5.1.6 Revitalizing role of "PHC Health Committees" for trust building & accountability for WCH	PHC Dep.	Health Promo. Dep / RMNCA Dep
	5.1.7 Promoting Corporate Social Responsibility among Public & Private media & tele communication channels (TV & Social Media) to raise awareness & behavior change on women & child health issues & services, through their existing programs	Media Dep. / CMC	RMCH Dep / Health Promotion Dep.
	5.1.8 Strengthening Multi-sectoral Coordination mechanisms with relevant ministries, NGOs, UN agencies at central level	Health Promo. Dep / School Health Sect.	RMNCA Dep / Media Dep.
Output 5.2: Expanded evidence-based	5.2.1 Develop & review a Multi-dimensional Human Centered LSCE Framework on Adolescent & Youth Health & Well Being, based on results of research & surveys,	School Health Sect. / Health Promo. Dep	Min. od Education / MoLSA / MoYS

institutional interventions targeting Adolescents & youth particularly in poor urban & rural zones, & in humanitarian settings	5.2.2	Integrating Multi-dimensional Human Centered LSCE Framework on Adolescent & Youth Health & Well Being into Educational curriculum & School Health interventions at Secondary & Intermediate Schools using an Interactive / Participatory approach	Min of Education /Sch. Health section	Health Promotion Dep. / UN agencies
	5.2.3	Integrating healthy Lifestyle & Life skills into Training courses of MoLSA's Vocational Centers, using an Interactive / Participatory approach	MoLSA / Sch. Health section	Health Promotion Dep. / UN agencies
	5.2.4	Integrating healthy Lifestyle & Life skills into Training / education courses of Youth centers using an Interactive / Participatory approach	MoYS / School Health sect.	Health Promotion Dep. / UN agencies
	5.2.5	Engaging Social Media influencers / role models for reinforcing key messages on Youth Health & well Being	Media Dep. School Health Sect.	MoYS / Youth Associations

Accountability & Partnership

the Iraq Ministry of Health will assume the overall responsibility for the strategy, both at national and governorate levels.

As per earlier mentioned "Guiding Principles", and considering the Multidimensional nature of the strategy, "Accountability & Responsibility" will be guided by the following parameters :

1) At central level: the "Overall Accountability & Responsibility" will be assumed jointly by three General Directorates, namely "Dir. of Public Health", "Dir. of Planning" and "Dir. of Technical affairs". The 3 Directorates will be supported by other entities within Ministry of Health, such as Dir. of Public Clinics, Quality Control Dep., Nat. Training center, ` .....).
2) At governorate level: Accountability will fall on DoH's General Director, jointly with heads of all relevant departments and sections, with technical support of Directorates & Departments at central level.
3) Multi-sectorial partnership: Several of the strategy's Main Intervention will require active participation and involvement of other ministries (MoLSA, MoE, MoHESR, MoYS, ….), Sunni & Shiaa Endowments, Iraqi CSOs, professional associations as well Private health Sector.

Implementation Modality

A. Formulation of Detailed / Costed Action Plans

After Strategy launching, Detailed & Costed Action Plans should be formulated ➔ at Central & DoHs levels.

1) Central Level - Action Plans

- *Scope*: Action Plans will be "Outcome-Based" ➔ ***Outcome Action Plans***
  - Each "Main Intervention" will be operationalized into "Clear/ Time Bound" Activities & Sub-activities, with its estimated costs .
- *Periodicity*: As per "Council of Ministers" Orientations, to ensure timely / adequate Budget allocation, "3-years" Detailed & Costed Action Plans should be formulated.
- *Responsibility*: The Leader of "Outcome Coordination Committee" will facilitate the process, jointly with relevant Internal & external partners (as per "Outcome Logical Framework")
  - One UN agency will support the OCC leader to formulate the "Outcome Action Plan"

2) Decentralized Action Plans (at DoHs level):

- DoH Director is the overall responsible for the formulation process, and will nominate a relevant department head for each of the Five strategy Outcomes
- The process will be similar as at central level, However it will be :
  - conducted with support from Central Directorates, and One UN Agency.
  - introduced gradually over the first 3 years of Strategy life-time (4-5 DoHs / year)

At Annual Basis, the 3-years Action Plans will be : a) reviewed & revised (if necessary); b) extended by an Additional Year

B. Implementation Responsibility

- Preliminary distribution of Responsibilities are defined within the Five "Outcome Logical Frameworks", mainly at "Main Interventions" level.
- Each "Main Intervention" was assigned to ONE or TWO entities of MoH or Other sector, with 1 or more partners (internal or external).
- Each activity / Sub-activity will be assigned to a Specific / Relevant Entity. Attribution of activities will mainly follow the "functions & attributions" of selected entity

Coordination & Monitoring Mechanism

Coordination / Monitoring mechanism is crucial to ensure a Timely implementation & regular Monitoring of Strategy and its "Action plans".

