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ABBREVIATIONS

CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CFSVA	Comprehensive Food Security and Vulnerability Analysis
CIDA	Canadian International Development Agency
COSIT	Central Office for Statistics and Information Technology
DFID	Department for International Development (United Kingdom)
EC	European Commission
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
GDP	Gross Domestic Product
GEF	Global Environment Fund
HIV/AIDS	Human Immunodeficiency Virus/Acquired immunodeficiency syndrome
HNSOT	Health and Nutrition Sector outcome Team
ICRC	International Committee of the Red Cross
IFHS	Iraq Family Health Survey
IFRC	International Federation of Red Cross and Red Crescent Societies
IHSES	Iraq Household Socio-Economic Survey 2008
ILO	International Labour Organization
ILS	International Labour Standards
IMC	International Medical Corps
IMF	International Monetary Fund
IMSMA	Information Management System for Mine Action
IOM	International Organization for Migration
I-PSMP	Iraq Public Sector Modernization Programme
IRFFI	International Reconstruction Fund Facility for Iraq
ITF	Iraq Multi-Donor Trust Fund
JICA	Japan International Cooperation Agency
KRG	Kurdistan Regional Government
KRSO	Kurdistan Region Statistics Office
MDG(s)	Millennium Development Goal(s)
MICS	Multiple Indicator Cluster Survey
NHDR	National Human Development Report
OCHA	Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the High Commissioner for Human Rights
SCR	Security Council Resolution
SRSG	Special Representative of the Secretary General
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAMI	United Nations Assistance Mission for Iraq
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDESA	United Nations Department of Economic and Social Affairs
UNDG	United Nations Development Group
UNDP	United Nations Development Programme

UNEP	United Nations Environment Programme
UNESCO	United Nations, Educational, Scientific and Cultural Organization
UNFIP	United Nations Fund for International Partnerships
UNFPA	United Nations Population Fund
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNIFEM	United Nations Development Fund for Women
UNISDR	United Nations International Strategy for Disaster Reduction
UNOPS	United Nations Office for Project Services
UNPD	United Nations Population Division
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WPAY	UN World Programme of Action for Youth

SECTION 1. INTRODUCTION

The Country Cooperation Strategy (CCS) reflects the medium-term vision for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS process reflects global and regional health priorities with the aim of bringing together the strength of WHO support at country, Regional Office and headquarters levels in a coherent manner to address the country's health priorities and challenges.

The CCS, in the spirit of Health for All and primary health care, examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and national policies and strategies that have a major bearing on health. The exercise aims to identify the health priorities in the country and place WHO support within a framework of 4–6 years in order to have a stronger impact on health policy and health system development, strengthening the linkages between health and cross-cutting issues at the country level. This medium-term strategy does not, however, preclude a response on other specific technical and managerial areas in which the country may require WHO assistance.

The CCS takes into consideration the work of all other partners and stakeholders in health and health-related areas. The process is sensitive to evolutions in policy or strategic exercises that have been undertaken by the national health sector and other related partners. The overall purpose is to provide a foundation and strategic basis for planning as well as to improve WHO's contribution to Member States for achieving the Millennium Development Goals (MDGs).

The CCS mission for Iraq was composed of the senior health staff from the Ministry of Health led by His Excellency the Minister of Health, the WHO Representative and WHO country staff and staff from the Regional Office in Cairo and headquarters in Geneva. The WHO country office, with support from staff of the Ministry of Health and the Regional Office, prepared the health situation and challenges in the country, in line with the Common Country Assessment and UNDAF. In the process of development of the strategy, a series of meetings and reviews were conducted with officials from concerned ministries and institutions, representatives of UN agencies, as well as key potential internal and external partners.

The CCS for Iraq 2012–2017 considers carefully the current and projected security issues and political landscape in Iraq during its transition to stability. The consolidation of health policies and strategies, strengthening of health systems, strengthening of primary health care through family medicine, noncommunicable diseases and lifestyle, enhancing partnership for social determinants of health and environmental health are all outstanding health issues for WHO collaboration.

SECTION 2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 Macroeconomic, political and social context

Iraq is still recovering from long period of conflict and political turmoil. While modernization of the public sector remains a top priority, limited focus on good governance is affecting the implementation of laws, provision of services and effective management of the country's resources. The Iraq Five Year National Development Plan 2010–2014, prepared through a consultative process within governmental and nongovernmental structures, reflects the shift in perspective and approach to development, strengthening a democratic and consultative political base, reforming governance and administration and optimizing the utilization of national natural and human resources.

Iraq's population almost tripled between 1970 (10 million) and 2010 (more than 33 million) and the United Nations Population Division estimates that by 2030, it will have quadrupled to almost 50 million. Currently, the Iraqi population presents a broad-based youthful age composition, with 40% under the age of 15 years. Approximately two thirds (66%) of the population lives in urban areas, though regions vary greatly, with Baghdad having the highest urban population (93%) and Diyala the highest rural population (56%). Though fertility rates have decreased in the past decade, fertility in Iraq remains high with a total fertility rate of 4.3 (Table 1).

Iraq's unprecedented population growth, with its youth/adolescent bulge, is of concern from a social and health perspective. High unemployment rates, limited economic opportunities and poor service delivery, coupled with forced migration, all have a negative impact on health and well-being of the people of Iraq and adversely affect the country's ability to achieve the MDGs.

Table 1. Demographic indicators

Population, total (2011)	33 227 000
Population growth rate (%) (2011)	3.5
Birth rate, crude (per 1000 people) (2011)	38.0
Death rate, crude (per 1000 people) (2011)	4.2
Life expectancy at birth, total (years) (2010)	72.7
Fertility rate, total (births per woman) (2010)	4.3
Urban population (% of total) (2010)	66.0

Source: *Demographic, social and health indicators for countries of the Eastern Mediterranean 2012*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2012.

Iraq is a middle-income country with gross domestic product (GDP) per capita estimated at US$ 3864 in 2011[1]. Its economy is heavily dependent on revenues from oil with relatively small contribution of non-oil sectors in GDP and in exports. Prudent fiscal policy has brought considerable progress towards macroeconomic stability since 2003[2]. Inflation has been reduced to single digits and economic growth has resumed, although the role of the private sector in the economy is very limited.

2.2 Other major determinants of health

There have been significant improvements in the education sector in Iraq. Primary school net enrolment reached 87% in the academic year 2007/2008, and encompasses more than 4.3 million pupils.[3] Some schools are being rehabilitated, and more alternatives also are on offer for thousands of out-of-school children/adolescents. According to Central Office for Statistics and Information Technology (COSIT) enrollment ratios of females to males have increased between 1990 and 2007 for all educational levels. As health literacy is now considered a part of basic life skills and schools plays a key role in development of such skills, a programme of health-promoting schools has been implemented.

