Abt Associates Inc.

Final Summary Report
Iraq Health Systems Strengthening Project

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Acronyms and Abbreviations

BIAP	Baghdad International Airport
CO	Contracting Officer
COP	Chief of Party
CRC	Continental-US Replacement Center
CTO	Cognizant Technical Officer
CPA	Coalition Provisional Authority
DHS	Domestic Household Survey
HIS	Health Information System
IEC	Information Education and Communication
IHELP	Iraq Health Empowerment and Leadership Program
IHSS	Iraq Health Systems Strengthening
IHSSP	Iraq Health Systems Strengthening Project
LDC	Least Developed Country
M&E	Monitoring and Evaluation
MOH	Ministry of Health
N-QIP	National Quality Improvement Program
NGO	Non-government Organization
NHA	National Health Accounts
OB/GYNE	Obstetrics and Gynecology
PCO	Project and Contracting Office
PHC	Primary Health Care
PHCI	Primary Health Care Initiative
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The Iraq Health Systems Strengthening Project was designed to provide assistance to the Iraq health sector using a top-down/bottom-up strategy. This focused on strengthening the ability of the MOH to support future health sector reform activities (top-down) and to increase the capability of health care providers at the PHC clinic level to provide care with an emphasis on the provision of maternal and child care (bottom-up). The project provided support through a broad array of technical advisors, development of tools and processes for the MOH, implementation of a small grants program, training of PHC providers, procuring essential PHC equipment, and leading the development of the vision and plan for health sector reform in Iraq for 2005 and beyond.

While the initial project award was set at approximately $43 million for one year, the project endured severe funding cuts of more than 50% in early January 2004 with final funding capped at approximately $23.5 million and extension of the project period of performance to 19 months (ending November 2004).

In addition to funding constraints, the project experienced a number of significant challenges including working under extreme security risk, mobilizing staff in an ongoing conflict environment, dealing with the complex relationships involving the CPA, USAID, and MOH, and managing client relationships.

In spite of these challenges and severe funding reduction, the IHSS project was able to successfully implement the IHSS Project under extreme conditions. Most importantly the Abt Associates Team has contributed a great deal to the strengthening of the Iraqi health care system and the development of reform strategies that will have tremendous impact on the Iraqi health care system. Abt has provided broad support regarding evaluation and assessment of the Iraqi health sector. Abt has completed the most comprehensive assessment of PHC capability in Iraq to date and assisted with the development of a detailed facilities database that is guiding the planning and resource allocation activity for the MOH. Abt has completed assessments of the capability of the Iraqi health system to deliver care in 11 governorates and has completed studies of costing and health care utilization, drug and medical supplies procurement and distribution, and PHC quality indicators and improvement strategies. The Abt team has improved PHC service delivery by establishing education and training centers in Basra, Al Kut, Kirkuk, Mosul, and Najaf, training core PHC trainers, and delivering training to more than 700 PHC providers. Abt worked with the MOH to develop equipment packages for PHC and procured this equipment for delivery to more than 600 clinics throughout the country. The I-HELP (IHSS) small grants program has funded approximately 30 grants that support broad strengthening of health care delivery, education and training, and health sector reform.

Abt has also supported the strengthening of core MOH functions, which have included capacity building in budgeting and expenditure tracking, capacity building in the establishment and use of NHA, delivery of a capacity-building workshop in Monitoring and Evaluation (M&E), and development of a system for the national rollout of M&E

training. Abt has played a lead role in developing the health sector reform strategies for Iraq. Through a laborious working group process, managed by Abt staff, a comprehensive strategic vision for health sector reform was developed to guide reform strategies for 2005 and beyond. This effort has continued and includes the development of detailed strategic and implementation plans for the national health information system, women's health, nursing and nursing education, pharmaceutical and medical supplies procurement and distribution, facilities master planning, and the introduction of NHA. Abt has also provided detailed recommendations regarding health care financing and the establishment of a provider payment system.

This document summarizes the IHSS project and its over 75 technical reports and documents. These deliverables encompass activity in the areas of general assessments and studies, support for health service delivery, support for health systems strengthening and reform, and a small grants program.

In addition, this document reviews various challenges and discusses some of the most significant lessoned learned regarding working in a dynamic post conflict environment, dealing with implementation obstacles, working with local Iraqi staff, procuring and delivering essential equipment, and dealing with the complex relationship between the CPA, USAID, and MOH. Recommendations are made for consideration in planning for future Iraqi health projects.

Introduction

The health environment in Iraq has been reduced to among the worst worldwide. Deterioration of the health system follows the Iran-Iraq War of 1980, the Persian Gulf War of 1991, and the subsequent imposition of UN sanctions on Iraq. Deterioration was further exacerbated by wide spread mismanagement at the hands of the government system in place before 2003 and redirection of government spending on health into other non-health related areas. The initiation of the Oil-for-Food program in 1995 has only partly mitigated the humanitarian crisis in the country. In spite of this, Iraqi infrastructure and basic public services have continued to deteriorate. This has further widened gaps in the provision of basic health services. The post war environment of 2003 and ongoing conflict in Iraq has resulted in additional deterioration of basic health services due to damage to public utilities and infrastructure, reduced access to drugs and medical supplies, the lack of repair and maintenance of hospitals and health clinics, and reduced access to clean water and proper sanitation.

In general the health and demographic indicators for Iraq describe a declining health system that is worse than most developing countries. As an example, based on a 2002 analysis by the Population Reference Bureau the total fertility rate in Iraq is 5.4 (least developed country – LDC average is 3.1), infant mortality is 103 (LDC average is 60), and life expectancy at birth is 58 years (LDC average is 65). In addition, as reported by UNICEF (UNICEF Emergency Update, October 7, 2002), almost one-third of all children in the south and central regions of Iraq suffer from chronic malnutrition. This same report describes a very high child mortality rate of 131 for children under 5 years, which has more than doubled from the previous decade. Low exclusive breast feeding, high prevalence of anemia among women, and a high incidence of low birth weight all contribute to this problem. Diarrhea and acute respiratory infections account for 70% of child deaths.

Improvement of the Iraq health sector and reducing the immediate and long-term risk for vulnerable populations requires a multi-faceted approach. In support of this, funding was made available through USAID for the Iraq Health Systems Strengthening project (IHSS). The IHSS contract commenced in May 2003 and completed its period of performance in November 2004. Most of the activity under this contract was concentrated within the period of November 2003 through April 2004.

This document summarizes IHSS activity and the deliverables that resulted. This includes a review of the more than 75 technical documents related to:

- Management of a small grants program
- Health policy and reform strategic planning
- Health care provider training and equipping
- MOH capacity building
- Technical advisory support
- Development of technical tools for the MOH
- Disease surveillance and HIS

- Assessments of the general health sector, PHC, medical facilities, and pharmaceutical and medical supply management capability among others.

A brief discussion of the development of project workplans is included as is a discussion of the impact that funding reductions had on the project. This document also provides a review of the major challenges faced and lessons learned from working in a post war, albeit ongoing conflict environment. Additional challenges related to the unique structure of the government and interrelationships between USAID, the Iraqi MOH, and the Coalition Provisional Authority are discussed.

Operations

General

The IHSS project began in May 2003 with an anticipated period of performance of one year and an award of approximately $43 million. In December 2003, the USAID Iraq program was forced to make broad cuts in funding. This resulted in reduction of funding for the IHSS contract to less than $21 million. This forced many changes to the project and subsequently resulted in the development of a new workplan which detailed project activity reflective of the reduced funding (See **Appendix A, B,** and **C** for the initial and revised workplans including the final amendment).

The environment in Iraq during the project period was one of instability and at times extreme security risk. Specific aspects of the security environment will be further discussed below. However, the rapid deterioration of the security situation in 2004, which began in April and continued a steady decline through November 2004, had a direct impact on the projects ability to move within the country and for the USAID logistics contractor Logenix to finalize delivery of essential primary health care equipment procured under the IHSS contract. In order to monitor this activity and coordinate with the Iraqi MOH and USAID, the IHSS contract was extended through November 2004 with total funding of approximately $23.5 million.

During the summer of 2003, the IHSS project established headquarters operations within a securable compound in central Baghdad. Following finalization of the workplan with USAID, the project proceeded to recruit and hire the necessary local staff and any remaining expatriate staff. Operations were subsequently expanded across the country with establishment of offices and support staff in Basra, Al Kut, Hilla, Kirkuk, and Erbil. Additional space was provided at the central MOH. As a result of lower activity than expected in Hilla and subsequent funding cuts made by USAID the decision was made to close the Hilla office in December 2003.

Staffing and Spending

Initial mobilization of project staff was challenging. The project fielded key managerial staff within 30 days of contract award. However the fielding of critical technical staff was delayed for several reasons. The environmental situation contributed to a moderate

delay in identifying a suitable site for long-term operation. This coupled with the mandatory requirement for all staff to attend CRC training in the United States resulted in additional delays in getting technical staff to the field. Additionally, TCN staff experienced delays in getting the appropriate VISA for transit through Kuwait or Jordan adding to the problem.

However, the most significant contributor to delayed fielding of technical staff was deterioration of the security situation. At the time of award in May 2003, it was anticipated that conditions on the ground in Iraq would experience steady improvement. Unfortunately this was not the case and lack of progress in this area significantly deterred mobilization of technical staff, short-term consultants, and subcontractors

Further compounding these environmental delays was the departure of the original COP in August 2003, departure of the Director of Finance and Administration in October 2003 and departure of the Manager of the Small Grants program in December 2003. An interim COP was provided until final replacement in November 2003. The responsibilities of the Director of Finance and Administration and Small Grants Manager were assumed by our remaining staff and supported by short-term visits by domestic specialists.

The project provided a mix of long-term and short-term advisors for the MOH. This mix of advisors was determined in close consultation with the Senior Health Advisor for the CPA and his Chief of Staff along with the USAID CTO. As with our core managerial staff, identifying and securing these advisors also posed challenging due to the nature of the working environment in Iraq. In addition, budget constraints imposed in December 2003 also reduced the number of advisors that could be fielded.

A summary of the staffing activity of the IHSS project is depicted in Figure 1. Panel A of Figure 1 describes the relative expatriate staff that were provided as short-term consultants and long-term managerial/advisory staff in Iraq. Panel B compares and contrasts local staff with expatriate staff. As can be seen, at the request of USAID the project attempted to maintain local Iraq staff in the field to the extent possible and at the expense of expatriate staff from June 2004 thru November 2004.

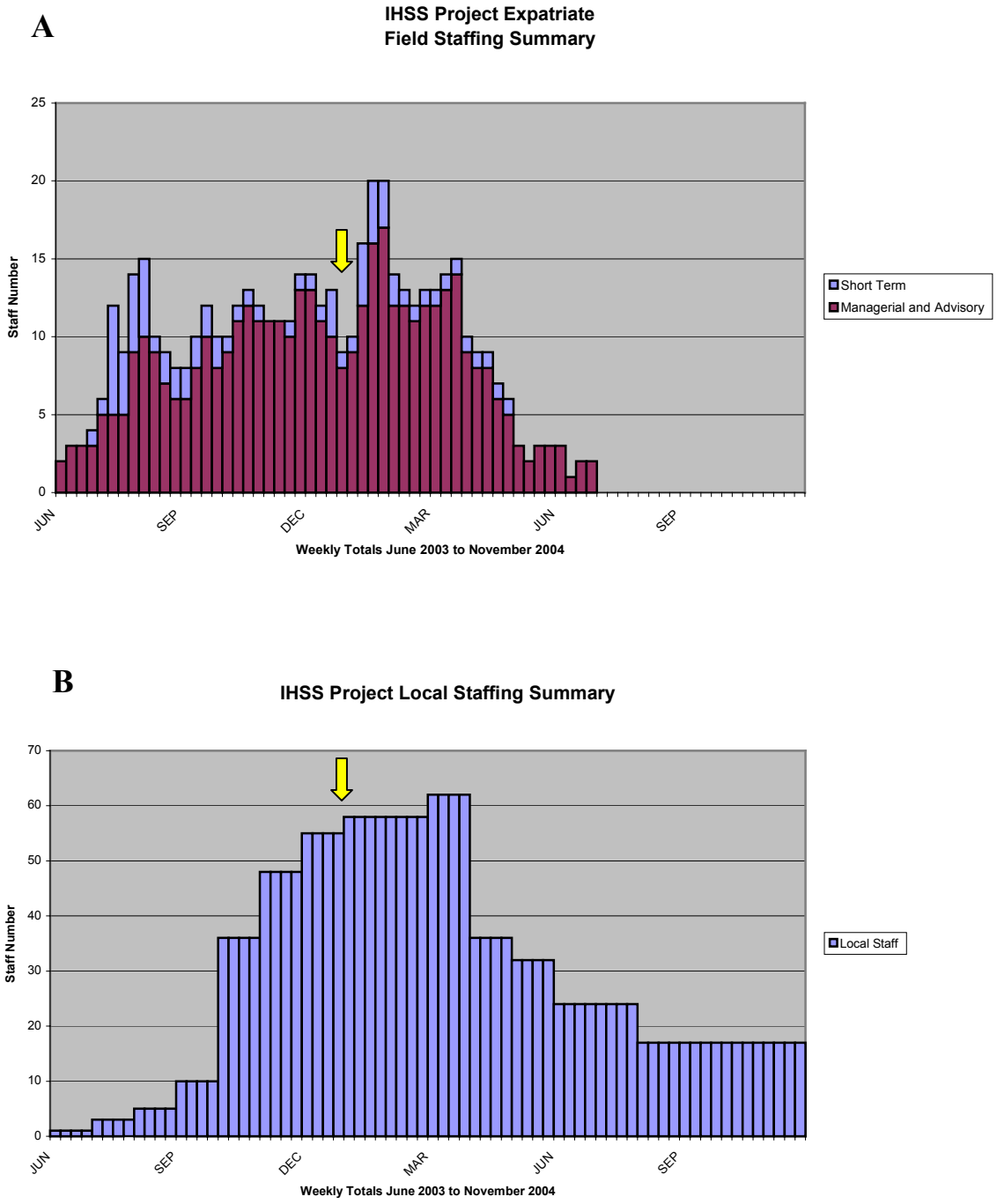

Figure 1. Summary and comparison of field staffing for the IHSS Project. Panel A summarizes the staffing of expatriates in Iraq. This includes both long-term technical and managerial staff as well as short-term consultants and advisors. Panel B summarizes staffing of local Iraqis for the project. The arrow in each Panel represents the point of notification by USAID of 50% reduction in overall funding of the IHSS contract.

Project spending and therefore overall project activity was directly correlated with the pattern of expatriate staffing. This is depicted in Figure 2. As can be seen from both Figure 1 and 2 the majority of project activity was concentrated between December 2003 and April 2004.

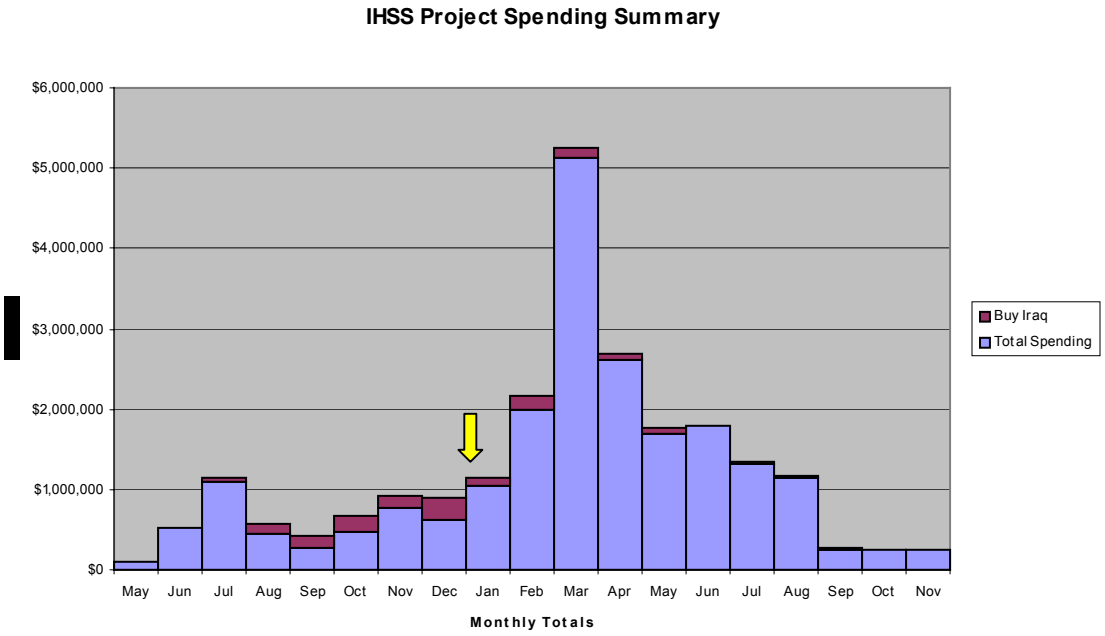

Figure 2. Summary of spending for the IHSS Project.
Spending is broken down into total spending and spending that directly supports the local Iraqi economy through purchases and salaries (Buy Iraq). The arrow represents the point of notification by USAID of 50% reduction in overall funding of the IHSS contract. Spending in Feb thru May includes payment of subcontractor expense as well as payment for a large procurement of Primary Health Care equipment as described below.