1. *At Central level:* Due to multiplicity of Stakeholders at central level, the Coordination mechanism will be established as follows:
    a. *Senior Steering Committee* (SCC)
    b. Outcome Coordination Committee (OCC): Five (5) OCCs
2. *At Governorate level:* ➔ Governorate Coordination Committee (GCC)

A) *Senior Steering Committee* (SCC)

At Strategy launching, MoH will nominate a "Senior Steering Committee".

- Membership: ➔ Restricted Structure (10 – 15 members)
    - ✓ Heads of the 3 main Directorates (DoPH, DoP, DoTA),
    - ✓ Heads of selected Main Departments of 3 Main Directorates
    - ✓ Heads of other MoH Entities (Dir Pub. Clinic, Nat. Training center, Quality Control Dep, ...)
    - ✓ Senior officials from other sectors (MoLSA, MoE, MoYS, ...), Sunni & Shiaa Endowment, Professional associations, selected national NGOs, 1-2 university research centers
    - ✓ Senior Officials of UN Agencies (UNFPA, UNICEF, WHO, ...)
- Leadership : SSC leadership will be assumed by the 3 Main Directorates (DoPH, DoP & DoTA), possibly on *Rotational basis for 1-2 years periods*
- Meeting Periodicity: SSC will meet at Semi-Annual basis
- Functions:
    - ✓ Approve & review Costed Outcome Actions Plans (central & DoHs levels);
    - ✓ Discuss Financial contribution of Partners (Cash & Non-Cash);
    - ✓ approve annual progress reports,
    - ✓ provide strategic orientations for future Action plans;
    - ✓ approve TORs & reports for Mid-term & Final Evaluation;

B) *Outcome Coordination Committee* (OCC)

For each of the Strategy Outcomes, an "Outcome Coordination Committee" (OCC) will be put in place

- Membership:
    - ✓ Heads of Departments that are directly contributing to Outcome's Interventions
    - ✓ Heads of departments from other sectors (MoLSA, MoE, MoYS, ...), Sunni & Shiaa Endowment, prof. associations, some national NGOs, university centers
    - ✓ UN Agencies (UNFPA, UNICEF, WHO, ...) ➔ Technical Officers
- Leadership / Focal Point: OCC will be led / animated by ONE of the 3 Main Directorates ➔ Selection is based on Functions / Role within each Outcome
    - ✓ One UN agency will provide technical & programmatic support to OCC Leader
- Meeting Periodicity: The OCC will meet at quarterly basis
- Functions: a) Define, review & Update a 3-years Outcome's Costed Action Plans; b) Monitor implementation of Annual Action plan; c) Harmonize efforts among partners at activity level; d) Discuss barriers & lessons learned.

C) *Governorate Coordination Committee* (GCC)

- Membership:
    - ✓ Heads of all departments directly involved in Strategy implementation.
    - ✓ Senior officials from other sectors (MoLSA, MoE, MoYS, ...), Sunni & Shiaa Endowment, prof. associations, Local NGOs / CSOs, university centers

- Leadership: GCC leadership will be assumed by DOH's General Director
  - ✓ One UN Agency will provide support for selected DoHs (based on DoH's request")
- Meeting Periodicity: GCC will meet at Quarterly basis
- Functions: ➔ Similar to functions of SSC & OCC (at central level)

Monitoring and Evaluation System & Tools

The success of any strategy depends on regular / systematic monitoring of the Strategy and its Action plans. The present Strategy includes THREE main components which will ensure adequate & regular monitoring and evaluation of the Strategy, namely:

i. Monitoring Tools (Standardized Annual Progress Reports)
ii. Monitoring & Evaluation Plan / Calendar.
iii. Monitoring Matrix: a set of SMART indicators for all Strategy's results (Goal/ Outcomes/ Outputs)

A) Monitoring Tools

- ✓ 3-years Detailed Costed Action Plans: These define all activities & milestones for each Outcome, and their respective Outputs, including all programmatic & financial details.
- ✓ Annual Progress Reports: these will identify progress and achievements of annual Action plans, including programmatic & Financial expenditures details, as well as outlining implementation challenges and barriers.