Poverty remains widespread in Iraq. The Iraq Household Socio-Economic Survey 2008 (IHSES) indicated that 23% of Iraq's population lives under the national poverty line of US$ 2.2 per day.[4] Poverty is almost twice as prevalent in rural areas, and households without a civil servant wage-earner or with less educated or female heads of households are more vulnerable to poverty, with one in ten households in Iraq female-headed, 90% of which are headed by widows.[5] The human development index ranking for Iraq is 132, out of 187 countries assessed.[6] Iraq is a signatory to several international human rights instruments and conventions of the International Labour Organization. In 2008 a law establishing an independent high commission for human rights entered into force.

Women in Iraq comprise roughly half the total population. Women's share of wage employment outside agriculture fell from 11% to 7% between 1990 and 2008. Just 18% of women aged 15 years and over participate in the labour force[7] and 26% are illiterate.[8] In recent years Iraqi women have suffered economic, social and political marginalization due to decades of war, violence and sanctions. One in every 10 Iraqi households is headed by a widow. An Oxfam survey recently showed that 55% of the female respondents had been a

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[1] World development indicators database. World Bank. Available at http://data.worldbank.org/data-catalog/world-development-indicators (accessed 16 January 2013).
[2]. *Republic of Iraq public expenditure review: Towards more efficient spending for better service delivery in Iraq*. The World Bank, Poverty Reduction and Economic Management Department Middle East and North Africa Region, June 2012 (Report No. 68682-IQ)
[3] Data from the Iraq Central Office for Statistics and Technology (COSIT).
[4] COSIT/World Bank IHSES, 2007.
[5] UNICEF/COSIT/Kurdistan Regional Statistical Office (KRSO) and Ministry of Health Multiple Indicator Cluster Survey 2006.
[6] *Human development report 2011: Sustainability and equity: a better future for all*. New York, United Nations Development Programme, 2011.
[7] COSIT Labour Force Survey 2008.
[8] WFP/COSIT/KRSO Vulnerability Analysis and Mapping Survey 2007.

victim of violence and 22% had experienced domestic violence. The number of women ministers has declined from six in 2003 to one in the last 2010 government formation.[9]

2.3 Health status of the population

2.3.1 Burden of communicable disease

Despite the critical security situation, communicable disease prevention and control have made major advances. However, due to critically poor environmental health conditions and the damage sustained by water supply and sewerage system since 2003, the incidence of water-related infectious diseases has risen. Improving environmental health is essential in order to reduce avoidable mortality and morbidity from water-borne diseases and will require strengthening both intrasectoral and cross-sectoral coordination to protecting health.

Contaminated water supply, unsafe sanitation and poor hygiene practices are the main causes of the spread of water-borne infections. Currently, an unacceptable percentage of drinking-water samples fail quality checks, and raw sewage is discharged directly into rivers. A WHO-supported study in 2006 found that hepatitis A was hyper-endemic in Iraq, with 96.4% of people exposed at one stage.[10] Hepatitis E is also endemic in the country, with an estimated prevalence rate of 20.3%. Both hepatitis B and C virus infections have low endemicity (1.6% and 0.4%, respectively).

Typhoid fever, a waterborne and foodborne disease, is endemic in Iraq. Hot weather and the frequent interruptions of electricity and water supply during the summer months have resulted in increased incidence. As a result, numerous interventions were implemented to prevent and control outbreaks. In 2007, 2008, 2009 and 2010, a total of 36 208, 58 247, 49 113 and 49 139 suspected cases of typhoid fever were reported, respectively.

Cholera is also endemic in the country. Following a large outbreak in 2007, smaller scale outbreaks were also reported in 2008, 2009 and 2010. A total of 4696 suspected cases including 24 deaths were reported from the 2007 outbreak. In 2010, only two cases were reported with no deaths.

In 2011, 9248 cases of tuberculosis were reported, with a notification rate of 28 cases per 100 000 population. As a result of deteriorating socioeconomic conditions during the past decade, the incidence of tuberculosis has been on the rise. With gradual security improvement and support from Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO and the Global Drug Facility, the national tuberculosis programme has been revitalized.

No indigenous malaria cases have been reported in Iraq since 2008. The last indigenous case due to *P. falciparum* was reported in 1969, while the last two local cases due to *P. vivax*

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[9] *Gender*. United Nations Development Programme in Iraq. (http://www.iq.undp.org/DynamicPages_View.aspx?q=SUQ9MyY%3D-4WLEvCsykY0%3D, accessed 1 July 2013).

[10] Joint Ministry of Health–WHO survey on viral hepatitis prevalence and incidence among a sample of 12 000 people, 2005–2006.

were recorded in 2008. Imported malaria cases originate from African and South-East Asian countries, but their numbers at present are very low and do not exceed several cases a year (11 imported cases reported in 2011). During 2011, a field malaria programme assessment was completed successfully with support from WHO. The results of the assessment were used to develop a strategy to maintain Iraq free of malaria for 2011–2015. The strategy emphasizes the importance of early detection and prompt treatment, epidemiological investigation of all cases, special surveys/screening of high risk populations, vector monitoring include monitoring of insecticide resistance and use of selective vector control measures in high-risk areas.

The cumulative number of HIV/AIDS cases registered from 1986 up to 2007 was 269. Among the registered cases, 85% are males and 77% are haemophiliacs who became infected in the early 1980s through contaminated blood products. Since 2003, sexual transmission has appeared as an important mode of transmission. Although the prevalence of HIV is currently less than 0.1% of the population, there is a need for improving public awareness about HIV transmission.

Since 2003, the Ministry of Health has strengthened its immunization programme, including revitalization of the disease surveillance system and reactivation and rehabilitation of the vaccine cold chain system. The Ministry commenced the process of immunizing the country's 4.2 million children under the age of 5 years against preventable diseases such as poliomyelitis, tetanus, diphtheria, pertussis, measles and tuberculosis. Iraq has been certified as polio-free, measles has been brought under control, and maternal and neonatal tetanus has been eliminated. The Ministry of Health has been supported in large measure by UNICEF and WHO for all aspects of vaccination and surveillance.

There has been marked improvement in the Expanded Programme on Immunization (EPI) despite lack of security, poor access and sub-standard primary health care services. However, the extensive measles outbreaks of 2008 and 2010 indicate the need for further vigilance and upgrading of the immunization programme. It is necessary to boost routine coverage of infants, including through national and subnational supplementary campaigns, to achieve the coverage targets of at least 90% nationwide and 80% in every district.

Although the Ministry of Health is using its own resources for purchase of all vaccines and supplies, UNICEF and WHO support is still needed to bridge gaps. More than 56% of primary health care centres provide immunization. The EPI surveillance system works well and more than 90% of the 1600 reporting sites provide regular and timely data. Hib, rotavirus and pneumococcal vaccines were made available to all eligible children in 2011. More efforts are needed to ensure that all hospital maternity wards and health centres have delivery facilities and trained staff to give BCG and hepatits B first dose at birth. The immunization programme has a robust surveillance system and committed staff but needs further capacity building, particularly in the area of forecasting.