Unfortunately, as the project was maximizing field activity USAID reduced overall funding by more than 50% (Figures 1 and 2). This forced rapid restructuring of the project in all areas and is represented as changes in the workplan described in **Appendix B and C**.

Security

At the time of contract award, we were not advised by USAID to secure additional security for the project. However, events during the first 3 months of the project warranted an expert assessment of the environment. The project proceeded to enlist the services of professional security consultants currently working in Iraq. Based on this assessment, the project obtained services from expatriate security consultants supported by additional local Iraqi security guards. In addition specific actions were taken to

maximize the security of our residential and headquarters compound which included the purchase and installation of concrete barriers surrounding the perimeter, purchase and installation of rolling gates at compound entrance points, purchase and installation of radio communication equipment and armored vehicles. Security was also increased in our regional offices.

Security consultants were deployed beginning in October 2003. The number of expatriate consultants was based on initial assessments and recommendations. In addition, specific policies were mandated by the CPA which dictated the minimum configuration of security details for transportation of project staff within Baghdad and elsewhere across the country. This had a major bearing on the total security consultants employed at any given time. This number was adjusted based on anticipated travel needs and the requirement to maintain adequate coverage of project sites. As a result, the number of expatriate security staff varied from 3 to 8 over the life of the project and the maximum number of local Iraqi security guards employed exceeded 40. As can be appreciated, the cost for security became a significant part of IHSS spending.

While significant measures were taken to secure our living and working spaces, the project experienced repeated disruptions that were directly related to changes in the security environment. These were mostly in the form of restricted movement of expat staff during "lock down" periods imposed in response to changes in the local security environment or through mandatory restrictions imposed by USAID or the CPA. These movement restrictions were most notable during significant religious or national holidays and during transitional periods for the Iraqi government and CPA.

During April-May 2004, the increased numbers of attacks and kidnappings of expatriates supporting the coalition and Iraqi government in combination with increases in the direct attacks along the access road to the international airport (BIAP) forced expatriate staff to leave the country and setup temporary operations in Amman, Jordan. During our extended period of stay in Amman, project staff continued to finalize documents and work through local Iraqi counterparts. As much of our technical work had completed by that time, the project proceeded to demobilize expatriate staff to the extent possible.

The security situation continued to deteriorate from July 2004 through November 2004. This involved increases in kidnappings and killings of humanitarian workers, increased attacks on Iraq police and military, increased targeting of Ministerial infrastructure and the BIAP, increased unrest within certain impoverished and religious communities, and general increase in tensions as the country drew near to the Iraq elections. Unfortunately, the environment in Iraq has continued to pose serious problems to humanitarian efforts. This is expected to worsen as the country moves closer to elections, which are anticipated to take place in January 2005.

Project Activities

Implementation Strategy

The IHSS project's broad and long-term vision was to empower the Iraqi's to shift the focus of the health delivery system from inpatient to PHC, to improve the performance of the health care system, and to establish a strategic foundation for the implementation of broad health sector reform initiatives.

Together with Iraqi partners, the implementation strategy IHSS used to create movement toward realization of the above vision consisted of four main parameters:

- A top-down, bottom-up approach;
- Focus on both short-term improvement of health system operations and longer-term development of a sustainable health system;
- Capacity building wherever possible through a small grants program and institutionalization of service delivery and reform activities;
- Close collaboration and coordination with USAID, the Coalition Provisional Authority/MOH and other donors and projects.

Top-down, bottom-up

The top-down approach is health systems strengthening. It is national in scope and largely relates to the policy and finance functions and to key system elements.

The bottom-up approach is health care service delivery. It largely relates to management functions and health care provider elements. It is targeted at the Governorate level and involves the development of service delivery capacity in several hundred-health centers in seven governorates.

Short-term and long-term improvements

The second parameter of the implementation strategy focused on both short-term improvement of operations and longer-term development of a sustainable health system. Strengthening of some systems and processes helped improve the operation of the health system in the short-term; however, it was critical to maintain focus on the longer-term development of a sustainable health system through design of longer term reform strategies.

Capacity Building

The third parameter involved institutionalization of capacity and activities wherever possible providing a long-term foundation for community involvement. Our small grant program was critical to the process of capacity building and institutionalization. The entire process was bottom-up and coordinated with Governorate and/or local health authorities. The small grants were consistent with the decentralization vision and tenets outlined by the MOH. The concept of community involvement in health issues were clearly in their planning as functions that should be strengthened and functions that should be delegated to the district and local level. As an example, rather than IHSS directly implementing nursing activities we provided a small grant to nursing associations. Another grant supported doctor and health professional organizations. This helped build capacity and create small victories that increased ownership and pride among the Iraqis. In addition, it was consistent with the MOH delegating functions such as continuing education or certification of nurses and medical professionals to associations in the future. Capacity building as a parameter of our implementation strategy applied to all activities.

Collaboration

The fourth parameter of the implementation strategy involved close collaboration and coordination with the Coalition Provisional Authority/MOH and all other donors and projects. It was a priority of IHSS to support the MOH through providing technical assistance where requested. In the short-term, the Working Group process and participation in various NGO and other donor forums provided an excellent vehicle to determine comparative advantages, collaborate on activities, and develop relationships.

Workplan

In support of IHSS activities, a workplan was drafted and approved in July 2003 (**Appendix A**). As a result of reduction in funding by USAID in December, 2003, a revised workplan was drafted and implemented in January 2004 and with slight modification was finalized in May 2004 (May Revised Workplan, **Appendix B**). This was further amended in July 2004 (**Appendix C**). This resultant workplan included project activity and related deliverables that were completed through December 2003 with modification for the period January through November 2004. Modifications in project activity were commensurate with funding reductions from the original contract amount of $43 million to the reduced contract funding of approximately $23.5 million.

Accomplishments

The changes Abt implemented in the fall of 2003 and the outstanding efforts of the IHSS team have resulted in successful implementation of the IHSS Project under extreme conditions. Most importantly the Abt Associates Team has contributed a great deal to the

strengthening of the Iraqi health care system and the development of reform strategies that will have tremendous impact on the Iraqi health care system. Abt has provided broad support regarding evaluation and assessment of the Iraqi health sector. Abt has completed the most comprehensive assessment of PHC capability in Iraq to date and assisted with the development of a detailed facilities database that is guiding the planning and resource allocation activity for the MOH. Abt has completed assessments of the capability of the Iraqi health system to deliver care in 11 governorates and has completed studies of costing and health care utilization, drug and medical supplies procurement and distribution, and PHC quality indicators and improvement strategies. The Abt team has improved PHC service delivery by establishing education and training centers in Basra, Al Kut, Kirkuk, Mosul, and Najaf, training core PHC trainers, and delivering training to more than 700 PHC providers. Abt worked with the MOH to develop equipment packages for PHC and procured this equipment for delivery to more than 600 clinics throughout the country. The I-HELP (IHSS) small grants program has funded approximately 30 grants that support broad strengthening of health care delivery, education and training, and health sector reform.

Abt has also supported the strengthening of core MOH functions, which have included capacity building in budgeting and expenditure tracking, capacity building in the establishment and use of NHA, delivery of a capacity-building workshop in Monitoring and Evaluation (M&E), and development of a system for the national rollout of M&E training. Abt has played a lead role in developing the health sector reform strategies for Iraq. Through a laborious working group process, managed by Abt staff, a comprehensive strategic vision for health sector reform was developed to guide reform strategies for 2005 and beyond. This effort has continued and includes the development of detailed strategic and implementation plans for the national health information system, women's health, nursing and nursing education, pharmaceutical and medical supplies procurement and distribution, facilities master planning, and the introduction of NHA. Abt has also provided detailed recommendations regarding health care financing and the establishment of a provider payment system.

Details of these accomplishments are described in the outputs and deliverables that follow.

Outputs and Deliverables

IHSS project activity was segregated into the following areas:

1. Preliminary health sector assessments and studies
2. Support for improving health care delivery
3. Support for health systems strengthening
4. Small grants program

The project deliverables and outputs for each area are described below. Each principle deliverable is numbered along with a brief description. The reader is referred to the original document for detailed information (see Bibliography).

Preliminary Health Sector Assessments & Studies

The major objective for the performance of preliminary assessments and studies was to establish baseline information that would help shape the IHSS project. This work focused on the overall quality of the health sector in Iraq. Field review of hospital and clinic capabilities helped establish priorities for various project activities. Governorate visits helped elucidate those governorates that would be most suitable for provider training and other decentralized activities. A study of resources and costs for the primary health care sector was performed in order to help guide health care finance reform strategies. A preliminary review of infant and maternal mortality helped to identify potential areas for provider based interventions. As a result, the project generated five general preliminary assessments/studies that are described below.

4. **Iraq Health Inputs, Indicators, and Facilities: Baseline Data for the Iraqi Health System Strengthening Project.** Jeanne Wendell. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. July 2003.

   This report was generated in conjunction with the IHSS subcontractor Huffman and Carpenter, and organizes and summarizes existing data relevant to the current Iraq health system including: 1) Inputs into the production of health in Iraq, 2) Planning data, 3) Health in Iraq, and 4) Data on health system facilities in Iraq. The following maps are part of this report but also provided as separate documents for independent use:

   - Governorates and Major Cities
   - Specialized Health Centers
   - Government Warehouses
   - Pharmacies for Rare Drugs
   - Chronic Illness Pharmacies per 100,000 People by District
   - Hospital Beds per 1000 Persons by District
   - Hospitals with at least 200 Beds
   - Largest Health Care Facility Type by District
     - Combined Data File Containing Maps for:
     - Underweight Children less than 5 Years Old
     - Water Supply from nearby Network, Tap, or Well
     - Water Supplied per Capita per Day by Network (Urban Areas)
     - Water Supplied per Capita per Day by Network (Rural Areas)
     - Population with Sanitation from Flush to Sewage or Septic Tank
     - Children 6-11 Years Old Enrolled in Primary School
     - Ethno-Religious Groups

2. **Field Visits to 11 Governorates by IHSS Staff: A Trip Report.** Nagib Hussein and Xingzhu Liu. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. July 2003.

This report provides an assessment and review of the health care system in 11 governorates in Iraq with the following primary objectives:

- Assess the availability and accessibility of primary health care (PHC)
- Identify the system and policy needs for health policy makers
- Gather information for planning the IHSS project and its implementation
- Identify potential challenges of improving the performance of the Iraqi health system

3. **Health System Strengthening in Post-Conflict Iraq: A Trip Report.** Tim Ward. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. July 2003.

   This report contains the results of an assessment of Iraq healthcare facilities made by a team of medical facility specialists from the IHSS-subcontractor, Health Services Engineering, Inc. (HSE). This group assessed a representative sample of primary healthcare clinics and hospitals in and around Baghdad. The assessment focused on the physical status of the medical facilities including existing systems and utilities and the capacity of these facilities to support new medical equipment and supplies.

4. **Resources and Costs in the Primary Health Care Sector of Iraq: Baseline Study.** Alexander Telyukov, Mary Paterson, Marwa Ezzat Faraq, Imad A. Salam, and Al-Shiakhli. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. September 2003.

   This study was undertaken to establish a basis for making improvements to the primary health care sector in Iraq and for establishing a baseline for demonstrating health system strengthening impacts. The overall aim was to examine organization, costs, financing, and delivery system accessibility before the conflict in 2002, and to take a snapshot again after the conflict in the Summer of 2003. Since no prior work had been done to document the expenditures in primary care facilities in Iraq, a secondary aim was to develop and validate a costing methodology and budgeting templates for primary care facilities that can be used by the MOH in the future.

5. **Preliminary Study of Deliveries and Infant and Maternal Mortality in Iraq.** M. Linda Brown. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

   In support of the maternal and child health focus of the IHSS project, this document reviews MOH data on infant and maternal mortality with special attention being given to the high rate of C-sections performed in Iraq and its potential correlation with low-birth weight and infant mortality.

Support for Health Care Delivery

The health care delivery component was designed to provide bottom-up support for the health system. This support was focused on the need to strengthen the provision of primary health care with an emphasis on maternal and child health. This emphasis was in

direct response to high infant and maternal mortality rates, low birth weights, and the goal of USAID programs to support a 50% reduction in infant mortality by 2005.

The IHSS Project focused it efforts on training PHC providers in best practices in PHC and supporting PHC clinics through the provision of essential equipment. Training was concentrated within 7 governorates which were agreed by USAID to form the core governorates of the IHSS project. These governorates were determined following assessments of the health care system and visits to select regions described in the preliminary reports and assessments above. Core IHSS governorates included Basra, Thi-Qar, Najaf, Karbala, Wassit, Tameem (Kirkuk), and Ninnewa (Mosul).

The training program was designed using a standard "training of trainers" model and utilized Iraq talent to deliver training across the country. The training program was a modification of the very successful program that was developed by Abt for the PHCI program delivered in Jordan. In total over 700 physicians were trained during a 5 month period.

In conjunction, essential equipment for PHC was procured for delivery to over 600 clinics across the country. This number reflected over 70% of the MOH clinics that were staffed by a physician. Essential equipment was determined through collaboration with the MOH and packaged in "kits" for final delivery by the USAID logistics contractor. Clinics were also selected by the MOH and were distributed across every governorate in the country. Essential equipment for emergency obstetric care at the hospital level was also determined and these lists were provided for future development by other donors.

In support of this program, the project performed a series of detailed assessments of the capability of clinics to provide primary health care. These assessments allowed the project to establish a baseline picture of the status of PHC delivery in MOH clinics and to further shape equipment packages and training to better meet the needs of Iraqi PHC physicians. In addition the health education component was directed at further elucidating the level of satisfaction and gauging opinions of users of clinics in order to structure future IEC materials and campaigns.

The deliverables associated with Health Care Delivery have been organized in the following categories and are further described below:

- Assessments of Primary Health Care Capacity
- Primary Health Care Provider Training
- Equipment
- Health Education

Assessments of Primary Health Care Capacity

The assessments of Primary Health Care (PHC) performed under the IHSS Project focused on assessing the capability of the PHC System to provide basic PHC Services.

The assessment established a baseline for downstream analysis of the effect of various interventions implemented by the IHSS Project or others.

The PHC assessment was based on a survey, designed for the Iraq health sector, that was implemented in 5 of the 7 core governorates of the IHSS Project (Basra, Wassit, Tameem (Kirkuk), Ninnewa, and Najaf). A consolidated report was also generated.

6. **Primary Healthcare Center Survey in Iraq: A Consolidated Report.** Xingzhu Liu and Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

   This is a combined report of all data and results obtained from assessments of PHC capability in the governorates of Basra, Wassit, Tameem (Kirkuk), Ninnewa, and Najaf.

   Support Documents and Files:

   - **Primary Healthcare Center Survey Data Collection Form**
   - **PHC Assessment Database, Tables and Charts (Spreadsheet)**

7. **A comprehensive survey of primary health care centers in Al-Basra governorate.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. January 2004.

   This is a PHC assessment for Basra governorate only.

   Support Document:

   - **Basra PHC Center Staff Survey**

8. **A comprehensive survey of primary health care centers in Al-Tameem governorate.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. December 2003.

   This is a PHC assessment for Tameem governorate only.

   Support Document:

   - **Al-Tameem PHC Center Staff Survey**

9. **A comprehensive survey of primary health care centers in Wassit governorate.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. January 2004.

   This is a PHC assessment for Wassit governorate only.

   Support Document:

   - **Wassit PHC Center Staff Survey**

10. **A comprehensive survey of primary health care centers in Al-Najaf governorate.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

    This is a PHC assessment for Najaf governorate only.

    Support Document:

    - **Najaf PHC Center Staff Survey**

11. **A comprehensive survey of primary health care centers in Ninewa governorate.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

    This is a PHC assessment for Ninewa governorate only.