B) M&E Calendar : This plan/calendar defines monitoring & evaluation activities, as well as surveys that provide values for Goal & Outcomes indicators.

	Yr 2023	Yr 2024	Yr 2025	Yr 2026	Yr 2027	Yr 2028	Yr 2029	Yr 2030
Quarterly Report	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Annual Review Report	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Senior Steering Committee	Semi-Annual	Semi-Annual	Semi-Annual	Semi-Annual	Semi-Annual	Semi-Annual	Semi-Annual	Semi-Annual
Outcome Coordination Committee	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly
Governorate Coordination Committee	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly
Evaluations	---	---	---	---	Mid-Term	---	---	Final
Households Survey	MICS	---	---	---	??	---	---	---
Global School Survey	---	Yes	---	---	---	??	---	---
Health Facility Survey	Yes	---	---	---	Yes	---	---	Yes

C) Monitoring Matrix (Indicators with Baseline & 2027 / 2030 Targets):

This matrix contains a set of "SMART" Indicators (Goal / Outcomes / Outputs), with Baseline & Targets for year 2027 & 2030 (See Annex 1). Each indicator should have the following: Responsibility, Source, Periodicity, as well as Baseline (2023) and Targets for 2027 & 2030.

a. Goal & Outcome Indicators will be extracted from National Surveys;
b. Outputs Indicators will be extracted from MoH's Statistical reports or other quick surveys during first year (2023). Data collection will be ensured regularly, and will be managed through a data base.

SMART indicators : Specific, Measurable, Achievable, Relevant, & Time-bound

Please refer to "Annex 1" (page 53 – to 58)

Annex 1: Monitoring Matrix & Indicators

Goal Indicators

SDG Indicators	*Baseline 2023*	*Target 2027*	*Target 2030*	*Source*	*Periodicity*	*Responsibility*
2.2.1 Prevalence of stunting among children under 5 years				MICS	4 – 5 years	Min. of Planning / DoPH
2.2.2 Prevalence of malnutrition among children < 5 years, by type				MICS	4 – 5 years	
2.2.3 Prevalence of anemia in women (15 to 49 years), by pregnancy status				Survey	4 – 5 years	
3.1.1 Maternal mortality ratio				MICS	4 – 5 years	
3.2.1 Under-5 mortality rate				MICS	4 – 5 years	
3.2.2 Neo-Natal mortality rate				MICS ??	4 – 5 years	
3.7.2 Adolescent birth rate (aged 10–14 years &15–19 years) per 1,000 women				MICS	4 – 5 years	Min. of Planning / DoPH
5.2.1 % of ever-partnered women & girls (> 15 years) subject to physical, sexual/ psychological violence by current or former intimate partner in previous 12 months, by form of violence & age				MICS / I-WISH	4 – 5 years	
5.2.2 % of women & girls (> 15 years) subjected to sexual violence by persons other than intimate partner in previous 12 months				MICS / I-WISH	4 – 5 years	
5.3.1 % of women aged 20–24 years who were married or in a union before age 15 and 18 yrs				MICS	4 – 5 years	
5.3.2 % of girls & women aged 15–49 years who undergone FGM				MICS	4 – 5 years	
16.2.1 % of children (1–17 years) who experienced any physical punishment or psychological aggression by caregivers in the past month				MICS / Survey	4 – 5 years	
16.9.1 % of children under 5 years whose births were registered with a civil authority, by age				MICS	4 – 5 years	
Post-Partum Maternal Morbidity				??		
.....						
.....						
.....						