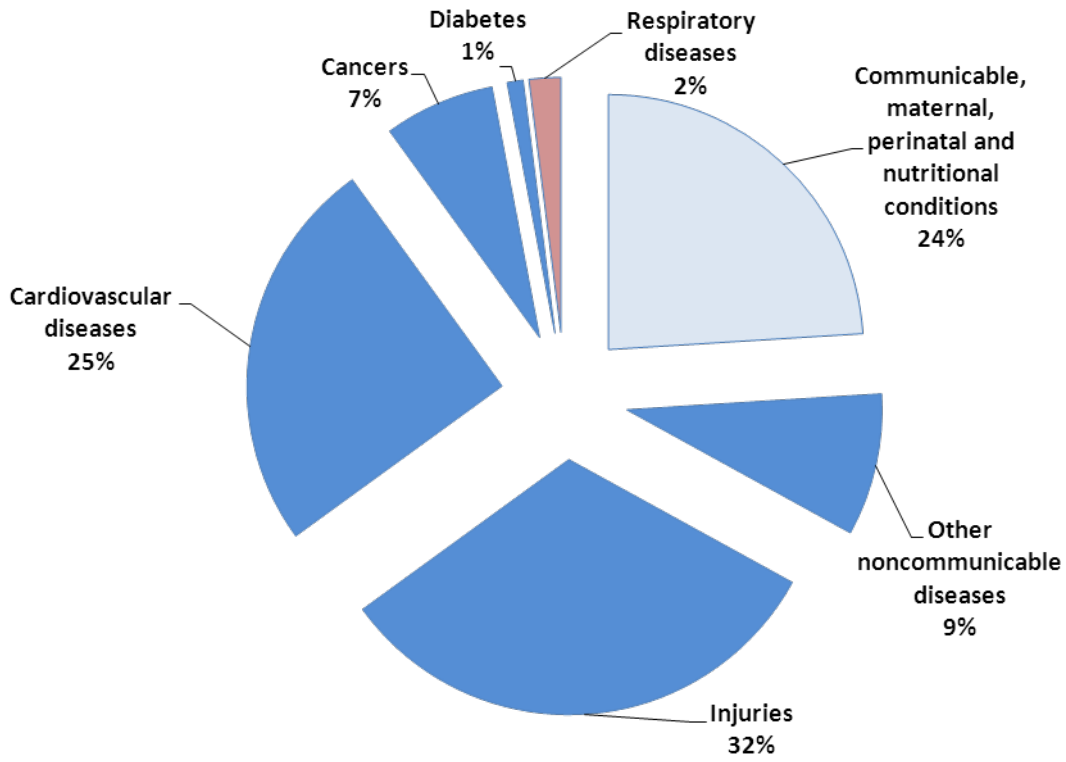

Figure 1. Proportional mortality, Iraq, 2011 (% of total deaths, all ages)[11]

2.3.2 Burden of noncommunicable diseases, mental health and injury

Noncommunicable diseases account for 44% of mortality in Iraq (Figure 1).[11] Chronic illnesses such as heart disease, stroke, cancer, respiratory diseases and diabetes are the leading causes of mortality (Ministry of Health, 2008). According to Iraq Family Health Survey (IFHS) 2006/2007, the most frequently reported chronic conditions are high blood pressure (41.5 cases per 1000 population), diabetes (21.8 cases per 1000), joint diseases (18.6 cases per 1000), heart disease (12.0 cases per 1000) and gastrointestinal disease (11.2 cases per 1000). The chronic noncommunicable diseases stepwise risk factor survey 2006 showed that 41.4% of the adult population (aged 25–65 years) suffered from raised blood pressure, 10.8% had hyperglycaemia, and 37.7% had hyper-cholesterolaemia. The survey also showed that 66% of the adult population was overweight and 33% were obese. Smokers constituted 21.9% of the adult population while 90.5% of the population had low fruit and vegetable consumption and 56.7% had low levels of physical activity. The 2008 Global Youth Tobacco Survey results showed that 7.4% of students aged 13–15 years in Baghdad had ever-smoked cigarettes (males 7.4%, females 6.8%).

[11] *Noncommunicable disease country profiles 2011. Iraq*. Geneva, World Health Organization, 2011. Available at http://www.who.int/nmh/countries/irq_en.pdf (accessed 1 July 2013).

The noncommunicable disease unit at the primary health care department of the Ministry of Health is fully engaged in prevention and control of noncommunicable diseases. A national action plan for the prevention and control of noncommunicable diseases in line with the global and regional plans has been developed and being implemented. The integration of noncommunicable diseases into primary health care centres has been successful and is gradually moving towards 50% coverage. At this stage the focus is on hypertension and diabetes.

According to the Iraqi cancer registry report for 2007 the five leading cancers among males in order of frequency were: lung and bronchial, leukaemia, urinary bladder, non-Hodgkin's lymphomas and brain and other central nervous system tumours. The five leading cancers among females were breast, leukaemia, brain and other central nervous system tumours, non-Hodgkin's lymphomas and lung and bronchial cancers. The number of cancer cases is expected to rise in the future, mainly due to the ageing population, widespread tobacco consumption and exposure to environmental hazards. The majority of cancer cases in Iraq are detected in advanced stages. Supplies of chemotherapeutic drugs are inadequate and irregular. Radiotherapy facilities are outdated.

The mental health programme has been active since 2003 with multiple sources of donor funding. Many high level international and national forums and conferences have been held on mental health and policies and strategies to deliver quality mental health services have been discussed and developed. The national mental health strategy developed for the period 2008–2013 needs to be reviewed and updated. Iraq has a substantial number of highly competent and skilled psychiatrists. However, most of these human resources are in urban centres. Mental health services have been integrated into primary health care in less than 50% of primary health care centres in the country. Psychosocial care and support to address post-traumatic stress disorders are grossly inadequate, particularly given the intensity and the frequency of traumas faced by Iraqis since 1980. Six trauma centres have been established: two in Baghdad, one in Mosul, one in Basra, one in Dahuk and one in Diwaniyah. Based on various surveys, it is estimated that the prevalence of mental disorders among the population is 35.5%[12], while the treatment gap for management of mental disorders is estimated at 94%.[13]

In 2007, the Ministry of Health reported 1794 deaths due to road traffic crashes. Sentinel sites have been established in northern and central Iraq in efforts to develop injury surveillance, violence prevention and treatment and rehabilitation programmes. Preliminary reports from these sites suggest that the leading causes of injuries registered at emergency rooms for the period 2007–2008 were traffic crashes (17.3%) and domestic accidents (17.2%).