    Support Document:

    - **Ninewa PHC Center Staff Survey**

Primary Health Care Provider Training

This training was focused on best clinical practice in primary care with an emphasis on the care of women and children (please see PHC Training Materials below for detailed info on the PHC Course and other related reference material). Training was delivered to health care providers from the core governorates of the IHSS Project. Training was delivered through a stepwise approach and involved regional trainers in these governorates. Regional training centers were established in Basra, Al Kut, Kirkuk, Mosul, and Najaf. Documents and other resources related to PHC training are described below:

12. **IHSS Primary Health Care Training Manual 2003.** *Iraq Health Systems Strengthening Project,* Abt Associates Inc. 2003.

    The PHC Training Course is an adaptation of the PHC Course developed by Abt Associates under the PHCI Project funded by USAID and implemented in Jordan. The course material focuses on the most current concepts regarding the diagnosis and management of problems commonly seen in a Primary Health Care environment. Contained in this course, in both English and Arabic are reference documents, presentations, guidelines and resource material covering topics in Adult Health, Child Health, Emergency, Pharmacy, Public Health, Women's Health, and Teaching Skills.

    PHC resources provided to program participants:

    - **The Cochrane Library**

      This has been included as part of the package of materials delivered to program participants. Cochrane reviews are based on the best available information about healthcare interventions. They explore the evidence for

and against the effectiveness and appropriateness of treatments (medications, surgery, education, etc) in specific circumstances. The Cochrane Library internet site (www.cochrane.org/reviews/clibintro.htm) has more information.

- **UpToDate**

UpToDate is a resource application specifically designed to answer the clinical questions that arise in daily practice and to do so quickly and easily so that it can be used right at the point of care. Physician editors and authors review and update content on a continuous basis. The published evidence is summarized and specific recommendations made for patient care. The UpToDate internet site (www.uptodate.com) has more information.

13. **Primary Health Care and Family Medicine Training Program Dissemination Conference: Report for the Consultative Panel.** *Iraq Health Systems Strengthening Project,* Abt Associates Inc. 2003.

    This document summarizes the PHC training program and details specific recommendations for future development.

PHC Training Evaluation Reports

14. **Evaluation of the Trainings Performed by IHSS Project: A Consolidated Report.** Ghaith J. Al-Eyd and Xingzhu Liu, *Iraq Health Systems Strengthening Project,* Abt Associates Inc. May 2004.

    This report summarizes training-session evaluation reports from each of the PHC training courses delivered under the IHSS project. Independent reports from specific sessions are provided below.

15. **Evaluation of the Workshop for Master Trainers in Primary Health Care**. Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. November 2003.

    Master Trainers evaluation report.

16. **ToT Workshop in Basra: M&E Report**. Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. January 2004.

    Training of Trainers (ToT) evaluation report for Basra.

17. **ToT Workshop in Kirkuk: M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. February 2004.

    Training of Trainers (ToT) evaluation report for Kirkuk.

18. **Training of Trainers Workshop in Wasit / Kut: M&E Report**. Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. December 2003.

    Training of Trainers (ToT) evaluation report for Kut (Wassit governorate).

19. **ToT Workshop in Mosul (Feb. 14-24, 2004): M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

    Training of Trainers (ToT) evaluation report for Mosul (Ninewa governorate).

20. **ToT Workshop in Najaf (Feb.16-26, 2004): M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

    Training of Trainers (ToT) evaluation report for Najaf.

Following are individual evaluation reports for roll-out training. This information has been summarized in the report "Evaluation of the Trainings Performed by IHSS Project: A Consolidated Report" described above.

21. **Roll – Out Training Workshop in Basrha (Jan. 17- 27, 2004): M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. February 2004.

22. **Roll – Out Training Workshop in Basrha (Feb. 8-18, 2004): M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

23. **Roll – Out Training Workshop in Basrah/Al-Razi 2 (April 3-14, 2004): M&E Report.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. May 2004.

24. **Roll – Out Training Workshop in Basrah/Al-Razi 1, Abulkhaseeb (April 3-14, 2004): M&E Report.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. May 2004.

25. **Roll – Out Training Workshop in Basrah/Qurna & Medyna (April 3-14, 2004): M&E Report.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. May 2004.

26. **Roll Out Training Workshop in Kirkuk: M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. February 2004.

27. **Roll Out Training Workshop in Kirkuk (Feb. 18-28, 2004): M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

28. **Roll Out Training Workshop in Kirkuk (March 6-16, 2004): M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

29. **Roll – Out 5th. Training Workshop in Kirkuk / (March 30-April 10, 2004): M&E Report.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. May 2004.

30. **Roll – Out 6th. Training Workshop in Kirkuk / (April 20-29, 2004): M&E Report**. Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. May 2004.

31. **Roll – Out 7th. Training Workshop in Kirkuk / (April 10-19, 2004): M&E Report.** Namir Al-Tawil. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. May 2004.

32. **Training of PHCCs Doctors Workshop in Wasit / Kut: M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. January 2004.

33. **Roll Out Training Workshop in Wasit / Kut (Feb. 8 – 18): M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. February 2004.

34. **Roll Out Training Workshop in Wasit / Kut (Feb. 22 – March 6): M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. March 2004.

Equipment

PHC Equipment

The IHSS project had a primary focus to increase the quality of Primary Health Care through a combination of training providers and providing equipment for PHC clinics. Equipment was procured for a total of 604 clinics in Iraq and was packaged in kits containing 58 items essential for basic PHC with an emphasis on maternal and child health care. In support of this procurement, a handbook was prepared for each equipment kit that contained information on the installation and use of equipment. The following documents were generated as a result of this effort.

35. **Summary Report: Primary Health Care Equipment for Iraq Primary Health Care Clinics.** Gerald A. Evans, Timothy P. Irgens, and Don Henry. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. October 2004.

    In support of strengthening the Iraq PHC delivery system, the IHSS project provided kits of PHC equipment for delivery to over 600 PHC clinics throughout Iraq. This document summarizes this component of the IHSS project and provides supporting documents related to MOH involvement, clinic selection, and kit content. It further describes the process for final delivery of PHC kits and documents participation and agreement of this process by the MOH.

36. **Medical Kit Equipment Information, User Manual, and Assembly Guide for Primary Health Clinics in Iraq.** Rebecca Jewsbury, Don Henry, Scott Leshner, and Alan Stankus. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. April 2004.

    This document served as a guide to health clinic managers and potential users of the PHC equipment. It was delivered to each clinic along with equipment and includes

specifications, instructions for use, maintenance instructions, manufacturer contact, and warranty information for each item.

OB/GYNE Equipment

The IHSS project provided support for the determination of basic equipment supporting emergency obstetrics and gynecology. This resulted in the generation of several equipment lists with varying budgets for future consideration by USAID or other donors supporting hospital level reform and re-equipping.

37. **IHSS - District Hospital Equipment and Proposed Cost.** M. Linda Brown and Don Henry. *Iraq Health Systems Strengthening Project,* Abt Associates Inc. April 2004.

Health Education

The IHSS project was tasked to provide support for the development of IEC campaigns focusing on maternal and child health. Due to funding cuts, the decision was made to coordinate this activity with an interested NGO and utilize funding provided through the I-HELP Small Grants Program. This focused on the performance of client exit interviews in the PHC setting in order to gauge the perceptions and opinions of users of the system in order to structure IEC materials and campaigns with future funding.

38. **Client Exit Survey on Satisfaction with Primary Health Care Services and Perception of Antenatal Care and Child Care in Basrah, Iraq**. *Al-Wafa Society.* March 2004.

    This study was focused on the following objectives: 1) To determine the extent to which users of Primary Health Care (PHC) Centers are satisfied with the care provided; 2) To obtain their opinions on major deficiencies, as identified by the clients themselves and; 3) To gather clients' suggestions for further improvements of quality of care provided at PHC Centers.

Support for Health Systems Strengthening

Health systems strengthening and health sector reform activity evolved as a major component of the IHSS Project. Central reform activity was focused on policy issues and was vested in the work of a series of working groups composed of staff from the MOH, CPA, USAID, Abt and other in-country organizations. In addition to facilitating these meetings and organizing their respective outputs, Abt provided technical advisors and related support. This resulted in the development of strategies and plans for health information systems, national health accounts, pharmaceutical and medical supply management, quality improvement, facilities master planning, and nursing. In addition, the IHSS Project provided support for budgeting and expenditure tracking, the development of a MOH facilities database, salary reform, monitoring and evaluation, disease surveillance, health care finance, household surveys, and resource mobilization. The following comprise the deliverables associated with these various areas.

Policy Reform

39. **Vision for the Iraq Health System.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. April 2004.

    This document provides a vision for the Iraq health system that was arrived at through a consensus-oriented process of nine working groups and a Steering Committee over the period from October 2003 to January 2004. The working groups and the Steering Committee were convened by the Ministry of Health (MOH), composed of ministry leaders, representatives from all sectors of the health care system, and NGOs, with support from the CPA and staff of the IHSS project funded by USAID.

    Supporting documents:
    - **Working Group Meeting Minutes**
    - **One-page technical discussion papers**
    - **Reference papers and related documents**
    - **Working Group and Steering Committee Participants List**
    - **English translation of the MOH laws**
    - **Health Policy Seminars and Associated Reference Papers**
    - **MOH Organizational Chart 2003**
    - **MOH Organizational Chart 2004**

40. **Women's Vision for the Iraqi Health System.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. March 2004.

    A group of eleven female physicians and nurses were invited to reconsider the "Vision of the Iraqi Health System" from a woman's perspective. This document summarizes their perspective and introduces points of consideration for further development by the working groups.

41. **Next Steps for the Working Groups: Recommendations for Future Work**. Marwa Ezzat Farag, Juhi Ginger Dagli, Xingzhu Liu, Paul Rader, Timothy Irgens, and Gerald Evans. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. May 2004.

    The Working Group process resulted in the creation of a vision for the Iraqi Health Sector. The vision was produced as a result of a consultative consensus process, which included key stakeholders in the Iraq Health Sector. This document provides recommendations for first-phase implementation of the vision.

42. **Results of Ministry of Health Local Health Forum Surveys**. Paul Rader, Ali Imad Al-Shaikhaly, Laith Al Hialy, Hemen Abdul Rahman, Jamal Kadhim, and Kalid Muhammed. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. March 2004.

    As part of its health reform activities, the Iraq Ministry of Health, with the assistance of Abt Associates Inc. conducted a series of local forums throughout the nation from February 8, 2004, through March 17, 2004. A team of Iraqi health experts supported by Abt associates traveled to the sessions to survey opinions from healthcare providers and

users about the current and proposed health care system in Iraq. Twenty-six separate public meetings were conducted in Baghdad (Al Karkh and Russafa Districts), Al Kut, Najaf, Kirkuk, Mosul, Sulaimeniyah, Erbil, Basra and Nassarya. Over 1,400 people submitted their responses to the survey instrument. This document summarizes the local health forum activity and survey responses.

Supporting documents/files:

- **Survey data (Microsoft Access database)**

Health Information Systems

43. **IHERP – Iraq Health Enterprise Planning: Information Technology for the MOH for the Year 2005 and Beyond.** Herbert Koudry. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. April 2004.

    This document describes a strategy for the implementation of an information system for the Iraq MOH**.** It presents administrative, legal, financial, and IT requirements as interleaved elements in a context that specifies the necessary actions and sequence to be followed in developing the Strategic Plan.

    Supporting documents:

    - **Organizational Structure for the MOH Office of Computerization and Communication Development**

National Health Accounts

44. **Proposal to conduct National Health Accounts in Iraq.** Marwa Farag. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. March 2004.

    As part of the MOH health reform activity and working group process, the Health Financing group recommended activities to address the crucial financial information gaps. The consensus in the group was that NHA should be conducted in Iraq as soon as possible. This document reviews the strategy for introducing NHA in Iraq.

45. **Seminar Series: An Introduction to National Health Accounts.** Marwa Farag. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. April 2004.

    This series of presentations was designed as a first step in the introduction of NHA in the Iraq MOH.

    Supporting documents:

    - **NHA Seminar list of participants**

Pharmaceutical and Medical Supply Management

46. **Progress Report #1: Database Software Analysis and Sample inventory.** Edgarh Cosic (IMC). *Iraq Health Systems Strengthening Project.* Abt Associates Inc. July 2003.

    This is an initial assessment of the Kimadia commodity management system and includes an analysis of inventory management of 40 selected commercial products.

47. **Progress Report #2: Kimadia System Overview.** Edgarh Cosic (IMC). *Iraq Health Systems Strengthening Project.* Abt Associates Inc. July 2003.

    This is the second of two initial reports that focus on assessing the Kimadia system.

48. **Final Report Phase 1: Kimadia Logistics Management and Inventory Control.** Edgarh Cosic (IMC). *Iraq Health Systems Strengthening Project.* Abt Associates Inc. July 2003.

    This is a summary report of the initial findings regarding the assessment of Kimadia commodity management systems. This assessment was focused on identifying problems and recommending activities to improve the system.

49. **Situational Analysis Report for Kimadia.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. July 2003.

    This document provides a general overview of the Kimadia system including a review of warehouse function, logistical support, software systems, staffing, coordination, and comparison of pre-war and post-war function.

50. **Methods for Estimating Demand for Drugs & A Model for Managed Competition in Pharmaceutical System in Iraq.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. July 2003.

    This document decribes various key aspects of estimating the demand for drugs in the Iraq health system with an emphasis on the use of a newly introduced formulary.

51. **Rapid Assessment of the Short-Term Risk of Pharmaceutical Shortage in Iraq.** Xingzhu Liu, Namir Al-Tawil, and Gaith Al-Eyd. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. November 2003.

    At the request of the CPA/MOH, the Iraqi Health System Strengthening Project (IHSSP) performed a rapid assessment of the risk of drug stock-outs at the national warehouses in Iraq, with an objective to identify the gaps between drug supply and demand and recommend short-term mitigation measures to reduce the gaps. This document reviews the findings of this assessment.

Quality Improvement

52. **Primary Health Care Quality: What can Iraq Learn From International Experience?** Jessica Smith, Marni Laverentz, and Xingzhu Liu. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. September 2003.

    The objectives of this report were (1) to review the international literature on both theoretical and operational definitions of quality of care, (2) to develop a framework that guides the definition and measurement of primary health care quality, (3) to review the literature on the management of primary health care quality; and to explore international

experience on how to improve the quality of primary health care, and (4) to propose a set of indicators that are suitable for Iraq health center situations.

53. **Concept Paper for the National HealthCare Quality Improvement Program in Iraq.** Xingzhu Liu, Mohamed Jaber Hawail, Marwa Ezzat Farag, Mousa Al-Zeyada, Nadia Ali, and Marni Laverentz. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. June 2004.

    This concept paper provides guidelines for the planning of the National Healthcare Quality Improvement Program (N-QIP). In this document, we present the major results of the rapid assessment of the quality problems in the Iraqi health system, assess the local administrative and technical capacity, identify the capacity gaps that exist for undertaking the (N-QIP), and specify the steps and technical components for the design and implementation of the N-QIP.

Facilities Master Planning

54. **A Strategy for Health Care Master Planning**. S. Dick Sargon. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. April 2004.

    The strategies outlined in this document focus primarily on the long-term plans and the master planning process required to support the vision for health care reform in Iraq. While the emphasis is on long-term objectives, the master planning process is designed with multiple horizons, including both short and medium term strategies. The concept of a health care master plan and the process to prepare such a plan are detailed in this document.

55. **Proposal for Regional Hospital Tour.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. October 2004.

    As requested by USAID, The IHSS project provided support for the MOH with regard to designing and planning a hospital tour of regional pediatric facilities. This was in direct response to the planned new construction of a small pediatric hospital in Basra by USAID. This document provides an overview of hospitals (hard copy only).

Nursing

56. **Strategy and Action Plan for the Development of Nursing and Midwifery in Iraq: 2004 – 2009.** World Health Organization and Iraq MOH. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. March 2004.

    This document is the result of a collaborative process that was initiated by the World Health Organization (WHO). The initial strategy for nursing that was developed in close collaboration between WHO and the Iraq MOH was subsequently introduced into the health reform activities and working group process that was managed by Abt. This resulting final document establishes the collective strategy for nursing reform in Iraq and was approved by the Minister of Health.

57. **Physician Review of the Strategy and Action Plan for the Development of Nursing and Midwifery in Iraq.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. March 2004.

    This is a physician review of the strategy for nursing reform in Iraq. It addresses the views of the physician with regard to feasibility and practicality, effectiveness, and constraints to implementation.