Outcome & Output Indicators

Outcome 1: Health Governance & Financing Systems

Result	Indicator	Baseline 2023	Target 2027	Target 2030	Source	Periodicity	Responsible
Outcome1: By year 2030, Enhanced Programmatic & Financial Management of WCAH Strategy	% Implementation of WCAH strategy in Mid-term & Final Reviews (Prog & Financial)	??	??	??	Review Report	2027 & 2030	Policy dep / Fin Dep
	% of Out-Of-Pocket health expenditure related to WCAH services	TBD	??	??	Socio-economic. survey	4-5 years	Min. of Plan
Output 1.1: Enhanced PH policies & plans in favor of WCAH at central & DoHs levels	% integration of WCA services into Health Insurance Package	TBD	??	??	Assessment Study	3 – 4 years	Policy Dep / RMNCA Dep
	# of DoHs that finalized a Budgeted 3-Years & yearly WCAH plans within Iraqi Timeline & Legal requisites	TBD	??	15	Central & DOHs Plans	Annually	DoP / Plan. Dep & Fin Dep
	% of Approved funding of submitted Budgeted WCAH Plans	TBD			Annual Budget	Annually	DoP / Fin Dep
	% of MoH's Annual Budget allocated to WCAH Strategy	TBD			Annual Budget	Annually	DoP / Fin Dep
	% of extra-budgetary contribution for WCAH Annual Action Plan	TBD			Annual report	Annually	DoP / Fin Dep
Output 1.2: Operationalized Efficient monitoring mechanism & System, for programmatic & Financial management of WCAH strategy at central & DoHs levels	# of Annual report (programmatic & financial) prepared (central & DOHs	TBD	??	??	Annual report	Annually	Policy Dep
	% Expenditures of Yearly Approved funding at central & DoHs level	TBD	??	??	Expense report	Annually	DoP / Fin Dep
	% of DoHs that implemented 75% of their Annual Action Plans	TBD	??	??	Annual report	Annually	DoP / DoPH
Output 1.3: Operationalized intra-ministerial & multi-sectoral coordination mechanisms	# of Quarterly Review Meetings for each "Strategy Outcome Committees"	5	5	5	Meeting minutes	Annually	DoPH
	# of Semi-Annual meeting of "Senior Strategy Steering Committee"	2	2	2	Meeting Minutes	Annually	DoP / DoPH

Outcome 2: Health Service Delivery System

Output	Indicator	Baseline 2023	Target 2027	Target 2030	Source	Periodicity	Responsibility
Outcome 2: By year 2030, Enhanced equitable availability & accessibility to quality client centered WCAH package at all levels including in humanitarian settings.	% of Births attended by skilled personal (**SDG 3.1.2)**	TBD	??	??	National Survey	4-5 Years	Min of Planning, & DoPH departments
	% of women (15-49 years) who have their FP needs satisfied with Modern Methods (**SDG 3.7.1)**	TBD	??	??	National Survey	4-5 Years	
	% of women & children covered by vaccines of National Prog. (**SDG 3.b.1)**	TBD	??	??	National Survey	4-5 Years	
	% Coverage of RMNCA service package (**SDG 3.8.1)** (ANC / PNC / FP /.....)	TBD	??	??	National Survey	4-5 Years	
	% of RMNCA users that get services from PHC centers (ANC/ PNC/ FP/ .....)	TBD	??	??	National Survey	4-5 Years	
	% of Quality of Care of RMNCA services (ANC / PNC / FP / .....)	TBD	??	??	National Survey	4-5 Years	
	% of FP users with "Fully Informed FP Choice"	TBD	??	??	National Survey		
	% of Children (1yr & 2yr) fully vaccinated as per Iraqi standards	TBD	??	??	National Survey	4-5 Years	
	% of Women & adolescents satisfied with their last experience at PHC system	TBD	??	??	National Survey	4-5 Years	
Output 2.1: Strengthen & scaling up delivery of equitable, convenient, Client-centered WCAH service packages, across PHC system & district hospitals, within a Continuum of Care approach, with particular focus on rural zones	% of PHC centers (by Type) that provide Integrated WCAH package	TBD	??		MOH	Annually	PHC Dep.
	% of Public Clinics that provide selected WCAH services	TBD	??	30 %	Annual Report	Annually	Pub. clinic dir.
	% of Health insurance clinics that provide selected WCAH services	TBD	??	50 %	Annual report	Annually	PHC Dep.
	% of District hospitals that provide Basic & Comprehensive EmONC services	TBD	??	100 %	EmONC dashboard	Annually	Curative dep / RMNC Dep
Output 2.2: Enhanced Supervision & monitoring of WCAH service delivery, with particular focus on rural / peripheral zones	% of PHCs fully equipped with Basic equipment, by PHC type	TBD	??	100 %	Annual Supervision report	Annually	PHC Dep.
	% of PHCs fully equipped with Basic Lab test, by PHC type	TBD	??	100 %		Annually	PHC Dep.
	% of PHC maternities adequately equipped for Vaginal / Normal Childbirth	TBD	??	100 %	EMONC Dashboard	Annually	RMNCA Dep
	% of district hospitals that are fully equipped for basic RMNCA package	TBD	??	100 %			Curative dep /
	% of Hospital Maternities that adequately implemented Robson system	TBD	??	100 %	Annual Report	Annually	Curative Dep
	% CS in Public hospitals	35 %	??	20%	MoH Stat. report	Annually	DoTA
Output 2.3: Improve WCAH Service Delivery Statistics & Surveillance Information systems	% of PHC facilities implementing a client-centered Data collection tools	0 %	??	?? %	Supervision report	Annually	Stat. Dep. / PHC Dep
	% of Maternal death records that provide all required information	TBD	??	100 %	Annual MPnDSR report	Annually	RMNCH Dep / Curative Dep.
	% of Peri-Natal death records that provide all required information	TBD	??	100 %			