[12] *Iraq mental health survey 2006/7*. World Health Organization, 2009.
[13] *WHO-AIMS Mental health systems in selected low- and middle-income countries: a WHO-AIMS cross-national analysis*. Geneva, World Health Organization, 2009.

2.3.3 Health over the life-cycle

Improvement of women's health is clearly articulated in the Ministry of Health's strategic plan for 2009–2013. Reproductive health services deteriorated sharply immediately after the 2003 conflict, but have since made a gradual recovery. However, access to reliable data on reproductive health remains somewhat limited. Estimates for maternal mortality vary widely, from 63 maternal deaths per 100 000 live births (United Nations Maternal Mortality Estimation Inter-Agency Group, 2010) to 24 per 100 000 live births (Ministry of Health, 2011). Currently, 50% of the population is under the age of 20 years. Marriage at young age is prevalent in some parts of the country, although fertility rates have decreased in the past decade.

The total unmet need for contraception is high,[14] and evidence of male involvement in fertility control is largely lacking. Family planning services are offered in less than 5% of primary health care centres and family commodities are rarely available except through private pharmacies at a high cost.[15] Although the rate of first-visit to antenatal care facilities is relatively high, the percentage of pregnant women who follow the recommended number of visits (four visits and above) is still low (29%). The same is true for postnatal coverage (41%) (Ministry of Health, 2009). It is reported that 32% of births occur outside health institutions, with 22% of deliveries at high risk and in need of advanced medical support.

The under-5 mortality rate was 25 per 1000 live births in 2011, with wide disparities between governorates. Because of unsanitary environmental conditions, unsafe water supply and poor hygiene practices, there is a high incidence of diarrhoeal diseases. Diarrhoeal and acute respiratory infections, compounded by malnutrition, account for two-thirds of deaths among children under 5 years of age. A Multiple Indicator Cluster Survey (MICS) carried out in 2012 showed acute malnutrition (wasting) at 7%, underweight at 8% and chronic malnutrition (stunting) at 22%. The exclusive breastfeeding rate was 25.1%. Based on available data, the prevalence of anaemia among women of reproductive age (15–49 years) is estimated at 35.5%, and 38% among pregnant women.[16]

The report of a survey on food security published in 2008[17] concluded that about four million people in Iraq (15.4% of the population) were food insecure and in dire need of humanitarian assistance – including food – in spite of the rations that they were receiving from the public distribution system. The survey also indicated that a further 8.3 million people (31.8% of the surveyed population) would be rendered food insecure if they were not provided with rations. The most recent food security survey (launched in 2008) found that an estimated 930 000 people were food insecure, representing 3% of the total population. An additional 6.4 million people, almost 22% of the population, were extremely dependent on food rations, without which they could become food insecure.

[14] Multiple Indicator Cluster Survey 2012.
[15] Ministry of Health, 2008.
[16] *World Health Statistics 2012*. Geneva, World Health Organization, 2012.
[17] *Comprehensive food security vulnerability analysis.* Baghdad, Central Organization for Statistics, 2008.

2.3.4 Environmental health, food safety, emergency preparedness, surveillance

Iraq is faced with significant environmental challenges. Years of war and neglect have seriously damaged environmental services such as water supply and sewerage systems. The country is grappling with decades-long drought, desertification, flooding, manmade disasters including conflict and deterioration of the physical infrastructure. Blessed with rich biodiversity and natural resources, Iraq is recognizing that exploitation of its natural resources must be accompanied by safeguards. The government has identified environment as a priority within the national development plan, in order to meet international treaty obligations and to ensure that its plans for economic and human development include environmental considerations.

As a consequence of the environmental situation, Iraq is the only country within the immediate region to show a decline in access to an improved drinking-water sources from 1990 to 2006 (from 83% to 89%).[18] The Baghdad Sewage Administration estimates that of the nearly 1.4 billion litres of wastewater/sewage generated daily in Baghdad city, only 34% is treated.[19] The rest remains untreated and is disposed of directly into rivers and waterways, with severe implications for public health and the environment.[20] Waterborne diseases are widespread due to contamination of drinking-water. Sustainable access to sanitation and safe water is poor, with 21% of households unable to access an improved water source and 16% without an improved source of sanitation. Disposal of hospital waste remains a major issue with a direct bearing on the health sector.

Iraq is also threatened by various natural hazards. Flooding, heat waves and high winds are a few, along with a risk of earthquake in the northwestern part of the country.[21] Apart from these, the country also faces the threat of disease outbreaks, epidemics and pandemics (such as the cholera and measles outbreaks), along with social unrest leading to conflict. The combination of these threats continues to directly affect the country's development. Addressing the vulnerabilities of communities thus needs to be on the priority list in order to avoid such consequences and accelerate development.

In light of the past situation as well as current threats, it is imperative that the country build capacity to prepare its health system based on real-time risk assessment. While strengthening the health system, it is important to integrate the perspective of emergency preparedness with a risk management approach, focusing especially on health facilities. Equally important is training health personnel on emergency management based on a

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[18] *Progress on drinking water and sanitation: special focus on sanitation*. WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation, 2008, and Multiple Indicator Cluster Survey 4, 2011.

[19] *Iraq country programme document 2009–2011*. Nairobi, United Nations Human Settlements Programme, Regional Office for Africa and the Arab States, 2009. Available at: http://www.unhabitat.org/downloads/docs/7476_49758_CPD%20Iraq-most%20updated9b.pdf

[20] Multiple Indicator Cluster Survey 4, 2011.

[21] *WHO e Atlas of disaster risk management for the Eastern Mediterranean Region*, version 2.0. Cairo, WHO Regional Office for the Eastern Mediterranean, 2011. Available at http://www.who-eatlas.org/eastern-mediterranean/index.html

thorough assessment of existing national capacity in line with the IHR. In order to reorganize the health sector involving all stakeholders, developing and implementing a national strategy for emergency preparedness and response integrating the requirements of the IHR is a priority for Iraq. This will facilitate a comprehensive approach to building capacity for emergency management with the all-hazards approach. It will also help in building IHR core capacities within the health sector.

The functional and structural safety of health facilities remains a priority for the country considering the ongoing situation. The most functional health facilities along with an integrated referral system will further strengthen the emergency management capacity of health sector and will contribute in reducing death and disability. Mass casualty management is another area where capacity needs to be built as an urgent priority.

2.4 National response to overcoming health challenges

The national development plan 2011–2014, which was prepared through a consultative process within governmental and nongovernmental structures, reflects a new perspective and approach to the development in Iraq. The national development plan has a direct relationship to the national poverty reduction strategy that was prepared with support from the World Bank.