Budgeting and Expenditure Tracking

58. **Technical Support for the MOH/CPA Budget and Finance Office: Task Overview.** Marwa Farag. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. January 2004.

    This document describes activities centered on assisting the MOH Budget and Finance office with tracking expenditures of health programs. The goal was to assess status of spending on the various programs monthly (or at any point in time, if needed) and to compare actual spending against the budget.
    The task consisted of three parts: 1) Assess the end of year (2003) actual spending against the budget situation; 2) Develop a process for tracking expenditures for 2004 and; 3) Identify and train individuals within the MOH to carry forward this activity in 2004.

59. **Technical Support for the MOH/CPA Budget and Finance Office: Tool Description.** Marwa Farag. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. March 2004.

    This document describes a budgeting and expenditure-tracking tool that was developed to assist the MOH in tracking health program expenditures.

    Support documents/files:
    - **MOH Expenditure Tracking Tool (Excel Spreadsheet)**

Facilities Database

60. **Summary Report: Iraq Medical Facilities Database - Ministry of Health.** Marwa Ezzat Farag, Mousa Al-Zeyada, Ali Al-Shiakhli, Thaer Dhai, Zaynab Abdul-Hadi, Michael J. Olson, David Zajac, and R. Davidson. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. January 2004.

    The main purpose of the database is for the MOH Department of Engineering to have: 1) an accurate and updated record of all MOH facilities; 2) information about the condition of these facilities; 3) information regarding facility problems and what is being done to remedy them. This database will also be used in the overall planning process for health sector reconstruction and facility expansion.

    Support documents/files:
    - **Guide for Answering the Building Inventory Database Questions**
    - **Translation of the Data Collection Form**

- **Meeting Minutes for Technical Design of the Database**

61. **Iraq Medical Facilities Database.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. January 2004.

    This is a Microsoft Access database designed to track all MOH facilities. Please refer to the Summary Report (above).

Salary Reform

62. **Technical Support for the MOH/CPA Budget and Finance Office: Development of proposal for the implementation of the new salary scale put forward by the Ministry of Finance (MOF) for public sector employees.** Marwa Farag. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. January 2004.

    This document reviews the technical support provided to the MOH with regard to developing a proposal for the implementation of a new salary scale established by the Ministry of Finance (MOF). Project staff supported the MOH Planning Directorate in articulating concerns and issues, in providing supporting data that documents the issues, and providing recommendations on how to move forward with implementing the new salary scale. This document reviews the following:

    A) Directorate of Planning concerns and proposed changes
    B) Steps to be taken towards implementation by the MOH.
    C) Supporting data and information

Monitoring and Evaluation

63. **Monitoring and Evaluation Workshop for Health Planning Staff from Directorates of Health in Iraq.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. September 2003.

    The structure of M&E (the department of planning, planning staff, and statisticians) exists in the Iraqi health system, but it mainly serves as a data warehouse. In most cases, data collected are insufficient to support M&E of health projects, and have rarely been analyzed properly and promptly for utilization by project managers, planners and decision makers. There is a clear need to strengthen M&E at governorate levels, which is essential for improving the performance of health projects, and the performance of health care system as a whole. As a part of the capacity strengthening activities, this document describes a M&E workshop that will develop a M&E course for the M&E staff at governorate Directorates of Health and strengthen their knowledge and skills related to monitoring and evaluation of health projects.

64. **IHSS Monitoring and Evaluation Training – DRAFT TRAINING MODULES.** The QED Group LLC. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. February 2004.

    This is a training course designed to meet the M&E needs of the MOH and build capacity for M&E. The training modules described here focus on the key components of a health monitoring and evaluation system and helps course participants develop a M&E plan for potential application to their health projects. The course combines lectures and course

participant exercises to present the training material and check on its comprehension as the course progresses. The lectures contain material from M&E literature and trainer experience. The exercises provide opportunities for the participants to demonstrate their mastery of the lecture material and receive feed back from the trainers.

65. **Seminar: Monitoring and Evaluation.** Nagib Armijo-Hussein. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. March 2004.

    This seminar is an introductory presentation for M&E workshop participants that provides an introduction to M&E followed by a presentation on Results-based Management. This was followed by the development of M&E course materials and a handbook on M&E described below.

    Supporting documents:
    - **Seminar Participant List**

66. **Course Syllabus of Monitoring and Evaluation for Graduate and Post-graduate Students**. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. March 2004.

    This document describes a course syllabus for the introduction of M&E into graduate and post-graduate training for students at Al-Nahrain Medical College. The goal of this program is to build the capacity of post-graduate students in the field of monitoring and evaluation, to establish a core institute for teaching the concepts of monitoring and evaluation (hence being the pioneers in this field in Iraq), and to build bridges between Al-Nahrain medical college and the other Iraqi colleges.

67. **Handbook on Monitoring and Evaluation.** Amjad Niazi and Namir Al Tawil. *Community Medicine Association*. March 2004.

    Through a grant provided under the IHSS project, the Community Medicine Association supported by Abt Associates developed this Handbook. It is intended to serve as the foundation around which a formal M&E program will be developed in conjunction with leading medical colleges in Iraq.

Disease Surveillance

68. **Smart Disease Surveillance Application: Final Report and Assessment.** Voxiva. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. May 2004.

    In conjunction with Voxiva, the IHSS project deployed the SMART Disease Surveillance System in the Karkh Health District of Baghdad. SMART is a real-time electronic disease surveillance system, the first of its kind in the Middle East. The system allows health workers to report cases of disease from any phone or over the web and allows health authorities to monitor the data in real-time. This document summaries this deployment and the pilot study that resulted

69. **Smart Disease Surveillance Application: Consultant and Monthly Reports.** Voxiva. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. May 2004.

In support of the SMART Disease Surveillance Pilot, various reports related to training of users, monthly activity, and deployment were generated. This document summarizes these reports.

Health Care Finance

70. **Flow Of Funds - Health Care Sector in Iraq.** Marwa Ezzat Farag, Rafah Gaafar, Ahmed Fadel, Mousa Al-Zeyada, Hemn Abdulrahman, and Khalid Muhammed Ali. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. April 2004.

    The Ministry of Health has initiated the process of conducting National Health Accounts (NHA) in Iraq. This report has been prepared as one of the first steps in this process. It provides a basic description of the health care financing system in the period pre- and post-conflict.

Household Survey

71. **A Report on the Development of a Household Survey Instrument for the Assessment of Health Need, Utilization of and Expenditure for Health Care.** Xingzhu Liu and Lily Zandniapour. *Iraq Health Systems Strengthening Project.* Abt Associates Inc. February 2004.

    The development of a household survey instrument was an integrated part of the work of the Resource Mobilization Team of the IHSS project. With an objective to assess the regional demand and supply for services, and health care financing, the Resource Mobilization Team performed its work on both the supply side and the demand side. The supply side of the work involved a health facility survey in selected districts and the construction of a facility database, which was reported separately from this document. The demand side work, which is reported here, involved a household survey with an initially designed sample size of 2000 households in selected districts.

    Owing to the reduced budget of IHSS project, and the increased concerns of security, the scope of work of the household survey was revised. It was decided that the IHSS project would design an instrument for the household survey, which can be used by the Iraqi Ministry of Health to conduct demand side analysis with technical support from the next round of USAID funded health projects in Iraq. This document describes the design of this instrument.

Resource Mobilization

72. **Discussion Paper: Restoring Pre-conflict Balances on Health Care Provider Bank Accounts.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. August 2003.

    On behalf of the MOH, the IHSS Project considered the issue of frozen balances in the bank accounts of primary health clinics (PHCs) in the Al Karkh Health District of Baghdad. This memorandum explains the background and importance of the issue, discusses the need for resolving it rapidly, proposes solutions for the PHC sector, and outlines the rollout to the entire health care sector of Iraq.

73. **User charges in Iraq: Preliminary Evidence and a Framework for Discussion.** *Iraq Health Systems Strengthening Project.* Abt Associates Inc. July 2003.

    This document is an initial but in-depth study of the health care financing system in Iraq with an emphasis on the introduction and historical use of user charges at the point of service. This document forms the foundation for further development of reform strategies related to health care financing and provides key recommendations for future development.

Small Grants Program

The Small Grants Program was launched in July 2003 using a defined set of objectives. The strategy of the program was to focus initially on training and capacity building of the Iraqis to form non-governmental organizations (NGOs) and engage in proposal application and submission, progressing into the proposal review and reward phase, finally ending with grant implementation and monitoring and evaluation phases. After conducting the workshops in several governorates the Iraqis were able to form non-governmental organizations and begin applying for grants. The grant review included reviewing grant applications by program staff, the Grants Manager, the Grant Review Committee consisting of technical team leaders working on the IHSS project, followed by the Chief of Party, after which selected grants were submitted to USAID for review and approval. During the change in management of the Small Grants Program, another step was added to finalize the grants approved for implementation. It included a more informal, yet equally mandatory process which involved reviewing the grants with the technical advisors of the Coalition Provisional Authority (CPA) Ministry of Health.

The original proposed budget for the grant program was set at $6 million. However, funding reductions by USAID reduced this amount considerably. As a result, the Small Grants Program successfully implemented 33 grants amounting to $1.2 million. The grants were spread across 11 of the 18 governorates and program focus areas included, renovation and rehabilitation, environment and public health, maternal and child health, school health, women's health, health information systems and health care delivery.

The program implementation strategy carefully incorporated a network of grant mentors and grant mentor assistants, distributed across seven regional offices (Erbil, Mosul, Kirkuk, Baghdad, Al Kut, Al Hilla which was closed in January 2004, and Basrah). The grant mentors assisted the grantees with administrative, budgetary and financial tracking activities. An additional responsibility assigned to the grant mentors was a weekly grants tracking mechanism to ensure the quality of implementation under the existing extenuating conditions. Partnered with the grants mentoring and tracking team was the grants monitoring and evaluation team that implemented a mid-program and end of the program evaluation to assess the impact of the intervention.

The IHSS project team encountered several security, staffing and logistical obstacles common to international projects in complex emergency countries. These challenges propagated through all the technical work areas of the IHSS project, including the Small Grants Program.

However, while the challenges were many, benefits were realized. Benefits to the grantees included the capacity building efforts of the workshops and the grant mentoring program and direct benefits of grant funds. Benefits to the local community were realized through the temporary jobs created in renovation and rehabilitation programs as well as through the health interventions supported.

Deliverables and supporting documents related to the Small Grants Program are as follows:

75. **Final Report Small Grants Program.** Juhi Ginger Dagli, Ahmed Abdul Razak, and Laith Al Hialy. *Iraq Health Systems Strengthening Project*. Abt Associates Inc. May 2004.

    This Final Report is a compilation of the strategies, activities, outcomes and lessons learned from implementing a Small Grants Program in Iraq.

76. **Evaluation of the Small Grants Program Performed by IHSS Project: A Consolidated Report.** Ghaith J. Al-Eyd and Namir G. Al-Tawil. *Iraq Health Systems Strengthening Project*. Abt Associates Inc. May 2004.

    This report reviews the monitoring and evaluation approach used for the small grants program and provides a summary of grant evaluations.

77. **I-HELP Grant Applicant's Handbook.** *Iraq Health Systems Strengthening Project*. Abt Associates Inc. July 2003.

    This Handbook is available in English and Arabic translation and contains a description of the program, review of the application process including appropriate forms, review of the selection and award process, and discussion of grant management and implementation.

78. **Small Grants Workshop in Northern Iraq: A Trip Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project*. Abt Associates Inc. October 2003.

    This document reviews the objectives and results from a small grants workshop in northern Iraq. The small grants workshops were designed to educate the public on the program, provide a foundation for grant applications, and outline strategies for ongoing monitoring and evaluation of projects.

79. **Small Grants Workshop in Baghdad: M&E Report.** Ghaith J. Al-Eyd. *Iraq Health Systems Strengthening Project*. Abt Associates Inc. November 2003.

    This document reviews the objectives and results from a small grants workshop in central Iraq (Baghdad).

    Support Documents and Files:

    - **Mid-term Small Grants M&E Reports**
    - **End-term Small Grants M&E Reports**

Lessons Learned and Next Steps

The delivery of a project in an ongoing conflict environment offers unique challenges. Many of the problems faced during this project were directly related to the environment in which we operated. Therefore, our ability to overcome obstacles and deliver on this contract has provided invaluable experience to our staff and for USAID for future projects in Iraq or similar post-conflict/ongoing-conflict environments. The following section discusses significant challenges and lessons learned which were not elaborated upon in the project documents previously described. Following this is a brief discussion of recommendations for next steps.

Security

Many aspects of the project were influenced by the security situation. The decision to move forward with professional expatriate security forces was a necessary and critical decision that allowed this project to proceed. However this decision was not made initially. The deterioration of the security situation and subsequent need to protect expatriates and civilian Iraqis working for the project was not anticipated by USAID nor by Abt Associates. The impact that this had on the project was mostly felt through delays in setting up and securing the residential and office compounds and mobilizing the majority of technical staff. It was fortunate that expatriate security forces were added to the project and the Baghdad office compound was secured just prior to the major period of decline in the security situation in September/October 2003.

It is also critical to note the importance of utilizing expatriates to lead and manage security. While many contractors were relying solely on Iraqi security guards, the IHSS project choose otherwise in order to ensure the quality of personnel and to guarantee loyalty to project staff in the event of civil uprising or insurgent attacks. These expatriate security guards were perceived in the same manner as other coalition forces by Iraqi insurgents. This eliminated the possibility of mixed loyalty that could have been experienced by using only Iraqi security guards. Unfortunately several kidnappings of US and British humanitarian workers during the final months of the project underscored the importance of the approach that we utilized for the project. These individuals were being “protected” by Iraqi security guards only.

The introduction of security specialists also required investment in related communications technologies, armored vehicles, etc. Much of this was an unplanned expense and could have been better prepared for if a security assessment was performed by USAID in conjunction with the award. In the future it will be critical for USAID and contractors to better estimate the cost for security in Iraq. In addition our experience would clearly suggest that a detailed security assessment be an integral part of any procurement with the cost and potential resulting changes in project implementation be anticipated and accommodated.

The most critical determinant of our ability to function in Iraq was our ability to exit if conditions required immediate evacuation. As road travel became increasingly risky, the only viable way out of country was via plane. Therefore any closure of the airport (BIAP) or inability to gain access to the airport became an untenable situation. It is therefore essential that any future activity in Iraq ensure that expatriates have the ability at all times to exit the country. If conditions suggest that access to the airport will be reduced serious consideration must be given to departure prior to potential restrictions.

Flexible Implementation

The dynamic environment in Iraq demanded that a project establish a flexible implementation plan. At the time of drafting and approval of the workplan this was not a major consideration. However, as movement restrictions were imposed within Baghdad as well as throughout Iraq, the need to adjust activities and shift emphasis was important. This was further compounded by changes in MOH need and the related activities of other donors and the CPA.

Translation of these changes into workplan modifications, contract modifications, and project action did not occur until late into the project. Recommendations were made to USAID however the resistance in recognizing and acting on these recommendations by modifying the contract and scope of work accordingly resulted in significant problems when these issues were finally addressed in April 2004.

For future work in Iraq, it is imperative that USAID and the contractor recognize that each party should be sensitive to the dynamics that will occur in the country environment and within MOH leadership. As a result of this, the project should have, built into the contract and workplan, provisions which promote flexibility in scope and in results demanded from the project.

Local Iraqi Staff

Flexible implementation requires that the project invest heavily in training of local Iraqi staff and MOH counterparts in the earliest stages of the project. This was pursued for much of the health service delivery work and small grants program. Our efforts here were a major contributor to our ability to rapidly delivery PHC training and establish a functional grant mentoring network.

The IHSS project however did not establish programs for the training of key high level managerial staff in the MOH or for training of MOH departmental counterparts. This must be a major consideration for future projects in order to provide for sustainable reform and to give an added dimension for implementation through creative utilization of properly trained MOH staff.

Equipment Procurement and Delivery

The procurement and delivery of essential equipment for PHC clinics was a major component of the IHSS project and carried with it significant problems. Delays in the initial procurement of equipment were due to ongoing problems with vendors and were compounded by interactions with CPA and MOH staff, delays in receiving final approval on the equipment list to be procured, and a greater than 80 day delay in receiving approval to procure from USAID. While these were all significant obstacles the equipment was procured and received in total by mid-May 2004.