Outcome 3 : Human Resources System

Result	Indicator	Baseline 2023	Target 2027	Target 2030	Source	Periodicity	Responsibility
Outcome 3: By Year 2030, Enhanced availability & distribution of skilled human resources for adequate delivery of RMNCA services, with particular focus on PHC system, and Peripheral / Rural zones (Equity concern)	% of PHC centers (Main & Sub-centers) with minimum & gender-sensitive Team of Qualified & Skilled health Care Providers	TBD	??	??	Health Facility Survey	4years	HR Dep / PHC Dep
	Satisfaction & Motivation of Health Care Providers at PHC system	TBD	??	??	National Survey	4years	
Output 3.1: Newly Graduated physicians, nurses/ midwives, public health workers have WCAH service delivery skills	% of Newly graduated HCPs that are posted for at least ONE year to PHC centers during their Graduation period (by HCP categories)	TBD	??	??	HR Dashboard	Annually	Human Resource Dep.
	% of Medical & Nursing colleges / institutes that integrated the WCAH skilled-based Package by category	TBD	??	??	Assessment	3- 4years	Hum Res. Dep / RMNCH Dep
	% of newly graduated HCPs (by categories) trained on WCAH package during their orientation course (prior to Graduation period)	TBD	??	??	Orientation Dashboard	Annually	Nat. Train. Center / PHC Dep.
Output 3.2 : Client-centered, Skills-based in-Service training provided to All Categories of HCPs, with priority for newly recruited at PHC system	% of DoH that have a "Unified" WCA Team of Trainers	TBD	??	??	Training Dashboard	Annually	RMNCA Dep / Nat. Train. center /
	% HCPs (by category) working at PHC system who completed the In-Service / Skills-based Client-centered WCAH training	TBD	??	??			
Output 3.3 : Enhanced management of existing HRs deployed to PHC system & district hospitals, with priority to peripheral & Rural zones & in Humanitarian Settings	% of PHC facilities & district hospitals with Minimum HCP Staffing (by type / governorates)	TBD	??	??	Hum. Res. Dashboard	Annually	DoP / HR Dep & Statistic Dep)
	% of PHC centers (Main & Sub-centers) where women & Child services are led / initiated by qualified & skilled female nurses	TBD	??	??	Supervision Dashboard	Annually	RMNCA Dep. / Nursing Dep