While Iraq does not have a national health policy per se, the national development plan provides a framework for the health sector in the country. The plan includes a timetable for implementation, identifying 26 strategic objectives which can be grouped under the following 10 strategic directions:

- Strengthening health system infrastructure in order to improve delivery of integrated and quality health care services at primary, secondary and tertiary levels, including emergency units and specialized health facilities;
- Improving health outcomes through reduction of morbidity, disability and mortality from various causes and for some selected population groups;
- Strengthening health security through improved communicable disease control and food safety;
- Improving health promotion and protection, including strengthening mental health services;
- Strengthening health technology support to service delivery through laboratory and blood transfusion networks, access to essential medicines and better management of biomedical devices;
- Improving information support to service delivery through modernized national management information systems and use of information technology;
- Mobilizing additional resources for health through increases in Ministry of Health budget and contribution from regional and local governments;
- Securing the necessary health workforce by 2013;
- Improving health legislation support; and
- Improving the administrative systems and combatting corruption.

2.5 Health systems and services: six core components or building blocks

The Iraqi health sector faces considerable and complex challenges. These challenges encompass improving access to quality health services by transforming the hospital-oriented system to a primary health care model, overcoming recurring shortages of essential medicines, dealing with budget deficits, rehabilitation of infrastructure, training and deployment of human resources. In any health system there is a dual focus on the individual (health care system) and on public health measures and interventions the target of which is a specific population group or the population at large (public health system). Both sub-systems have been affected by the prevailing circumstances in Iraq.

2.5.1 Service delivery

The health care delivery system in Iraq has historically been a hospital-oriented and capital-intensive model with less emphasis on preventive measures. The Ministry of Health is the main provider of health care, both curative and preventive. The private sector also provides curative services. About half the health centres are staffed with at least one medical doctor. The rest have trained health workers (medical assistants and nurses).

The Ministry of Health has a network of health care facilities which in 2010 comprised 2331 primary health care centres, out of which 37 centres deliver family health care. In addition, the Ministry operates 229 public hospitals of various levels and a group of specialized health care centres. Public health care facilities are not equitably distributed across governorates and between rural and urban populations. While medical services in the public sector hospitals are free apart from nominal charges, many people choose to seek care in the private sector health centres to avoid longer waiting times in the public facilities and adverse perceptions of quality.

The private health sector plays an important role in delivering personal health care, in part due to the omnipresent “dual practice” – health staff employed in the public sector and working privately inside and outside government facilities. The total number of private hospitals in 2010 was 92, many of which are small and mainly concentrated in Baghdad. The main concern in service delivery is the quality of publicly provided services.

2.5.2 Health workforce

Approximately 47% of the Ministry of Health budget is allocated for human resources. Despite the relatively high numbers of health workforce in the health system (6.28 per 10 000 population), the proportion of funds allocated to personnel in total Ministry of Health expenditure is lower than the average of middle-income countries. In 2010, according to the Ministry of Health’s annual report of 2010, Iraq had 206 746 health workers. The total number of physicians was 24 745. The average ratio of physicians to population was 7.5 per 10 000 population. The total number of nurses in the country was 46 024, with an average ratio of 14 nurses per 10 000 population (a decline from the previous average of 15.2 nurses per 10 000 population in 2009). The majority of nurses (53.6%) graduated from nursing high schools of the Ministry of Health. 34% of midwifes were working in Ministry of Health

facilities. The remaining 66% worked in the private sector, and only 66% were certified. The total number of paramedics was 54 898, with an average ratio of 16.7 paramedics per 10 000 population. The total number of administrative and support staff in the Ministry of Health and various other units in Iraq was 56 197. The production of health workforce is coordinated by two major partners: the Ministry of Health and Ministry of Higher Education and Scientific Research. The Ministry of Health manages nursing high schools and midwifery high schools. The education and training of various categories of health professionals is carried out in the public sector, where education is free. There is no education policy or pre-service education strategy to guide the country's health workforce production. There is no database on pre-service qualifications or in-service training completed by staff.

2.5.3 Health information system

The health information system supports all health system functions and building blocks and is often considered as a proxy for the level of development of the health system. Data are collected through the national information system and supplemented by population-based surveys, vital registration system and health research.

The routine information system is part of the main activities of the health management information system, which deals with three types of data records: 1) health and disease records (including surveillance); 2) health service records; and 3) resource records. Another health-related population-based data source is the vital registration system, which the Ministry of Health coordinates with the Ministry of Interior at national and subnational levels.

2.5.4 Health technologies and pharmaceuticals

Medicines and other health technologies encompass a wide range of areas. Since 2003, the state-run company Kimadia distributes medicines and other health technology-related supplies to the public sector. Health and biomedical technologies, including pharmaceuticals, constitute the second major input in the provision of health care services. Access to medicines and health technology are among the indicators of health system responsiveness.

2.5.5 Health care financing

National health accounts were prepared in April 2011 by the Ministry of Health and WHO using data from 2008, adjusted for 2010. The national health accounts show that the total expenditure on the health sector during 2010 was 8150 billion Iraqi dinars. The Ministry of Health is the biggest financing agent of health sector expenditure, accounting for 80.3% of expenditure on health in the public sector, followed by other ministries which account for less than 1%. Out-of-pocket expenditure on health is estimated at approximately 19% (Table 2). The private insurance market is still nascent in Iraq, while health insurance for the general population is non-existent. In terms of health care expenditure by the government in the public sector, the biggest share goes to pharmacies of the Ministry of Health: 1 365 298 million Iraqi dinars, or 26.6% of total health care expenditure. In general, health care expenditure in Iraq is primarily spent on curative care (more than 37%). Transportation

absorbs 9% of out-of-pocket health spending. The Kurdistan Regional Government receives 17% of medicine procured by the Ministry of Health.

Table 2. Health expenditure (2011)

Total expenditure on health (per capita) Average US$ exchange rate	259.0
Per capita government expenditure on health	200.0
Total expenditure on health as % of GDP	8.0
General government expenditure on health as % of total health expenditure	81.0
Out-of-pocket expenditure as % of total health expenditure	19.0
General government expenditure on health as % of total government expenditure	9.0
Ministry of Health budget as % of government budget	6.6

Source: WHO regional health observatory. http://rho.emro.who.int/rhodata/ (accessed 16 January 2013)

2.5.6 Health governance

The Ministry of Health plays a leading role in health development through the formulation of a national vision and strategic health planning and management. The Ministry is constitutionally mandated to provide necessary health care services in partnership with the private sector and to guarantee health and social security to all citizens. Although the Ministry does not have an explicit health policy document, its vision for health development and its guiding values and principles are highlighted in the five-year national development plan.

The function of standard-setting, an important element of health governance related to the quality of health care services, is relatively weak in Iraq. National accreditation standards for centres were prepared in June 2010 with technical support from International Medical Corps. However, the accreditation system is still in ‘pilot’ stage.