However, at the time of this writing the equipment has yet to be received in all clinics. The responsibility for receipt, packaging, transport into Iraq, and final delivery became that of the USAID third party logistics contractor, Logenix. While the use of Logenix was stipulated in the IHSS contract and may be the most cost effective approach for logistics management, there was no mechanism whereby the IHSS project could influence or direct this final activity. Logenix was only responsible to USAID.

The lack of control over final receipt, packaging, and delivery of equipment was a major problem for the project. This is further detailed in the summary report for this activity [35]. In order to more effectively control this type of activity in the future, a project such as the IHSS project should have clear control over the delivery of commodities in collaboration with USAID whether or not the project utilizes a third party contractor such as Logenix. In this example, the recommendation would be that provisions are incorporated into the appropriate contracts which would allow the project to have some responsibility for logistics and management of any third party USAID logistics contractor.

Relationship with USAID, CPA, and MOH

The relationships with USAID and the in-country MOH were non-traditional for the IHSS project. Because of the war and occupation the CPA became the governing body until June 2004 and the CPA Senior Health Advisor was the effective Minister of Health until March 2004. In spite of these realities, the IHSS project leadership was given clear direction by USAID in the early stages of the project to ignore direction by the CPA and focus its efforts on Iraqi MOH staff. This resulted in repeated conflict with the CPA leadership and USAID technical guidance and posed serious problems and delays in project implementation. Further compounding this was the general resistance by USAID for providing written direction or written approvals for activities, which led to further implementation problems.

Changes in field leadership by Abt in November 2003 coupled with clarification and agreement on reporting responsibilities and direction by USAID and the CPA provided a new foundation for project implementation. While this allowed for the successful implementation of the IHSS project, it followed a period of significant dissatisfaction by all parties involved.

In conjunction with these early problems, continued instability of USAID leadership was a problem throughout the project. Between May 2003 and February 2004, USAID provided 4 different CTOs. Changes in implementation philosophy and technical direction among these CTOs posed a challenge to field staff. This was further complicated by having 6 different Contracting Officers for the project through November 2004.

While these changes would not normally pose a problem, serious confusion existed regarding the role that the approved workplan would play in guiding overall project delivery and contractual requirements. Early in the contract period verbal agreement was provided which allowed the workplan to determine all aspects of project implementation. Repeated requests to modify the contract accordingly were ignored which caused problems at every change of CTO or CO. To circumvent similar problems in the future it is strongly suggested that any contract include language which places a requirement for the approved workplan or implementation plan to act as the final scope of work and lead to the appropriate contract modifications.

Recommendations for Next Steps

The IHSS project established a strong foundation for further health sector development in Iraq. It is clear that much attention has been given to the improvement of Iraq health care and much still needs to be done. Of considerable importance is continued efforts to reestablish the clinic and hospital infrastructure that is essential for proper health care delivery. This should be coupled with continued institutionalization of training programs and continuing education programs for all health professionals and specialties. Much of this is intuitive and can be applied to most developing health sectors. However, our experience in Iraq has provided certain insight that may prove useful in designing future programs.

Essential for future programs is consideration of critical aspects of program implementation that can be influenced by the Iraq environment. These include:

- Appreciation for the dynamics of a post-conflict/ongoing conflict environment
- Consideration of the costs for security as early in the development process as possible
- Development of a flexible implementation approach that would consider mechanisms to maximally utilize local Iraqi talent and/or to provide educational/training support to MOH staff outside Iraq (Amman, Jordan)

In addition to suggestions provided above as relates to security, flexible implementation, local Iraqi staff, equipment procurement and delivery, and client relationships the following are important recommendations for future Iraq projects:

1. **Utilize a flexible task order process for future Iraq procurements.**

The dynamic nature of the Iraq environment, the infusion of large amounts of support through the $18 billion supplemental appropriation managed by the PCO, and efforts of additional donors creates a situation whereby needs could change rapidly and support for previously established programs may be offered from multiple sources. In order to manage this process and provide the most cost effective solution for USAID allocation of defined funds under the auspices of ad hoc task orders provides the most logical mechanism.

2. **Establish clear contractual requirements that allow the implementation plan developed after award to serve as the ultimate definer of scope and expected results from the contract.**

   This has been elaborated on previously.

3. **Enlarge the grants program.**

   The success of the IHSS small grants program and the capabilities of local Iraqis clearly warrants broader utilization of this mechanism for health sector development. In addition, the visibility of these types of projects would provide an extremely important public relations benefit that was only minimally captured during the IHSS project. This is important for the Iraqi MOH and more important for USAID with regard to winning of the hearts and minds of the Iraqi people. It is further recommended that consideration be given to creating a mechanism whereby grants in excess of $250,000 could be provided directly to the MOH or governorate DOHs. Creative establishment of a grant management program in this manner coupled with specific areas of focus could have a profound and lasting effect in Iraq.

4. **Continue investment in MOH strategic planning and cooperate with the MOH to establish mechanisms for donor guidance and adherence to the MOH vision.**

5. **Increase investment in training and education of nurses and allied health professionals.**

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APPENDIX A

Initial Approved Workplan (July 2003)

Iraqi Health Systems Strengthening Project
(IHSS)

Coordinated Workplan

Abt Associates
July, 2003

Table of Contents

Background

A review of the available data on the health status in Iraq is presented in Annex A. This review highlights maternal mortality, infant mortality, and malnutrition as major societal problems. Further, these issues are sensitive indicators that reflect on the general production of health within a society. Research has shown that high maternal and infant mortality rates reflect general health system inadequacies as well as lack of knowledge regarding health matters within the household.

Further, these data illustrate that the health status of the most vulnerable groups in Iraqi society can be improved. Health promotion and preventive measures that strengthen the capacity of the household to provide for the health of its members, together with nutritional support, maternal health programs, and child health programs will do much to improve the situation. However, for these programs to be sustainable it is also important to strengthen the Iraqi primary health care system. Preliminary evaluation of the Iraqi health care system has revealed a severe deterioration in system organization, financial planning, budgeting, and monitoring and evaluation of health system performance. For this reason it is clear that solving the immediate health care needs of the Iraqi population is not the entire answer. In addition, strengthening the basic health system and assuring sustainable financing for maternal and child health programs is essential.

Health system strengthening requires the combined effort of the Ministry of Health, local health officials at the governorate and district as well as the providers of care. Basic information on the performance of the health system needs to be collected from the households themselves, consumers of health services, and at the clinic level. This basic information will provide the basis for extended analysis and policy guidance at the MOH. Sustainable policy change will result from strategies that assure ownership of the process by the Iraqi health community. The statement of work that follows incorporates the following principles: 1) Support for and collaboration with the MOH at central and governorate levels in every major activity, 2) Inclusion of private sector providers and consumers of health care 3) Consideration of the cost and sustainability of every health program developed in this workplan, and 4) Coordination with other international partners in the health development community.

Statement of Work

The activities to be carried out under the Iraqi Health System Strengthening (IHSS) contract will contribute to the reestablishment and strengthening of the national and governorate public health system in post-conflict Iraq, and its management by the MOH. These activities refer to the needs of the Iraqi people and support the goal of the Ministry of Health (MOH) to provide a sustainable foundation for an efficient and effective health system.

IHSS will implement activities in collaboration with other health partners including WHO and UNICEF, under the authority of the Ministry of Health. The strategic approaches to implementation are: 1) Support the needs of the Ministry of Health to build a strong national health system, 2) Support decentralization of activities and 3) Develop the capacity of Iraqis to lay a sustainable foundation for better health care including the ability to conduct monitoring and evaluation of health sector interventions.

The IHSS has three main objectives. These are:

1. Technical Assistance to the Ministry of Health in the areas of provision of health services, health education & behavior change, health information systems, and direct technical assistance on policy and finance.
2. Technical support to the USAID Mission and
3. Rapid response Grants to address specific health needs.

1 Ministry of Health Technical Assistance

1.1 Provision of Health Services (decentralized)

1.1.1 Facility Renovation

1.1.1.1 Provide technical assistance to the Ministry of Health, in collaboration with other partners, to set criteria for prioritization and selection of clinics to be renovated and supplied.
1.1.1.2. Provide technical assistance to the Ministry of Health to develop a facilities database, and train local MOH staff to maintain it.
1.1.1.3 Provide technical assistance to the Ministry of Health, in collaboration with other partners, to develop "minimal quality standards" for clinic renovation.

1.1.2 Primary care equipment procurement

1.1.2.1 Develop and review list of primary care equipment to be provided with key MOH and donor stakeholders.
1.1.2.2 Finalize number of primary care equipment packages to be procured with USAID and complete procurement.
1.1.2.3 Collaborate with the MOH, USAID health partners, NGOs, and other USAID contractors to ensure distribution and installation of equipment packages to designated facilities.

1.1.3 Referral network improvement, focused on ER and OB/GYN

1.1.3.1 In collaboration with the Ministry of health and other health partners, identify at least 21 referral hospitals or specialty clinics for

improvement – these should be part of a re-equipped and re-trained primary care clinic network.
1.1.3.2 Agree on essential equipment for the emergency room and OB/GYN Department with the MOH and/or directorates and/or districts.
1.1.3.3 Procure essential equipment (must interface with facility renovation)
1.1.3.4 Train staff of OB/GYN Department and ER Department in essential
patient management skills and techniques based on internationally accepted clinical protocols and accepted diagnostic coding systems.
1.1.3.5 Design and initiate quality improvement programs and referral tracking programs in each hospital ER and OB/GYN Department.

1.1.4 Quality of Primary Care with a focus on the Health of Women and Children

1.1.4.1 Propose and review training program on integrated primary care and care of women and children with the MOH (focus on safe motherhood, reproductive health, nutrition, well-baby care, breastfeeding promotion and BFHI in collaboration with UNICEF, and childhood preventive health)
1.1.4.2 Initiate train the trainers program
1.1.4.3 Organize and deliver training to clinic staff in accordance with MOH standards
1.1.4.4 Design quality improvement program in coordination with MOH and other key stakeholders.
1.1.4.5 Assist MOH in implementing quality improvement program in selected clinics.
1.1.4.6 Train and support regulators in use of Quality Improvement program to assure quality primary care.
1.1.4.7 Technical assistance to MOH and/or to health care associations to establish licensure and accreditation standards focused on women's and children's care in primary care clinics.

1.2 Health Information Systems Improvement

1.2.1 Disease Surveillance System

1.2.1.1 With guidance from, and in cooperation with MOH ongoing activities, develop plan for strong national disease surveillance system and specific role for Abt
1.2.1.2 Build on existing MOH activity
1.2.1.3 With MOH, develop training materials to train local MOH staff to manage, maintain and build on system.
1.2.1.4 Ensure local capacity and sustainability

1.2.2 Kimadia Warehouse inventory and distribution systems

1.2.2.1 Situation analysis of central and governorate Kimadia Warehouses
1.2.2.2 Rapid inventory at central Kimadia warehouses
1.2.2.3 Capacity building at Kimadia central and governorate warehouses.
1.2.2.4 Training needs assessment
1.2.2.5 Training programs as required by assessment.
1.2.2.6 System analysis of existing inventory system
1.2.2.7 Technical specifications of communication system and protocol
1.2.2.8 Link communication system for reporting to inventory management system at governorate and central level

1.3 Health Education

1.3.1 Collaborate with UNICEF and other health partners to collect information on community health knowledge, attitudes and practices.
1.3.2 Conduct focused surveys to understand the nature of household demand for health care
1.3.3 Design behavior change strategy based on suvey/focus groups/assessment to have greatest impact on public health outcomes
1.3.4 In cooperation with Iraqi experts, design behavior change interventions
1.3.5 Implement behavior change program at select local, governorate, and national levels
1.3.6 Evaluate effects of intervention on household production of health.

1.4 Assistance to Ministry in Health Policy Development

1.4.1 In close coordination with the MOH, define organizational structures at selected districts, directorates, and central level, produce a map of key relationships and recommend possible improvements.
1.4.2 Analyze Iraqi health care models from 1990, 2002, and 2003, legal regulations, strengths and weaknesses.
1.4.3 Support MOH by holding focus groups in 10 cities and rural areas to gather information to evaluate current policy changes, expectations, and to test ideas and concepts.
1.4.4 Assist with steering group process to develop national health policy as needed
1.4.5 Rationalize the national health policy draft with existing laws and regulations in health and other related sectors.
1.4.6 Based on the national health policy draft, formulate a medium term health strategy, develop guidelines and a process to coordinate resource allocation plans and budget with the national health policy.

1.5 Assistance to the Ministry of Health in Resource Mobilization (health care finance)

1.5.1 Review, assess and propose model of health finance based on experiences of countries with similar experience (post-conflict, history of centralized authoritarian government).
1.5.2 Projection of demand for operating recurrent funds
1.5.3 Funds flow map for the publicly funded health care sector
1.5.4 Assess and project resources and needs in the health care sector of Iraq.
1.5.5 Present a methodological and data framework to the MOH for the annual planning of health care expenditures during and after reconstruction for the next 10 years based on population growth.
1.5.6 Initiate capacity strengthening at the national and/or sub national levels in specific technical areas of health policy and financing.

1.6 Monitoring and Evaluation of Ministry of Health Assistance

1.6.1 In collaboration with the MOH select model districts in which to develop Iraqi MOH capacity in planning and Monitoring and Evaluation (M&E) capacity.
1.6.2 Conduct a workshop/consensus building activity focused on monitoring and evaluation. Participants will examine several M&E strategies and data from selected districts.
1.6.3 With district MOH counterparts, develop a strategy to strengthen planning and M&E at the District level based on discussion/findings at the workshop
1.6.4 Implement the strategy in selected districts and assist MOH district staff in formulating a district level M&E plan.

2 Technical and Liaison Support to the USAID Mission and Health Program.

2.1 Facilities liaison with Bechtel and other contractors

2.1.1 Appoint a facilities liaison to serve as a communication and task interface between Bechtel, the MOH, and USAID for primary care facility renovation.

2.2 Facilitate and enable overall coordination with USAID contractors, grantees, partners, and NGOs.

2.2.1 Design and implement an information and data coordination strategy for major knowledge products from USAID contractors, grantees, partners, and associated NGOs.

2.2.2 Provide staff assistance and follow-up to coordinate knowledge sharing between USAID contractors, grantees, partners, and associated NGOs.

3 Rapid response grants to address specific health needs in-country.

3.1 Provide a grants application manual and application form in Arabic and English for use in the small grants program.
3.2 In cooperation with USAID design grants award criteria and appoint a grants review panel.
3.3 Disseminate information on the small grants program throughout the qualified NGO community.
3.4 Hold capacity-building training with interested NGOs to assist them in grants preparation.
3.5 After grants award hold a training session in grants administration and documentation.
3.6 Design and implement a grants monitoring and evaluation program that includes internal M and E, performance-related payment, and collaborative review of grant achievements before final payment is made.

IHSS Monitoring and Evaluation Plan

1) Develop a Program Monitoring Plan (PMP) for USAID to monitor progress towards required results – including specific indicators and timelines for achieving them.
2) Development of guidelines for internal M&E of IHSS
3) Field visits by the team members for development of the M&E plan for each sub-objective of the technical areas
4) Communication with M&E contractor to develop and implement the mechanisms of coordination and collaboration
5) Communication with other organizations for M&E activities and data sharing
6) Development and implementation of internal M&E (continuous quality improvement approach).

Management Plan

Project Management Team:
The core project management team consists of the following:

Chief of Party
(Currently Vacant)

Timothy Irgens
Deputy for Operations

Nagib al Hussein, MD, MPH
Health Care Delivery

Kevin Stupay
Deputy for Finance and Administration
(Amman Office)

Sharon Pittman Ph.D (Consultant)
Small Grants Manger

A Coordinator for Health Systems is still under discussion. Currently the project relies on the local knowledge and assistance of IMC, Rabih Torbay. However, a recruitment is planned for this position.

The subcontractors from which consultants will be utilized is attached in Appendix B.

This team is assisted by a transportation/security consultant team supplied by Near East Resources Inc. a firm based in Chicago with a Baghdad Office.

The following individuals have been assigned to lead the work in objective areas as defined in the workplan:

Subobjective 1.1: Provision of Health Care	Nagib Al Hussein, MD, MPH
Subobjective 1.2: Health Information Systems	George Scheffenberger, Voxeiva Edgarth Cosic, IMC
Subobjective 1.3: Health Education	Riad El Khoury
Subobjective 1.4: Health Policy	TBA Jeanne Wendel, Ph.D
Subobjective 1.5: Resource Mobilization	Sasha Telyukov, Ph.D
Subobjective 2.1: Liaison with Bechtel	Health Systems Engineering (TBA)
Subobjective 2.1: Coordination	TBA
Subobjective 2.3: Rapid Response Grants	Sharon Pittman, Ph.D. (Grants Coordinator and Grants Managers in Regional Offices)

These staff will provide an overview of their staff, consultants, and local hires. These staffing plans will be part of the budget and administrative plan that is presented for each sub- objective.