Outcome 4 : Health Technologies & Pharmaceuticals System

Output	Indicator	Baseline 2023	Target 2027	Target 2030	Source	Periodicity	Responsibility
Outcome 4 : By Year 2030, Enhanced sustainable availability & accessibility of Essential WCAH commodities & equipment	% of health facilities (by level) that have a core set of essential RMNCA medicines available & affordable on a sustainable basis ➔ **SDG 3.b.3**	TBD	??	??	Health Facility Survey	Every 3 – 4 years	Pharm. Dep / PHC dep.
	% of RMNCA clients who received Basic WCAH commodities (Ferro – Folic, Vit A, ...), from PHC system & Public sector	TBD	??	??	National Survey	4-5 years	Min. of Plan / DoPH
	% of FP users who received FP Commodities from Public sector	10% (yr 2021)	??	??	National Survey	4-5 years	Min.of Plan / DoPH
Output 4.1: Basic WCAH commodities adequately included into Iraqi EDL, respecting rights & needs of women, children & adolescents	% of Essential WCAH commodities included on Iraq EDL / EML as per National WCAH Guidelines (segregated by categories)	TBD	??	100%	Annual report	Annually	Pharmacy Dep. / DoPH
	# of registered WCAH "products & producers" by category & commodity	TBD	??	> 3-5 [11]	Annual Report	Annually	Registration Dep.
Output 4.2 : Forecasting, & Procurement systems are updated to secure adequate stocks of WCAH essential commodities & Basic equipment for all levels of PHC systems	% of essential WCAH items (supplies & Equipment) procured by KIMADIA compared to National Guidelines & EML	TBD	??	??	Annual report	Annually	KIMADIA / RMCH Dep
	% of quantities of WCAH items (supplies & equipment) procured by KIMADIA compared to forecasted	TBD	??	??	Annual report	Annually	KIMADIA
	% or Number of Public Clinics, Pharmacies & Private Clinics (Profit & Non-Profit) collaborating with Social Marketing program	Zero	??	??	Annual report	Annually	Collaborating partners
Output 4.3 : Enhanced management & distribution of WCAH Basic supplies at all levels to minimize over or under-stocking at SDPs	% of SDPs (segregated by categories) submitting complete & accurate periodic reports for selected WCAH items	TBD	??	??	eM&LIS	Semi-annual	Pharm dep.
	% of PHC SDPs (segregated by categories) with no stockouts of selected WCAH commodities for last 3 months	TBD	??	??	eM&LIS	Semi-annual	Pharm. Dep

[11] 3-5 Producers with at least one relevant product

Outcome 5 : Demand Creation

Output	Indicator	Baseline 2023	Target 2027	Target 2030	Source	Periodicity	Responsibility
Outcome 5: By Year 2030, Improved Demand & Utilization of Preventive WCAH services, including adoption of healthy lifestyle among women, children & adolescents, particularly in rural & poor urban zones, & in humanitarian settings	Age Standardized Prevalence of Current Tobacco use among persons aged 15 to 24 years (**SDG 3.a.1)**	TBD	??	??	National Survey	4- 5 years	Min of Plan / DoPH
	Proportion of Women (15-49 years) who make their own informed decisions regarding SRH & contraception (**SDG 5.6.1)**	TBD	??	??	National Survey	5 years	Min of Plan / DoPH
	% of Women & Girls victims of domestic violence in previous 12 months who looked / sought professional assistance (**SDG 16.3.1)**	TBD	??	??	National Survey	4 - 5 years	Min of Plan / DoPH
	Comprehensive Knowledge of HIV Prevention among young female & male (15-24 years)	TBD	??	??	National Survey	5 years	Min of Plan / DoPH
	Discontinuation Rate of WCAH services (ANC 1st & 4th / Infant Visits)	TBD	??	??	National Survey	5 years	Min of Plan / DoPH
	% of FP users that used "Modern FP methods"	~ 66 % (2021)	??	90 %	National Survey	5 years	Min of Plan / DoPH
	Fully immunized children by one year of age	TBD	??	??	National Survey	5 years	Min of Plan / DoPH
	% Coverage of 3rd PNC visit (at 6 weeks after Delivery)	TBD	??	??	National Survey	5 years	Min of Plan / DoPH
Output 5. 1: Expanded evidence-based "Community & Mass media interventions on women & Child Health issues, particularly in poor urban & rural zones & humanitarian settings	% of MOLSA / NGOs social centers that integrated Women/Child health, & Domestic Violence issues into their community-based awareness activities	TBD	??	??	Reports	Annual	MOLSA
	% of illiteracy eradication centers that integrated awareness on Women/ Child health, & Domestic Violence into their curriculum	TBD	??	??	Reports	Annual	Min. of Education
	% of population reached with WCAH messages through TV, Radio, SMS	TBD	??	??	Quick Survey	Annual	CMC / Media dept.
	% of Mosques where Imams & Female religious educators integrated RMNC health issues, into their educational activities for men & women	TBD	??	??	Reports	Annual	Sunni & Shiite endowments
Output 5.2 : Expanded evidence-based institutional interventions targeting Adolescents & youth particularly in poor urban & rural zones, & in humanitarian settings	% of youth centers that integrated healthy Life style & Life skills into their existing training / educative courses (by governorates & gender/sex)	TBD	??	??	Reports	Annual	Min. of Youth & Sports
	% of Intermediary & secondary schools that integrated Healthy Life style & Life skills into their health education Activities	TBD	??	??	Reports	Annual	Min. of Education
	% or Number of districts of youth centers & other social centers that offer 'Pre-marital courses for newly-engaged / married young couples	TBD	??	??	Reports	Annual	MoYS & MoLSA