2.6 Contribution of to the country to the global health agenda

Iraq is actively working to build a solid basis for establishment of the necessary instruments, facilities and action to meet the requirements of the IHR and safeguard national and international health security. WHO is supporting Iraq in taking the necessary steps to ensure compliance with the IHR, including revision of Iraq’s public health laws to facilitate implementation of the Regulations.

The attainment of the Millennium Development Goals and the associated target indicators is a top priority for the government and the UN Country Team. While some MDG indicators such as those for child mortality are on track, others lag far behind and will require significant action in the few years left until 2015. The benchmarks for achievement of these by 2015 are stipulated in both the national development plan and the United Nations Development Assistance Framework.

2.7 Challenges

Like other sectors in Iraq, the health system has suffered critical damage over the past two decades, with significant damage to infrastructure and conditions that have forced a large number of the trained and experienced health staff leaving the country. Iraq today faces economic and human development challenges including poverty, malnutrition and insecurity. Such conditions result in fewer resources for social sectors, including health. The major challenges are summarized below.

Reproductive health

- The full range of services for reproductive health need to be implemented through the basic health services package.
- There is a shortage of female staff in the country, especially nurses and midwives.

Health system

- Planning is mostly based on projects, and evidence-based policy and strategy formulation are not widely practised.
- Accountability and transparency are lacking in decision-making, along with social participation in decision-making processes.
- Regulation of the health service delivery mechanisms is weak in the public and private sectors.
- Decentralization in the health care delivery system has been addressed to certain degree in national legislation; however, implementation of these mechanisms presents major challenges.
- The budget-making process faces issues in preparation and in passage by the legislature. Disbursement of funds in a timely and predictable manner is a major challenge.
- Stronger national capacity is needed to identify alternate means of health financing, such as social insurance, prepaid options, risk-pooling mechanisms and targeting vulnerable communities, in order to move towards universal health coverage.
- The quality of care in both the public and private sectors in Iraq is far from desired levels. Effective standards and an accreditation system for health service providers is urgently need to be put into place.
- The dual practice model (civil servants working in the private sector) in Iraq is a major management issue leading to the unavailability of adequate health staff in public sector facilities. This adds to the problem of inequitable distribution of human resources for health across the country.
- There is no integrated information system that brings data from across different information subsystems in Iraq.
- Management of health technology is weak, starting from needs assessment to selection, procurement, maintenance and disposal.
- An effective medicine policy is needed which includes regulation, rational use and equitable access.

Health promotion

- Partnership mechanisms and linkages between the Ministry of Health and health-related sectors need to be strengthened.
- The Ministry of Health needs a stronger health advocacy role and presence for influencing policies and actions of other sectors and stakeholders including nongovernmental organizations (environment, nutrition, human rights, gender, etc.).

Communicable diseases

- Challenges are maintaining good progress on gains made in communicable disease prevention and control in general and minimizing the occurrence of public health threats due to communicable diseases.

Noncommunicable diseases, healthy lifestyles and mental health

- Noncommunicable disease prevention and control needs to be integrated into the agenda of the national development plan. This will facilitate the adoption of integrated policies and programmes by all sectors with a role in the prevention and control of noncommunicable diseases.
- A multisectoral approach needs to be developed for promoting healthy lifestyles, such as tobacco control and engaging in a healthy diet and physical activity.

SECTION 3. DEVELOPMENT ASSISTANCE AND PARTNERSHIP: AID FLOW, INSTRUMENTS AND COORDINATION

3.1 The aid environment

The current external support to the health sector in Iraq may be categorized into four main groups:

- United Nations agencies and The World Bank;
- bilateral donors, predominantly the European Commission (EC), United States Agency for International Development (USAID), United Kingdom Department for International Development (DFID), and the Governments of Italy, Japan and Australia;
- the United States Department of State and Provincial Reconstruction Teams;
- International and national nongovernmental organizations (most of which are coordinated by the Nongovernmental Organization Coordination Committee) including: International Committee of the Red Cross, Mercy Corps, International Medical Corps, Première urgence, Danish Refugee Council, Un ponte per, Médicins sans frontières (MSF), Mercy Hands, Handicap International, Life for Relief and Development, International Medical Group, Arche nova, MedChild, Action Against Hunger, Christian Aid Organization, Médicins du monde, Save the Children, Oxfam, Japan Emergency, International Rescue Committee, Caritas, Agency for Technical Cooperation and Development (ACTED), People in Need and Intersos-Humanitarian Aid Organization.

The Ministry of Health is interacting with the donor community and international agencies through these groups, with implementation supported by international and national nongovernmental organizations.

The Health and Nutrition Sector Outcome Team (HNSOT) is chaired by WHO, with UNICEF as deputy chair. Active partners in the HNSOT are WHO, UNICEF, UNFPA, WFP, UNDP, IOM, UNIDO, UNEP, UNIFEM, OCHA, International Committee of the Red Cross (ICRC) and nongovernmental organizations including Première urgence, Médicins sans frontières, International Medical Corps and others.

In 2003 the United Nations system assumed a critical role in both emergency humanitarian aid and development. The role of the UN in Iraq is derived and defined from Security Council Resolution SCR1546 (2004) and SCR1770 (2007) and is implemented through the UN Assistance Mission for Iraq (UNAMI) led by the Special Representative of the Secretary-General. Since then UNAMI's mandate has been repeatedly extended and is expected that the mission will be a partner to WHO throughout this CCS. In May 2010, the UN Development Assistance Framework (UNDAF) for 2011–2014 was endorsed. This builds on the UN Assistance Strategy for 2005–2010. Most of the assistance to the Iraqi health sector has been channelled through two major mechanisms: the United States Department of State and the UNDG International Reconstruction Facility for Iraq (IRFFI)/Iraq Multi Donor Trust Fund (ITF).

In May 2010, WHO had an approved budget of total US$ 128 159 758 from the ITF with 86.4% implementation rate. The United States disbursed US$ 31.304 billion in economic assistance to Iraq between 2003 and 2008. However, it is difficult to determine how much the United States Department of State has provided in assistance in the sector health and what the long-term impact of this assistance has been. The United States Department of State and Agency for International Development do continue to play an important role in the health sector and announced in 2010 a US$ 80 million investment in primary health care in Iraq for the coming years. The EC donated 933 million Euros between 2003 and 2008.[22] and remains WHO's key donor, representing over 80% of WHO Iraq's voluntary contributions. In August 2010, the EC pledged another 42 million Euros for development assistance to Iraq, of which nothing had been allocated to the health sector. This is a concern. Other major bilateral donors to Iraq include the Canadian International Development Organization, Department for International Development (UK) and the Governments of Sweden and Australia.