According to the terms and conditions of this cover memo, staff will be provided to the Ministry of Health to work under well-defined scopes of work, timelines, and deliverables. These staff will provide direct technical support and products to the MOH and will also mentor assigned MOH counterparts.

Regional Offices:
Abt Associates will establish regional offices in Mosel, Al Hillah, and Basrah. Premises have been leased and are in the process of being furnished in Mosel. Staff are presently reviewing the situation in Al Hillah with a view to bringing trailers for officers there. Finally the premises previously located in Basrah were lost due to a security incident, therefore new premises or trailers will have to be established there.

It is planned to staff these offices with local hires. Each office will have a core staff of three 1) Office Manager 2) Regional Coordinator with Monitoring and Evaluation responsibility 3) Grants Coordinator. If the volume of small grants increases in any region, additional grants coordinators will be hired. Additional local staff/consultants can be added as the workload requires.

Timeline for opening of Regional Offices:

Mosel	July 20
Al Hillah	August 1
Basrah	August 15

Bethesda HQ Office:
The Iraq Health Systems project has a core team in the Bethesda Office consisting of:
George Laudato, Technical Liaison
Jeffrey Gould Program Manager
Lillian Kidane, Travel Coordinator
Henriette Den Ouden, Personnel Administration
Altay Karakulov, Grant Manager
Zina Al Youssif, Administrative Assistant

Timeline

See following pages

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
1. Ministry of Health Assistance										
1.1 Facilities Renovation										
1.1.1 Provide technical assistance to the Ministry of Health, in collaboration with other partners to set criteria for prioritization and selection of clinics to be renovated and supplied.										
1.1.2 Provide technical assistance to the Ministry of Health to develop a facilities database, and train local MOH staff to maintain it.										
1.1.3 Provide technical assistance to the Ministry of Health, in collaboration with other partners to develop "minimal quality standards" for clinic renovation.										
1.2 Primary Care equipment procurement										
1.2.1 Review the proposed list of primary care equipment to be provided with key MOH and donor stakeholders.										
1.2.2 Finalize number of primary care equipment packages to be procured with USAID and complete procurement.										
1.2.3 Collaborate with the MOH, USAID health partners, NGOs and other USAID contractors to ensure distribution and installation of equipment packages.										
1.3 Referral Network Improvement Focused on ER and OBGYN										
1.3.1 In collaboration with the MOH and other health partners, identify at least 21 referral hospitals/speciality clinics for improvement – these hospitals should be part of the re-equipped primary care clinic network.										
1.3.2 Agree on essential equipment for the emergency room and OB/GYN Department with the MOH and/or directorates and/or districts										

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
1.3.3 Procure essential equipment (must interface with facility renovation)										
1.3.4 Train staff of OB/GYN Department and ER Department in essential patient management skills and techniques based on accepted clinical protocols and accepted diagnostic coding systems.										
1.3.5 Initiate quality improvement programs and referral tracking programs in each hospital ER and OB/GYN Department.										
1.4 Quality of Primary Health Care – focus on Women and Children										
1.4.1 Propose and review training program on primary care of women and children with the MOH (focus on safe motherhood, reproductive health, nutrition, well-baby care, breast feeding promotion and childhood health prevention and promotion in collaboration with UNICEF)										
1.4.2 Initiate train the trainers program										
1.4.3 Organize and deliver training to clinic staff.										
1.4.4 Design quality improvement program in coordination with MOH and other key stakeholders.										
1.4.5 Implement quality improvement program in selected clinics.										
1.4.6 Train and support regulators in use of Q/I program to assure quality primary care.										

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
1.4.7 Establish licensure and accreditation standards for women's and children's care in primary care clinics.										
1.5 Health Information Systems Improvement										
1.5.1 In cooperation with MOH, WHO, and other stakeholders, develop user requirements and deployment options for rapid prototype deployment of disease surveillance system using best available information.										
1.5.2. Implement customization.										
1.5.3 Develop training plan and produce training materials										
1.5.4 Deploy prototype surveillance system										
1.5.5 User support system set-up/operation										
1.5.6 Assess prototype deployment										
1.5.7 Use experience gained from rapid prototype to specify modifications and build-out strategy for national system										
1.6 Kimidia Warehouse Inventory and Distribution Systems										
1.6.1 Situation analysis of central and governorate Kimidia Warehouses										
1.6.2 Rapid inventory at central Kimidia warehouses										
1.6.3 Capacity building at Kimidia central and governorate warehouses										
1.6.4 Training needs assessment										
1.6.5 Training programs as required by assessment										
1.6.6 System analysis of existing inventory system										
1.6.7 Technical specification of communication system and protocol										

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
1.6.8 Link communication system for reporting to inventory management system at governorate and central level										
1.7 Health Education										
1.7.1 Collaborate with UNICEF and other health partners to collect information on community health knowledge, attitudes and practices										
1.7.2 Conduct focused surveys to understand the nature of household demand for health care.										
1.7.3 Design behavior change stragegy based on suvey/focus groups/assessment										
1.7.4 In cooperation with Iraqi experts design behavior change interventions										
1.7.5 Deliver behavior change interventions to selected communities .										
1.7.6 Evaluate effects of intervention on household production of health										
1.8 Assistance to Ministry in Health Policy Development										
1.8.2 In close collaboration with the MOH, define organizational structures at selected districts, directorates, and central level and produce a map of key relationships.										
1.8.2 Identify and convene the MOH and other government stakeholders who will work with international experts to lead the policy process.										
1.8.3 Convene a stakeholder meeting to define goals and objectives of the policy process and define information requirements.										

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
1.8.4 Hold a national health policy seminar to compile a final national health policy draft.										
1.8.5 Rationalize the national health policy draft with existing laws and regulations in the health and other related sectors.										
1.8.6 Based on the national health policy draft, formulate a medium term health strategy, develop guidelines and a process to coordinate resource allocation plans and budget with the national health policy										
1.9 Assistance to the Ministry of Health in Resource Mobilization (health care finance)										
1.9.1 Projection of demand for operating recurrent funds										
1.9.2 Funds flow map for the publicly funded health care sector										
1.9.3 Assess and project resources and needs in the health care sector of Iraq										
1.9.4 Present a methodological and data framework for the annual planning of health care expenditures during and after reconstruction.										
1.9.5 Initiate capacity strengthening at the national and/or sub national levels in specific technical areas of health policy and financing.										
1.10 Monitoring and Evaluation of Ministry of Health Assistance										
1.10.1 In collaboration with the MOH select model districts in which to develop planning and M and E capacity.										
1.10.2 Conduct a workshop/consensus building activity focused on monitoring and evaluation. Participants will examine several M and E strategies and data from selected districts.										

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
1.10.3 Develop a strategy to strengthen planning and M and E at the District level based on discussion/findings at the workshop.										
1.10.4 Implement the strategy in selected districts and assist in formulating a district-level M and E plan.										
2. Technical an dLiaison Support to the USAID Mission and Health Program										
2.1 Facilities liaison with Bechtel and other contractors										
2.1.1 Appoint a facilities liaison to serve as a communication and task interface between Bechtel, the MOH, and USAID for primary care facility renovation.										
2.2 Facilitate and enable overall coordination with USAID contractors, grantees, partners, and NGOs										
2.2.1. Design and implement an information and data coordination strategy for major knowledge products from USAID contractors, grantees, partners, and associated NGOs.										
2.2.2 Provide staff assistance and follow-up to coordinate knowledge sharing between USAID contractors, grantees, partners, and associated NGOs.										
3. Rapid resonse grants to address specific health needs in-country										
3.1 Provide a grants application manual and application form in Arabic and English for use in the small grants program.										
3.2 In cooperation with USAID design grants award criteria and appoint a grants review panel.										

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
3.3 Disseminate information on the small grants program throughout the qualified NGO community.										
3.4 Hold capacity-building training with interested NGOs to assist them in grants preparation.										
3.5 After grants award hold a training session in grants administration and documentation										
3.6 Design and implement a grants monitoring and evaluation program.										
4. Monitoring and Evaluation Plan										
4.1 Develop a Program Monitoring Plan (PMP) for USAID to monitor progress toward required results – including specific indicators and timelines for achieving them.										
4.2 Development of guidelines for internal M&E of IHSS										
4.3 Field visits by the team members for development of the M and E plan for each Sub-objective of the technical areas										
4.4 Communication with M and E contractor to develop and implement the mechanisms of coordination and collaboration										
4.5 Communication with other organizations for M and E activities and data sharing										
4.6 Development and implementation of internal M and E (continuous quality improvement approach)										

Annex A: Overview Information: Health in Iraq

Basic Measures: life expectancy, infant mortality, child mortality

Life expectancy and infant mortality are primary measures of the production of health. As shown in the following table (Table 1) of UN comparative data, *Iraq's life expectancy is low for both males and females* and infant mortality is high.

Of the 17 Middle East countries reporting life expectancy for men, life expectancy is at least 70 in 11 countries, and it is at least 65 in 15 countries. Only Iraq and Yemen have life expectancy below 60. Data is available for life expectancy for women in 15 countries: it exceeds 75 in 5 countries, it exceeds 70 in 12 countries, it exceeds 65 in all countries except Iraq and Yemen.

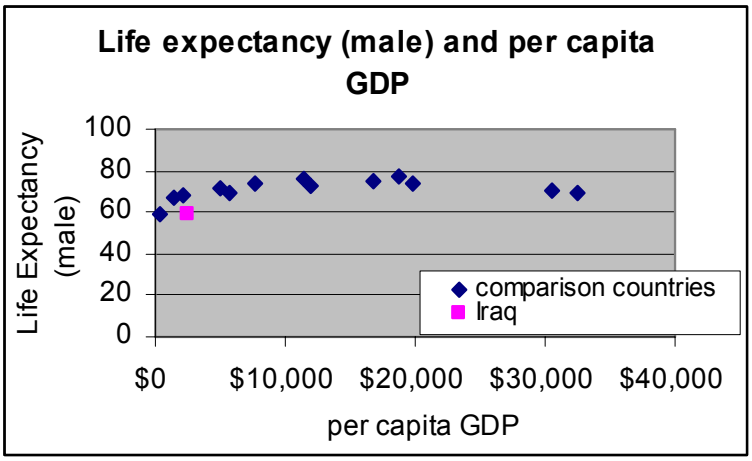
Infant mortality in Iraq is high. Of the 17 Middle East countries reporting infant mortality, 6 report fewer than 0- 15 deaths per 1000 live births, 6 report 16-30 deaths, and 3 report 31-45 deaths per 1000 live births. Iraq reports 83 deaths per 1000 live births. The median number is 21; Iraq's infant mortality rate is nearly four times the median rate.

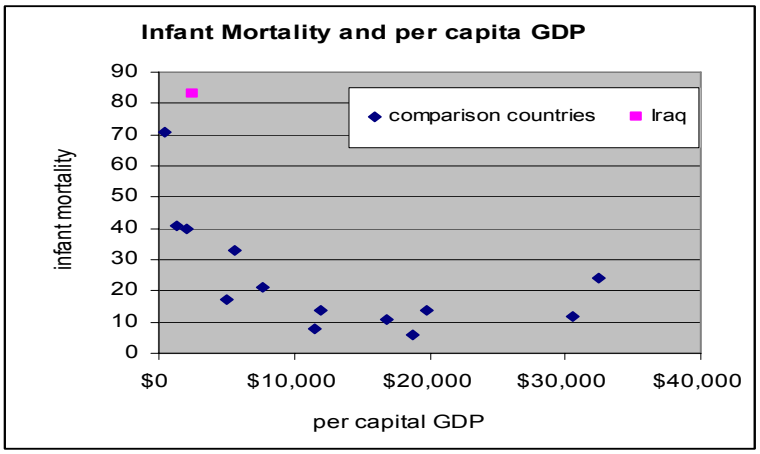
Table 1
Key Measure of Health System Performance:
- **Life Expectancy**
- **Infant Mortality**

Country	Life expectancy at birth (years) male	female	Infant mortality/1000 births (projected 2000-05)
Bahrain	72.5	75.9	14
Cyprus	76.0	80.5	8
Egypt	66.7	71.0	41
Iran	68.9	71.9	33
Iraq	**59.2**	**62.3**	**83**
Jordan	69.7	72.5	24
Kuwait	74.9	79.0	11
Lebanon	71.9	75.1	17
Occ. Pal. Terr.	70.8	74.0	21
Oman	71.0	74.4	20
Qatar	70.5	75.4	12
Saudi Arabia	71.1	73.7	21
Syria	70.6	73.1	22
UAE	73.3	77.4	14
Yemen	58.9	61.1	71

Sources:
Life expectancy and infant mortality estimates from Population Division of the United Nations Secretariat, World Population Prospects: The 2002 Revision, Volume I: Comprehensive Tables (United Nations publication, forthcoming), supplemented by Demographic Yearbook 2000 (United Nations publication, Sales No. E/F.02.XIII.1) and Population and Vital Statistics Report, Statistical papers, Series A Vol. LV, No.1 (Data available as of 1 January 2003); child mortality from Demographic Yearbook 2000.
Technical notes:
Life expectancy at birth is an estimate of the expected number of years to be lived by a female or male newborn, based on current age-specific mortality rates. Estimates and projections of life expectancy are prepared every two years by the Population Division of the United Nations Secretariat from data compiled by the Population Division and Statistics Division from national statistical sources. As many developing countries lack complete and reliable statistics of births and deaths based on civil registration, various estimation techniques are used to calculate life expectancy using sources of data other than civil registration, mainly population censuses and demographic surveys. Life expectancy at birth by sex gives a statistical summary of current differences in male and female mortality across all ages. However, trends and differentials in infant and child mortality rates are the predominant influence on trends and differentials in life expectancy at birth in most developing countries. Thus, life expectancy at birth is of limited usefulness in these countries in assessing levels and differentials in male and female mortality at other ages.
Infant mortality rate is the total number of deaths in a given year of children less than one year old divided by the total number of live births in the same year, multiplied by 1,000. It is an approximation of the number of deaths per 1,000 children born alive who die within one year of birth. This series is taken from the estimates and projections of the Population Division of the United Nations Secretariat, based on a review of all available national sources. In developing countries where civil registration data are deficient, the most reliable sources are demographic surveys of households. Where these are not available, other sources and general estimates are made which are necessarily of limited reliability.
Where countries lack comprehensive and accurate systems of civil registration, infant mortality statistics by sex are difficult to collect or to estimate with any degree of reliability because of reporting biases and thus disaggregation of infant mortality by sex is not shown here.
Other factors which hinder comparability of data are differences in the method used to determine age at death and the quality of information relating to age at death. For these and other reasons related to deficiencies in data reporting, small differences between male and female child mortality rates in most developing regions should not be considered statistically significant in the absence of corroborating research and analysis.

Per capita GDP is a determinant of life expectancy and per capita GDP. As per capita GDP increases, life expectancy generally increases and infant mortality decreases. Improving these numbers in Iraq will be particularly challenging because Iraq's per capita GDP is low, its life expectancy is low even given its low per capita GDP, and it's infant mortality rate is high given its low per capita GDP.





Mortality of children age younger than age 5 is a third key indicator of health system performance, reflecting health care, public health and other inputs into household and societal production of health. These other inputs may include water and sanitation, nutrition, adequate housing, vaccination, and absence of violence. Table 2 shows the history of two mortality rates in Iraq: the child mortality rate (under age 5) and the infant mortality rate. This data reflects the results of the 1999 Child and Maternal Mortality Surveys. The table presents one sad fact: much of the progress made in reducing child and infant mortality rates from 1960 to 1990 has been lost.

Table 2

Infant and Child

Mortality

Year	U5MR	IMR
1960	171	117
1970	127	90
1980	83	63
1990	50	40
1995	117	98
1998	125	103

Source: http://www.childinfo.org/cmr/Irq/Gj99804.pdf. UNICEF. This page was last updated 8/26/99.