Critical factors of Success

1. Decision makers at central and local levels would demonstrate earnest buy-in and commitment to address root causes affecting PHC system within a multidimensional & horizontal perspective. This commitment has to be a sustained, long term expression of interest that is neither transient nor elective.
2. It is critical to reach consensus around shared responsibility of all relevant stakeholders for addressing challenges, which cannot be possibly handled by a single government institution, and which require Both "Intra-sectoral" and "Multi-sectoral" collective action.
3. It is crucial to ensure a dynamic engagement of Iraqi CSOs, as well as the private sector. Coordination becomes of paramount significance to avoid duplication of efforts and prevent wasteful use of resources.
4. It is critical to create space for introducing and applying creative innovations that can proportionately respond to magnitude and complexity of issues and problems, with an emphasis being placed on demonstrating renewed commitment towards implementing the traditional solutions that have proven to be successful in other developing countries of comparable contexts.
5. It is critical to have in place a vigorous monitoring and evaluation system, both at central & Governorate levels. This should be supplemented with a robust component for social science research with focus on social Health determinants, and population satisfaction and acceptability of services provided at all levels, particularly at PHC system.

Conclusion and Way Foward

This document should be used together with other important national documents such "National Health Policy". Moreover, this updated *Strategy* serves as an important guide and step forward to reach Iraq vision of ensuring that all women, children and adolescents not only avoid deaths but also thrive. the Strategy provides an overall operational vision, as well as main key interventions with targets (indicated within the Monitoring Matrix).

Meanwhile, the "Way Forward" demands :

- ✓ continuing the promotion of UHC and comprehensive essential health services,
- ✓ strengthening health systems,
- ✓ investing in building a diverse and professional health workforce, and most importantly .
- ✓ strengthening of government leadership and regulatory functions to ensure sustainable health investment for basic health services and adoption of policies & standards that address risk factors.

Multisectoral action through "Health-in-All-Policies" approach will not only promote health but will also help to address health risk factors and determinants, including by mitigating health impacts of COVID-19 pandemic and climate change.[12]

[12] Progress on Health-related SDGs and targets in the Eastern Mediterranean Region, 2020: http://www.emro.who.int/images/stories/est/documents/progress-on-health-related-sdgs-and-targets.pdf?ua=1

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List of Participants

≠	Names	Job Location
	Directorate of Public Health	
1	Dr	DG of Public Health Directorate
2	Dr. Raghad Abdul-Ridha	RMNCA Department / Dir. of PH
3		
4	Dr. Lujain Kadhim Muhammed	
5	Dr. Tayseer Salah Ghaffoori	
6	Dr. Thanaa Hussein Salih	School Health section / Youth health manager/ Dir of PH
7	Dr. Ihab …….	PHC Dep. / Dir of PH
		Nutrition Dep / Dir. Of PH
		Immunization Dep. / Dir of PH
		NCD Dep / Dir PH
		Health Promotion Dep. / Dir of PH
	Directorate of Technical Affairs (DoTA)	
		Pharmacy Dep.
		Registration Dep.
		Need Estimation Dep.
		Curative Dep.
	Directorate of Planning (DoP)	
		Policy / Planning Dep.
	Dr Omar Abdul Ameer	Finance Dep.
	National Center for Training & HR Dev.	
	Quality Control Dep.	
	Governorate Directorate of Health	
List of UN Participant		
1		WHO Representative / Iraq
2		
4		
5		UNICEF
6		
7		UNFPA
8		