The WHO country programme has been very effective in mobilizing resources from donors for rehabilitation and strengthening of all programmes in the Ministry of Health and related ministries. WHO, as leader of the United Nations Health Sector Outcome team, has a key responsibility to attract funds from the ITF, as well as from bilateral and multilateral sources such as the Central Emergency Relief Fund.

3.2 Coordination and aid effectiveness

The Iraqi Trust Fund Facility mechanism in line with the Paris Declaration on Aid Effectiveness is coordinating and harmonizing the external assistance. It has been agreed that a new Multi Donor Trust Fund based on the UNDAF will be established.

Iraq currently has a Humanitarian Coordinator and an office for OCHA. OCHA is expected to be phased out and the UNAMI's section for Development and Humanitarian Support under the leadership of the Humanitarian Coordinator will take a bigger role for humanitarian coordination in close collaboration with the sector outcome teams. The Iraq humanitarian action plan was developed to address humanitarian issues in a coordinated manner. Three response tracks of the plan combine emergency preparedness, key interventions in most vulnerable areas, and strategic thinking to mitigate potential humanitarian crises. The country is still challenged by pockets of deep vulnerability and a lingering but silent humanitarian crisis.

As an active member of the UN Country Team, WHO has been entrusted with leading the Health and Nutrition Sector Outcome Team. WHO's work in support of the Ministry of Health of Iraq is articulated within the UN Development Assistance Framework (UNDAF). WHO is actively involved in coordination of assistance in health with other UN agencies, with national and international nongovernmental organizations, with civil society and with the broader development community. This coordinating support function of WHO is one of the most important features of WHO role within the UN Country Team. Besides leading the

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[22]. *Development and cooperation – Iraq*. European Commission. Available at http://ec.europa.eu/europeaid/where/gulf-region/country-cooperation/iraq/iraq_en.htm

Health and Nutrition Sector Outcome Team, WHO is working in close collaboration with partners in the governance, protection, water and sanitation sector outcome teams.

3.3 UN reform status and the CCA/UNDAF process

Building on the experience of the United Nations Assistance Strategy, the UNCT developed the first Iraq UNDAF for 2011–2014.[23] In advance of the development of the UNDAF, which was signed in May 2010, the government and UNCT first conducted the common country assessment (CCA), while the Government of Iraq simultaneously prepared its first national development plan. The national development plan and UNDAF provide future directions for Iraq's strategic priorities for 2011–2014.

The UNDAF is aligned with the development priorities stipulated in the national development plan. Both the plan and UNDAF provide a strategic development vision that the Government of Iraq and the UNCT are committed to realizing over the coming years. Developed around five priority areas, the UNDAF will guide the UNCT's support to implementing national development priorities in the period 2011–2014.

The five UNDAF priority areas are as follows.

- Improved governance, including the protection of human rights
- Inclusive, more equitable and sustainable economic growth
- Environmental management and compliance with ratified international environmental treaties and obligations
- Increased access to quality essential services
- Investment in human capital and empowerment of women, youth and children

In relation to health and WHO involvement in UNDAF, there are direct and indirect linkages in these five priorities. Table 3 below shows the UNDAF outcomes where WHO is involved.

Table 3. UNDAF outcomes

UNDAF (2011–2014) outcomes where WHO are working	Projected/estimated budget	
	% of total	US$
Outcome 1.1: The Iraqi state has a more inclusive and participatory political process reflecting improved national dialogue.	7.4	10 399 467
Outcome 1.3: Iraq has an improved legal and operational Rule of Law framework for administration and access to justice.	0.2	265 302
Outcome 1.4: Governmental and nongovernmental institutions better protect and promote the human rights of all people in Iraq, with a focus on the most vulnerable.	0.3	400 000
Outcome 2.1: People in Iraq have improved access to job and income	0.7	1 016 000

[23] The UNCT for Iraq is composed of the following agencies, offices, programmes and funds: UNESCWA, FAO, ILO, IOM, UNDP, UNEP, UNESCO, UNFPA, UN-HABITAT, UNHCR, UNICEF, UNIFEM, UNOPS, WFP, WHO, UNIDO, OCHA, UNCTAD, OHCHR and UNODC.

opportunities in a diversified and competitive market economy.		
Outcome 2.2: Vulnerable people in Iraq are benefiting from means-tested social transfers which stimulate economic growth and reduce dependency.	1.1	1 600 000
Outcome 2.3: Government of Iraq has institutionalized a universal social security system covering unemployment, health, old age, disability and other social risks.	1.4	2 000 000
Outcome 3.1: The Iraqi state has institutionalized policy and operational framework for the sustainable management and conservation of natural resources.	0.9	1 200 000
Outcome 3.3: Government of Iraq has improved programmes for the prevention and control of pollution.	2.3	3 240 000
Outcome 3.4: Government of Iraq has institutionalized improved mechanisms to prevent, mitigate and respond to natural and manmade disasters.	2.4	3 404 000
Outcome 4.1: Government of Iraq has participatory and accountable policy framework and implementation mechanisms for the delivery of quality basic services at all levels.	19.0	26 602 145
Outcome 4.2: Government of Iraq has enabled more children and youth to access and complete quality basic, vocational, higher and non-formal education.	1.8	2 497 200
Outcome 4.3: Government of Iraq has enabled improved access to and utilization of quality primary health care services for all people in Iraq.	50.3	70 389 886
Outcome 4.4: People in Iraq have improved access to safe water, sanitation, electricity and municipal services.	2.6	3 700 000
Outcome 4.6: People in Iraq have improved food and nutrition security, and food safety.	2.7	3 796 000
Outcome 5.1: The Iraqi state has improved knowledge, attitude and practices regarding the roles and rights of women, youth and children in line with international conventions, the Iraqi Constitution and legislation.	2.0	2 800 000
Outcome 5.2: Women and young people actively participate in the political, social and economic development processes in Iraq.	1.3	1 790 000
Outcome 5.3: Government of Iraq has institutionalized policies, strategies, plans and budgets responsive to gender, youth and children at national and sub-national levels.	0.6	900 000
Outcome 5.5: The Iraqi state has institutionalized preventive and protective mechanisms to combat gender-based violence	2.9	4 000 000
Grand total forecasted required resources for WHO; 2011–2014	100	140 000 000

The UNDAF will be implemented by the UNCT under the government's leadership and guidance. For coordinated implementation and oversight of the UNDAF, a steering committee and priority working groups will be established for each UNDAF priority area. The working groups are expected to develop shared strategic approaches towards the achievement of the relevant UNDAF priority area.

3.4 Challenges

- The UNDG Iraq Trust Fund is closed for new projects. The flow of assistance remains unclear after closure of the ITF mechanism.