Fertility and maternal health

Four widely-used measures of fertility and maternal health are:

- Total Fertility Rate: the total number of children a girl will bear if her child-bearing follows the current fertility patterns and she lives through her entire child-bearing years
- Estimated Maternal Mortality Ratio: the number of maternal deaths per 100,000 live births
- Contraceptive prevalence among married women of child-bearing age: the percentage of women of childbearing age reporting use of either "modern" contraceptive methods or any method. "Modern" methods include sterilization, IUDs, the pill, injectable hormonal contraceptives, condoms and female barrier methods.
- Incidence of low birth weight

As shown Table 3 below, the *total fertility rate in Iraq is high, the maternal mortality ratio is high, and contraceptive prevalence is low.* Fertility rates are important factors affecting economic development, as well as health. Maternal mortality is clearly an important outcome measure for health systems. Comparison data on the *incidence of low birth weight is presented in Table 4, showing that the incidence in Iraq is high*. Low birth weight is a critical measure because it both: reflects maternal health, nutrition and prenatal medical care and indicates the child's health prognosis.

Table 3
Fertility
Middle East countries with available data

UN Data from the years 1995-2000; estimates for 2000-2005

Country	Total Fertility Rate	Estimated Maternal Mortality Ratio	Contraceptive Prevalence Married women; Childbearing age	
			Method	
			% any	% modern
Bahrain	2.66	38 +	62 s aa	31 aa
Cyprus	1.90			
Egypt	3.29	170	56	54
Iran	2.33	130	73	56
Iraq	4.77	370 +	14 a aa	10 aa
Jordan	3.57	41	53 a	38
Kuwait	2.66	25	50 s aa	41 aa
Lebanon	2.18	130 +	61	37
Occ. Pal. Terr.	5.57	120 + bb		
Oman	4.96	120 +	24 s aa	18 aa
Qatar	3.22	41	43 s aa	32 aa
Saudi Arabia	4.53	23	32 s aa	29 aa
Syria	3.32	200 +	36 a	28
UAE	2.82	30 +	28 aa	24 aa
Yemen	7.01	850	21	10

Sources:
Total fertility rate estimates from Population Division of the United Nations Secretariat, World Population Prospects: The 2002 Revision, Volume I: Comprehensive Tables (United Nations publication, forthcoming), supplemented by Demographic Yearbook 2000 (United Nations publication, Sales No. E/F.02.XIII.1); maternal mortality ratio estimates from World Health Organization, United Nations Children's Fund and United Nations Population Fund, Maternal Mortality in 1995: Estimates developed by WHO, UNICEF, UNFPA (Geneva, WHO/RHR/01.9); contraceptive use from World Population Monitoring, 2002(ESA/P/WP.171*, 9 January 2002), supplemented by Demographic and Health Survey national reports, Gulf Family Health Survey national reports, DHS + Dimensions, vol. 3, no. 2, Fall 2001, DHS Comparative Reports No. 1, Unmet Need at the End of the Century, Sept. 2001, Reproductive Health Survey national reports and Women's Indicators and Statistics Database (Wistat), Version 4, CD-ROM (United Nations publication, Sales No. E.00.XVII.4).
Footnotes:

+For countries lacking complete vital registration or other acceptable national estimates of maternal mortality, the estimates are developed using a model. For each country, the regression model was used to predict the proportion maternal among deaths of women of reproductive age (PMDF), and the prediction was then applied to an envelope of deaths of women of reproductive age in 1995 to estimate maternal deaths. The MMR was then obtained by dividing the number of maternal deaths by an estimate of the number of births in 1995. In almost all cases, the deaths envelope was obtained from the UN population projections (1998 Revision).
A Adjusted from source to exclude breast-feeding.
s Including the lactational amenorrhoea method and/or breastfeeding if reported as the current contraceptive method.
Aa households of nationals of the country.
Bb Data refer to Gaza Strip only.
Technical notes:
Total fertility rate estimates the total number of children a girl will bear if her child-bearing follows the current fertility patterns and she lives through her entire child-bearing years. Total fertility rate is estimated by the Population Division of the United Nations Secretariat using the latest available demographic data from countries and given as five-year averages.
Maternal mortality ratio is defined as the number of maternal deaths divided by the number of live births for a given year and expressed per 100,000 live births. Estimates shown here have been rounded according to the following scheme: <50 : no rounding; 50-99 : round to nearest 5; 100-999 : round to nearest 10; 1000 and over : rounded to the nearest 100.
Maternal deaths are defined as those caused by deliveries and complications of pregnancy, child-birth and the puerperium. However, the exact definition varies from source to source and is not always clear in the original, particularly as regards the inclusion of abortion-related deaths. Furthermore, the World Health Organization observes that most maternal deaths go unregistered in areas where maternal mortality rates are highest. To address this information gap, WHO and the United Nations Children's Fund recently developed new estimates of maternal mortality using a dual strategy. This involved using available data wherever possible, adjusted to account for the common problems of under-reporting and misclassification of maternal deaths, and developing a simple model to predict values for countries with no reliable national data. The estimates derived from this approach are considered to be more reliable than earlier ones and are the ones shown here.
Contraceptive use among currently married women of childbearing age has been compiled by the Population Division of the United Nations Secretariat from the results of national surveys associated with the Demographic and Health Surveys, the Maternal and Child Health Surveys and numerous other national surveys, and published in World Population Monitoring, 2002(ESA/P/WP.171*, 9 January 2002). Where possible, women in consensual unions are included. Age groups interviewed vary slightly across countries: most African, Asian and South American countries cover women aged 15-49; most Central American and Caribbean countries cover women aged 15-44; while European countries tend to cover a narrower age range, such as 15-44, 20-49 or variations falling close to these ranges.

Both overall contraceptive prevalence (that is, percentage using contraception regardless of method) and prevalence of modern methods are shown. The group *modern methods* refers to clinic and supply methods, and includes highly effective methods widely developed and adopted for contraceptive practice over the past few decades. These are the methods most often offered by family planning programmes. Specifically, they include male and female sterilization, IUDs, the pill, injectible hormonal contraceptives, condoms and female barrier methods (diaphragm, cervical cap, spermicidal foams, creams, jellies and sponges).

Low Birthweight

Table 4

Low Birthweight

Middle East countries with available data

UNICEF Global Database (as of September, 2001)

Country	Year of Estimate	Estimated Percent Low Birth Weight	Method	Source
Bahrain	2000	9.6		National Report on Follow-up to the World Summit for Children
Egypt	2000	10.0	DHS adjusted	Tabulation of data file
Iran	1995	7.0		National Report on Follow-up of the World Summit for Children
Iraq	1998	23.1		National Report on Follow-up of the World Summit for Children - no supporting docs for MICS 2000
Jordan	1997	9.8	DHS unadjusted	DHS report, p. 86 (data file is restricted)
Kuwait	1997/98	7.0	official stats	WHO draft LBW database - October 2000
Lebanon	2000	6.0		National Report on Follow-up to the World Summit for Children
Occ. Pal. Terr.	2000	8.6	other survey	2000 Health Survey (is this MICS?) - Tessa to check
Oman	1999	7.9	official stats	1999 Annual Statistical Book, Ministry of Health (MoH). Pages 8-15 and 2-4
Qatar	1999	9.7		National Report on Follow-up of the World Summit for Children - Ministry of

				Public Health
UAE	-	NA		
Yemen	1997	25.7	DHS unadjusted	DHS report, p. 119 (data file is restricted)

Diarrhea Incidence and Treatment

The incidence and treatment of diarrhea lies at the nexus of standard-of-living, public health and health care issues. While the table footnote indicates that inter-country comparisons of the incident rate must be made with caution due to seasonality issues, inter-country comparisons of treatment rates are valid. A relatively high proportion of children with diarrhea receive ORS packets, fluids and feeding in Iraq; only one country reports a higher percentage: Oman. On the other hand, fewer than half of these children receive ORS packers, fluids and feeding.

According to the WHO Communicable Disease Profile for Iraq, March 2003, acute lower respiratory infections and diarrhea diseases account for 70% of deaths in children.

Table 5
Diarrhea Incidence and Treatment
Middle East countries with available data

Country	% of children < 5 with diarrhea 2 weeks before survey	% with diarrhea who receive ORS packet	% with diarrhea who receive ORS packet + increased fluids+ continued feeding
Bahrain	8.4	35.5	
Egypt	7.1	33.7	37.1
Iran	11.3	36.9	
Iraq (N)	**27.8**	**43.0**	**37.4**
Jordan	18.0	24.0	
Kuwait	10.2	29.2	
Lebanon	19.3	44.4	29.8
Oman	6.7	82.0	88.0
Qatar	8.8	21.1	23.9
S. Arabia	9.1	52.1	
Syria	8.6	29.0	37.0
UAE	8.8	39.9	
Yemen	27.5	32.4	35.3

Sources of information listed on UNICEF website database.
* The prevalence of diarrhea may vary by season. Country surveys were administered at different times, rendering the diarrhea prevalence data incomparable between countries.

Maternal and neonatal tetanus

By 1999, maternal and neonatal tetanus had been eliminated in much of the world. UNICEF states of goal of eradicating this disease.

Table 6
Neonatal Tetanus in Middle East Countries

Country	estimated cases	estimated deaths	estimated mortality rate
Egypt	1,570	628	0.37
Iraq	**870**	**522**	**0.66**
Yemen	3,012	2,339	2.90

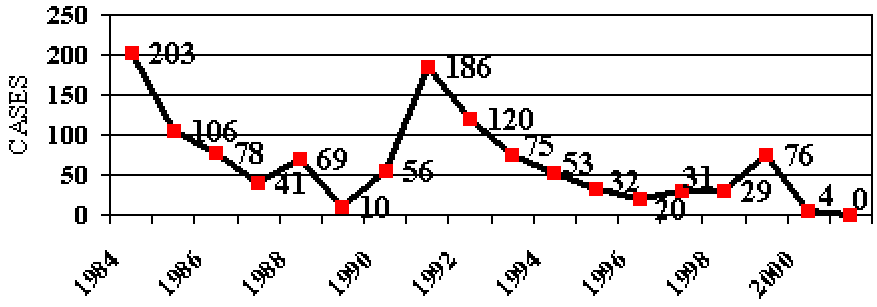
Source: WHO, 1999.
UNICEF End Decade Databases - MNTEnd-decade Databases Indicators Multiple Indicator Cluster Surveys (MICS)

Infectious diseases

In 1988, the Library of Congress Country Study reported:
high incidence of trachoma, influenza, measles, whooping cough, and tuberculosis
considerable progress in control of malaria
continuing shortage of modern trained medical and paramedical personnel, especially in rural areas and probably in northern Kurdish areas.

More recent data stems from operation of the UN Oil-for-Food Program:

- "The country remained polio free for 36 months following National Immunization Days that provided door-to-door vaccinations and reached 95 per cent of the 3.6 million targeted children under five years of age.



- In the central and southern governorates, major medical surgeries increased by 40 per cent and laboratory investigations by 25 per cent between 1997 and early 2003. There was a reduction in the transmission of communicable diseases, such as cholera, malaria, measles, mumps, meningitis and tuberculosis. The Oil-for-Food Programme also helped to improve health care delivery in several new or rehabilitated centres in the centre/south, including: the Saddam Centre for Neurological Sciences; the AIDS Research and Study Centre; the Acupuncture

Therapy Centre; the Tuberculosis Control Institute and; the National Centre for Haematology Research.

- In the three northern governorates, cholera was eradicated and the incidence of malaria was reduced to 1991 levels. The incidence of measles declined to levels ranging from 4 - 8 per cent and like the rest of the country, the north remained polio free for almost three years.
- Between 2000 and 2001, deliveries of medicines and medical supplies to the northern governorates doubled. Among the supplies delivered were high-demand items including antibiotics, intravenous solutions and oral suspensions. As a result, the rationing of medicines such as antibiotics was substantially reduced. "

Recent health indicators

The UN Oil-for-Food Program report identifies the following current issues (portions covering key topics excerpted below):

- **Basic health indicators for Iraq 2001**
  - life expectancy at birth: 58.7 years for men and 62.9 years for women
  - infant mortality rate: 98 per 1000 live births
  - mortality rate for children under the age of five: 133 per 1000 live births
  - maternal mortality 291 per 100 000 live births.

  Sources: WHO, UNICEF

  While these numbers differ somewhat from the UN and UNICEF data presented above, the differences do not alter the conclusions noted above.

- **Communicable diseases**

  Primary causes of communicable disease among children:
  - lower respiratory infections,
  - diarrhoeal diseases and
  - measles.

  Lack of adequate sanitation and clean drinking water lead to a high risk of diarrhoea outbreaks.

  Tuberculosis

  rates have risen in the last decade: new cases of tuberculosis nearly tripled from 46.1 per 100 000 people in 1989 to an estimated 131.6 per 100 000 people in 2000. One cause is the interruption in supply of anti-TB medicines used for Directly Observed Treatment (DOTS). The supply of anti-TB medicines has improved through the OFFP.

  Malaria

  outbreak occurred with a peak of about 100 000 cases per year in 1994 and 1995. This epidemic was caused by the vivax strain of the malaria parasite, which is rarely life-threatening. The outbreak

has been attributed to movement of people from endemic into malaria-free zones, delays in access to effective treatment and a lack of effective control measures. Vector control programmes (indoor residual spraying to break the transmission cycle, distribution of insecticide-treated nets) have now led to a decline in malaria incidence to pre-1991 levels.

- **Noncommunicable illnesses**

Cardiovascular disease is the leading cause of death (Ministry of Health statistics)

Cancer risk factors:

increasing tobacco use

changes in lifestyle, particularly diet.

{Iraq established a computerized population-based cancer registry in 1976 (one of the first in the region} Source of additional cancer statistics: Globocan 2000 statistics.

Diabetes incidence unknown, but likely to be a large-scale problem in Iraqi 2000 estimate: 600 000 cases; close to 3.0% of the population.

Echoing the concepts of individual, household and society production of health, the report notes factors that affect the prognosis of people with chronic illnesses:

Nutrition and income,

Availability of essential medicines and medical equipment, and

Access to properly staffed medical services.

- **Food security and nutrition**

Estimates suggest that 18 million out of a population of 24.5 million people in Iraq lack secure access to food. Currently, almost 60% of the population is solely dependent on food distributed by the government each month. Food made available in 2002 included wheat flour, rice, sugar, tea, cooking oil, milk powder, dried whole milk and/or cheese, fortified weaning cereal, pulses (beans, chickpeas and lentils), and iodized salt, together with soap and detergent. In July 2002, the daily ration provided through OFFP was raised to 2215 kilocalories per day

- **Vaccine-preventable diseases**

Pertussis (whooping cough) incidence: reported to be increasing.

Diphtheria: cases reported.

Polio: major outbreak in 1999, but – as a result of intensive immunization efforts - there have been no cases since January 2000.

Measles immunization rates in children under five over the last few years were: 79% (1998), 96% (2000), 78% (2001) and 96% (2002). Many older children (age 6-12) were not vaccinated in the mid-1990s when vaccines were in short supply. As a consequence, more than two-thirds of measles cases in southern Iraq are occurring in older children. Measles mortality is higher in children suffering from malnutrition.

- **Health services, facilities and personnel**
  Public health and water quality control hindered by shortages of laboratory reagents
  Emergency services are sometimes unable to function due to inadequate equipment and supplies.
  Physical condition of some health facilities deteriorated: many lack potable water and constant electricity supplies.
- **Environmental health**
  Reports of increased rates of cancers, congenital malformations and renal diseases
    The Iraqi government attributed this increase to exposure to depleted uranium (DU). Iraqi health officials and scientists, working with WHO, have developed plans for the surveillance of cancers, congenital malformations and renal diseases, for investigating the health effects of environmental risk factors including depleted uranium, and for improved cancer control. The plans have yet to be implemented.

Note that some of this data is provided by a UNICEF-supported household survey conducted by the Iraqi Ministry of Health and the Central Statistical Organization in February 2002.

Data on health system facilities in Iraq

The Health Facilities Overview dated May 11, 2003 provides data on the locations and numbers of types of health facilities across Iraq, as outlined in Table 7. This recent preliminary data will be evaluated and correlated with facility assessments, DOD information, and data available from other implementing partners.

Table 7	
Health Facilities Included in the Health Facilities Overview	
Health Facilities Overview 5/11/03	
Facility Type	**Number included in the 5/11/03 overview**
Ministry of Health	1
Directorates of Health	23
Other Directorates	Environmental Protection
	Technical Affairs
	Public Clinics
Research Institutes	14
Pharmacies	
Chronic Illness	254
Rare Drugs	32
Health Centers	
Without doctors	736

With doctors	734
Health Insurance Clinics	308
Public Clinics	324
Specialized Centers	110
Hospitals	269
Warehouses	142
Production Plants	10

Annex B Subcontractors

APPENNDIX B

Revised Workplan (May 2004)

Specific Tasks

Tasks that the Contractor will undertake are listed below.

Ministry of Health Technical Assistance

Provision of Health Services (decentralized)

This Project Component is consistent with decentralizing and strengthening health management and service delivery functions per discussion in the Vision and Strategy section.

Facility Renovation

Primary health care renovations undertaken under separate USAID funding will also be supported by technical assistance from Abt Associates to develop facility standards for renovation. Selected renovated clinics will be equipped under IHSS procurement.

Abt will also assist in the development of a health facilities database for the MOH Planning Department to: identify what medical facilities exist and where they are located; determine what condition they are in; determine what are the physical infrastructure requirements or investments for them to become fully functional; and, determine what donors or other organizations are involved with the facility. The facilities database will be available to other interested MOH departments, NGO's, and donors.

- Provide technical assistance to the Ministry of Health, in collaboration with other partners, to set criteria for prioritization and selection of clinics to be renovated and supplied.
- Provide technical assistance to the Ministry of Health to develop a facilities database, and train local MOH staff to maintain it.
- Provide technical assistance to the Ministry of Health, in collaboration with other partners, to develop "minimal quality standards" for clinic renovation.

Primary care equipment procurement

This activity will consist of developing a standard list for 600 kits of basic PHC equipment, procuring equipment, and facilitating installation in selected health centers to include primary health care clinics renovated by RTI and Bechtel as well as in the seven governates where IHSS is intervening.

- Develop and review list of primary care equipment to be provided with key MOH and donor stakeholders.
- Finalize number of primary care equipment packages to be procured with USAID and complete procurement.

- Collaborate with the MOH, USAID health partners, NGOs, and other USAID contractors to facilitate distribution and installation of equipment packages to designated facilities.

Referral network improvement, focused on emergency obstetric care

IHSS will focus on emergency obstetrics care and OB/GYN is a good area to start the referral system to address the high maternal mortality and low rate of deliveries in hospitals. The referral system will install a discipline of a progressive treatment system where all entry and initial treatment is at re-equipped primary health care clinics with established standards of quality care.

- In collaboration with the Ministry of health and other health partners, identify at least 21 district referral hospitals clinics for improvement – these should be part of a re-equipped and re-trained primary care clinic network
- Agree on essential equipment for emergency obstetric care with USAID, the MOH and/or directorates and/or districts.

Quality of Primary Care with a focus on the Health of Women and Children

Activities to improve quality of services under this program element will emphasize the care of women and children as well as critical elements of PHC.

- Propose and review training program on integrated primary care and care of women and children with the MOH (focus on safe motherhood, reproductive health, nutrition, well-baby care, breastfeeding promotion and BFHI in collaboration with UNICEF, and childhood preventive health)
- Initiate train the trainers program
- Organize and deliver training to clinic staff in accordance with MOH standards
- Design a quality improvement program using internationally recognized primary health care indicators.
- Technical assistance to MOH and/or to health care associations to establish licensure and accreditation standards focused on women and children's care in primary care clinics.

Health Information Systems Improvement

This program element contributing to design of a national health information system as part of the MOH/CPA Working Group process and developing and implementing a disease surveillance system.

Another area of assistance will be with Kimadia and technical assistance may require various interventions from basic warehouse management to development of a drug formulary. The pharmaceuticals work related to Kimadia can be categorized into a very

short-term rapid assessment and two other activities planned for the next six months where technical assistance will be required.

Disease Surveillance System

- With guidance from, and in cooperation with MOH ongoing activities, develop plan for strong national disease surveillance system and initiate a disease information surveillance prototype.
- Customization of the prototype
- With MOH, develop training materials to train local MOH staff to manage, maintain and build on system.
- Provide training to increase local capacity and sustainability of the disease information surveillance prototype.

Kimadia Warehouse inventory and distribution systems

- Situation analysis of central and governorate Kimadia Warehouses
- Rapid inventory at central Kimadia warehouses
- System analysis of existing inventory system

Health Education

Collaborate with UNICEF and other health partners to collect information on community health knowledge, attitudes and practices. As a result:

- Design behavior change strategy based on survey/focus groups/assessment to have greatest impact on public health outcomes
- In cooperation with Iraqi experts, design behavior change interventions
- Design focused surveys to understand the nature of household demand for health care.

Assistance to Ministry in Health Policy Development

The main program activity driving health policy, planning, and finance will be the on going support to the MOH/CPA Working Group (WG) process. It is planned that the initial WG process will take sixty days starting around October 21st. There are nine WG's – Public Health, Healthcare Delivery, Healthcare Finance, Health Information Systems and Technology, Pharmaceuticals and Medical Supplies and Equipment, Education and Training of Health Professionals, Human Resources, Licensing and Credentialing, and Legislation and Regulation.

- Analyze pre-conflict Iraqi health care models, legal regulations, strengths and weaknesses.
- Support MOH by holding focus groups in selected permissive sites to gather information to evaluate current policy changes, expectations, and to test ideas and concepts.

- Assist with Working Group process to develop national health policy as needed.
- Rationalize the national health policy draft with existing laws and regulations in health and other related sectors.
- Based on the national health policy draft, formulate a medium term health strategy; develop guidelines and a process to coordinate resource allocation plans and budget with the national health policy.

Assistance to the Ministry of Health in Resource Mobilization (health care finance)

Abt will work with the MOH to assist it to fully assume its role in policy development, strategic planning, and managing the health system in Iraq.

- Review, assess and propose model of health finance based on experiences of countries with similar experience (post-conflict, history of centralized authoritarian government).
- Assist with capacity building related to MOH budget projections and expenditure tracking.
- Funds flow map for the publicly funded health care sector
- Develop tool to perform a household survey in a demonstration governorate for the assessment of health need.
- Initiate capacity strengthening at the national and/or sub national levels in specific technical areas of health policy and financing.

Monitoring and Evaluation of Ministry of Health Assistance

The project M&E team will develop and test an instrument for primary health center assessment. The assessment will be first conducted by project-trained personnel in about 300 primary health care centers in three of the seven focal governorates to which training and equipment kits will be delivered. This will be one of the most comprehensive and useful assessments done in Iraq.

- In collaboration with the MOH select model districts in which to develop Iraqi MOH capacity in planning and Monitoring and Evaluation (M&E) capacity.
- Conduct a workshop/consensus building activity focused on monitoring and evaluation. Participants will examine several M&E strategies and data from selected districts.
- With governate MOH counterparts, develop a strategy to strengthen planning and M&E at the Governate level based on discussion/findings at the workshop

Technical and Liaison Support to the USAID Mission and Health Program

Technical assistance in the form of providing short-term advisory services to the MOH and USAID mission.

Rapid response grants to address specific health needs in country

This component is consistent with building capacity in Iraqi health sector institutions and potentially delegating functions from the MOH to other entities in the health sector. The specific institutions or stakeholders that Abt will support in building capacity and initiating realignment are NGO's, Professional Associations, community organizations, businesses, and the population.

- Provide a grants application manual and application form in Arabic and English for use in the small grants program.
- In cooperation with USAID design grants award criteria and appoint a grants review panel.
- Disseminate information on the small grants program throughout the qualified NGO community.
- Hold capacity-building training with interested NGOs to assist them in grants preparation.
- After grants award hold a training session in grants administration and documentation.
- Design and implement a grants monitoring and evaluation program that includes internal M and E, performance-related payment, and collaborative review of grant achievements before final payment is made.

IHSS Monitoring and Evaluation Plan

This program element includes three activities: Support for the MOH/CPA Working Group process in developing a national monitoring and evaluation system to help Iraq monitor the progress of their health system reform, monitor and evaluate the health care delivery pilots, and build capacity for monitoring and evaluation; IHSS will develop a capacity, system and process to establish baseline data and monitor and evaluate the PHC delivery programs in the seven governorates and the small grants activities to improve and document the models for national replication; and IHSS will initiate the process of developing institutional capacity to monitor and evaluate health related programs at the central and governorate level.

1. Develop a Program Monitoring Plan (PMP) for USAID to monitor progress towards required results – including specific indicators and timelines for achieving them.
2. Development of guidelines for internal M&E of IHSS
3. Field visits by the team members for development of the M&E plan for each sub-objective of the technical areas
4. Communication with M&E contractor to develop and implement the mechanisms of coordination and collaboration
5. Communication with other organizations for M&E activities and data sharing
6. Development and implementation of internal M&E (continuous quality improvement approach).

APPENDIX C

Amendment to May Revised Workplan

Iraq Health Systems Strengthening Project
USAID contract no. RAN-C-00-03-00010-00

Amended Workplan

January 2004 through September 2004

Introduction

In response to the reduction of funding for the Iraq Health Systems Strengthening Project (IHHS) from the original contract award of $43 million to $20,995,000, Abt Associates Inc. has detailed several amendments to the IHSS approved work-plan of July, 2003 and which have been submitted to USAID in a revised work-plan of May 2004.

This document further details those work-plan items from the May revised work-plan, and additional items requested by USAID, that can be completed between January 2004 and the remainder of the contract term which includes an extension through September 2004. Additional work items not in the original work-plan are indicated by ** and include Sections **1.1.1.2**, **1.4.6**, and **2.2**.

This document is designed to supplement the revised work-plan and with the exclusion of the Statement of Work below, refers to other parts of the revised May work-plan that remain unchanged.

Statement of Work

The activities to be carried out under the Iraqi Health System Strengthening (IHSS) contract will contribute to the reestablishment and strengthening of the national and governorate public health system in post-conflict Iraq, and its management by the MOH. These activities refer to the needs of the Iraqi people and support the goal of the Ministry of Health (MOH) to provide a sustainable foundation for an efficient and effective health system.

IHSS will implement activities in collaboration with other health partners including WHO and UNICEF, under the authority of the Ministry of Health. The strategic approaches to implementation are: 1) Support the needs of the Ministry of Health to build a strong national health system, 2) Support decentralization of activities and 3) Develop the capacity of Iraqis to lay a sustainable foundation for better health care including the ability to conduct monitoring and evaluation of health sector interventions.

Abt Associates will work in seven selected governorates as agreed upon by USAID and in conjunction with the MOH.

The IHSS has three main objectives. These are:

1. Technical Assistance to the Ministry of Health in the areas of provision of health services, health education & behavior change, health information systems, and direct technical assistance on policy and finance.
2. Technical support to the USAID Mission and
3. Rapid response Grants to address specific health needs.

1. Ministry of Health Technical Assistance

1.1 Provision of Health Services (decentralized)

This Project Component is consistent with decentralizing and strengthening health management and service delivery functions per discussion in the Vision and Strategy section.

1.1.1 Facility Renovation

Primary health care renovations undertaken under separate USAID funding will also be supported through provision of PHC equipment to selected clinics

Abt will also assist in the development of a health facilities database for the MOH Planning Department to: identify what medical facilities exist and where they are located; determine what condition they are in; determine what are the physical infrastructure requirements or investments for them to become fully functional; and, determine what donors or other organizations are involved with the facility. The facilities database will be available to other interested MOH departments, NGO's, and donors.

1.1.1.1 Provide technical assistance to the Ministry of Health to develop a facilities database, and train local MOH staff to maintain it.

****1.1.1.2** Organize and manage a tour, by up to 4 participants from the MOH, of select international hospitals in the region that provide high quality pediatric services. This tour will focus on facilities, operations, and pediatric services provided.

1.1.2 Primary care equipment procurement

This activity will consist of developing a standard list for 600 kits of basic PHC equipment, procuring equipment, and facilitating installation in selected health centers to include primary health care clinics renovated by RTI and Bechtel as well as in the seven governates where IHSS is intervening.

1.1.2.1 Finalize number of primary care equipment packages to be procured with USAID and complete procurement.

1.1.2.2 Collaborate with the MOH, USAID health partners, NGOs, and other USAID contractors to facilitate distribution and installation of equipment packages to designated facilities.

1.1.3 Quality of Primary Care with a focus on the Health of Women and Children

Activities to improve quality of services under this program element will emphasize the care of women and children as well as critical elements of PHC.

Primary health care training will emphasize care of women and children including safe motherhood, reproductive health, nutrition, well-baby care, breast feeding promotion, and childhood health prevention and promotion. Conceptually, this initial PHC training will build a foundation for the longer-term introduction of family practice.

1.1.3.1 Initiate train the trainers program

1.1.3.2 Organize and deliver training to clinic staff in accordance with MOH standards

1.1.3.3 Design a quality improvement program using internationally recognized primary health care indicators.

1.1.3.4 Technical assistance to MOH and/or to health care associations to establish licensure and accreditation standards focused on women and children's care in primary care clinics.

1.2 Health Information Systems Improvement

This program element contributes to design of a national health information system as part of the MOH/CPA Working Group process and developing and implementing a disease surveillance system.

1.2.1 Disease Surveillance System

1.2.1.1 With guidance from, and in cooperation with MOH ongoing activities, develop plan for strong national disease

surveillance system and initiate a disease information surveillance prototype.

1.2.1.2 Customization of the prototype

1.2.1.3 With MOH, develop training materials to train local MOH staff to manage, maintain and build on system.

1.2.1.4 Provide training to increase local capacity and sustainability of the disease information surveillance prototype.

1.3 Health Education

Collaborate with UNICEF and other health partners to collect information on community health knowledge, attitudes and practices. As a result:

1.3.1 Design behavior change strategy based on survey/focus groups/assessment to have greatest impact on public health outcomes

1.3.2 Design focused surveys to understand the nature of household demand for health care.

1.4 Assistance to Ministry in Health Policy Development

The main program activity driving health policy, planning, and finance will be the on going support to the MOH/CPA Working Group (WG) process. There are nine WG's – Public Health, Healthcare Delivery, Healthcare Finance, Health Information Systems and Technology, Pharmaceuticals and Medical Supplies and Equipment, Education and Training of Health Professionals, Human Resources, Licensing and Credentialing, and Legislation and Regulation. This activity will be part of ongoing reform activity within the MOH.

1.4.1 Analyze pre-conflict Iraqi health care models, legal regulations, strengths and weaknesses.

1.4.2 Support MOH by holding focus groups in selected permissive sites to gather information to evaluate current policy changes, expectations, and to test ideas and concepts.

1.4.3 Assist with Working Group process to develop national health policy as needed.

1.4.4 Rationalize the national health policy draft with existing laws and regulations in health and other related sectors.

1.4.5 Based on the national health policy draft, formulate a medium term health strategy; develop guidelines and a process to coordinate resource allocation plans and budget with the national health policy.

****1.4.6** Assist USAID and the MOH with the facilitation of working group meetings focused on the development of a health sector reform results framework.

1.5 Assistance to the Ministry of Health in Resource Mobilization (health care finance)

Abt will work with the MOH to assist it to fully assume its role in policy development, strategic planning, and managing the health system in Iraq.

1.5.1 Review, assess and propose model of health finance based on experiences of countries with similar experience (post-conflict, history of centralized authoritarian government).

1.5.2 Assist with capacity building related to MOH budget projections and expenditure tracking.

1.5.3 Develop a funds flow map for the publicly funded health care sector.

1.5.4 Develop tool to perform a household survey in a demonstration governorate for the assessment of health need.

1.5.5 Initiate capacity strengthening at the national and/or sub national levels in specific technical areas of health policy and financing.

1.6 Monitoring and Evaluation of Ministry of Health Assistance

The project M&E team will develop and test an instrument for primary health center assessment. The assessment will be first conducted by project-trained personnel in about 300 primary health care centers in three of the seven focal governorates to which training and equipment kits will be delivered.

1.6.1 Increase Iraqi MOH capacity in planning and Monitoring and Evaluation (M&E) capacity.

1.6.2 Conduct a workshop/consensus building activity focused on monitoring and evaluation. Participants will examine several M&E strategies and data from selected districts.

1.6.3 Develop a strategy to strengthen planning and M&E at the governorate level based on discussion/findings at the workshop

2 Technical and Liaison Support to the USAID Mission and Health Program

2.1 Provide technical assistance in the form of short-term advisory services to the MOH and USAID mission.

****2.2** Provide administrative and technical support to the Office of the Minister of Health as may be requested based on funding availability.

3 Rapid response grants to address specific health needs in country

This component is consistent with building capacity in Iraqi health sector institutions and potentially delegating functions from the MOH to other entities in the health sector. The specific institutions or stakeholders that Abt will support in building capacity and initiating realignment are NGO's, Professional Associations, community organizations, businesses, and the population.

3.1 After grants award hold a training session in grants administration and documentation.

3.2 Design and implement a grants monitoring and evaluation program that includes internal M and E, performance-related payment, and collaborative review of grant achievements before final payment is made.