- Increased cost sharing with the Government of Iraq will be necessary in order to maintain current programmes. The challenge is how to strengthen the capacity and the role of the Ministry of Health and the Ministry of Planning to manage and ensure sufficient funding for health using national resources.
- As leader of the HNSOT, WHO has the responsibility to help strengthen the channels of external assistance to the Ministry of Health. The challenge for WHO collaboration is how to strengthen Ministry of Health interaction with all sources of external assistance and foster harmonization and coordination of external assistance by the Government of Iraq.
- The other challenge for WHO is how to collaborate closely with all health stakeholders, particularly the stronger donors, in seeking support for implementation of policies and strategies already prepared to address the most urgent needs.

SECTION 4. WHO CURRENT COUNTRY PROGRAMME

4.1 Historical overview and partners

Iraq was one of the first countries to join WHO in the late 1940s and since then the collaboration between Iraq and WHO has been close and productive. During the UN sanctions after 1991 first Gulf war and in the aftermath of the March 2003 conflict, WHO provided, under oil-for-food-and-drugs programme, emergency support to the Ministry of Health until April 2004. Since 2003, WHO collaboration has been at the forefront of emergency health relief and development in Iraq.

WHO works closely with the Ministry of Health mainly, but also with other ministries including the Ministry of Environment, Ministry of Planning, Ministry of Education and Ministry of Higher Education, Ministry of Agriculture, Ministry of Municipality and Public Works, Ministry of Water Resources, Ministry of Labour and Social Affairs and Ministry of Finance. WHO also collaborates directly with Directorates of Health in all governorates.

WHO collaborates closely with partners in the UN Country Team to create an integrated UN presence in Iraq. Key programme partners include UNICEF, UNDP, UNFPA, UNIDO, FAO, WFP, UNESCO, UNOPS, UN Habitat, UNAMI, UNHCR, IOM and OCHA.

Key partners among nongovernmental organizations and associations include International Rescue Committee, International Medical Corps, ACTED, Save the Children, Mercy Corps, Première urgence, International Federation of Red Cross and Red Crescent Societies (IFRC) and ICRC, Iraq Medical Association and civil society groups.

Table 4 summarizes all voluntary contributions to WHO Iraq between 2004 and 2010.

Table 4. Breakdown of extrabudgetary funds, 2004–2010

Top donors	US$ million	Additional donors	US$ million
ITF (of which the majority are earmarked EC funds)	128.0	UNFIP	0.8
Global Fund to Fight AIDS, Tuberculosis and Malaria	Round 6 = 14.5 Round 9 = 14.8	Japan	0.7
EC	21.8	UNDP	0.6
USAID	10.0	Korea	0.5
DFID	9.8	Netherlands	0.5
Italy	6.9	UNDP	0.6
Australia	2.8	OCHA Flash Appeal	0.2
UNFIP	1.9	Greece	0.2
Spain	1.5	Norway	0.1
Sweden	1.0	TOTAL	202

Source: WHO Iraq financial records. All funds allocated between the flash appeal post-conflict period and April 2010.

4.2 Current organization

A WHO Representative's Office in Baghdad was reactivated in mid 2007. The WHO Representative spends a considerable amount of time inside the country working closely with national officials. The UNCT and UNAMI are located in shared office buildings inside what is commonly known as the "green zone".

Following the evacuation of all international staff in September 2003 from Iraq, the main office of the WHO Representative in Iraq was situated in Amman, Jordan, pending improvement of the security situation and the return of the international staff to Iraq.

WHO has two sub-offices, in Erbil and Basra. There are also meeting points in the Ministry of Health in Dahuk, Ninewa, Kirkuk, Solaymanya, Salah el Din, Dialah and Babel. WHO has a network of national and international staff in the country.

4.3 WHO collaboration in 2005–2010

Development of the health system

In the past three biennia, the WHO collaborative programme has been involved in the development of national policies and strategies for various key health programmes, human resources development, and strengthening of the health system with emphasis on system reform and primary health care. Collaborative efforts aim to strengthen the Iraqi health care delivery and referral system to move from a curative hospital-based system to a decentralized primary health care-based system. The devolution is ongoing and it will constitute the major input of WHO technical support in the coming biennia.

- Health service delivery: integrated district health system based on family medicine, referral system, basic package of health services
- Health workforce: baseline assessment (mapping and gaps identifications) plans under preparation
- Health information system: baseline assessment
- Medicines and supplies: support is provided for development of medicine policy, strategy, distribution system
- Health financing: national health accounts report
- Governance: Iraq public sector modernization project, functional review and health system performance assessment and road map

Maternal and child health and reproductive health

- Making pregnancy safer
- Essential newborn care
- Integrated management of child health
- Increase the number of trained birth attendants
- Improving maternal mortality surveillance
- National maternal and child reproductive health strategy (2011–2015)

- Integration of reproductive health into primary health care

The main challenges for reproductive health are the urgent scale-up in coverage of maternal and child health through primary health care, training and production of sufficient skilled birth attendants, rapid reduction in the percentage of deliveries in risky conditions and rapid improvement of prenatal and postnatal care. WHO in the next two biennia will focus on helping the Ministry of Health address these challenges.

Health promotion

Health promotion in Iraq is implemented through different programmes: health promotion in schools, community-based initiatives and media and communication. Main activities implemented are as follows.

- Health promotion in schools: student health screening for vision, hearing and musculoskeletal defects; oral health; awareness on health and hygiene; mental health first aid services and psychosocial support
- Community based initiatives: increasing access to basic health services and addressing social determinants of health and responding to basic development needs through multisectoral, rights-based and gender-sensitive programme development.
- Communication and media: health-related communication and information exchange among physicians, health care providers, patients, community and media and partners, through specialized communication strategies for certain programmes such as Stop TB. The Iraqi media sector has expanded dramatically in all areas of news and information delivery, from traditional outlets such as, print, radio and television, to emerging technologies like the internet and mobile phones.

Prevention and control of communicable diseases

In the past 5–6 years WHO collaborative support for communicable diseases has been substantial and covers wide range of activities, including assessments, situation analysis, support for development of policies, guidelines, strategies and operational plans of action. A high priority was accorded to assist in strengthening the national immunization, disease surveillance, outbreak preparedness and response, laboratory upgrading and disease prevention and control. The collaborative activities have a special focus on tuberculosis control, malaria elimination, leishmaniasis control, control of waterborne diseases, vaccine-preventable diseases control, sexually transmitted infections and HIV/AIDS.

Specific attention is being given to strengthen national preparedness for responding to pandemics and epidemics such as pandemic influenza, cholera and poliomyelitis. In this connection WHO has supported Iraq to upgrade its capacity in line with International Health Regulation for disease surveillance, early warning system and response.

Prevention and control of noncommunicable diseases including risk factors

The collaborative programme has assisted in strengthening the programme for early detection of noncommunicable diseases and integration of the prevention and control programme into primary health care. WHO assisted in conducting the first WHO stepwise survey in 2006 in relation to noncommunicable disease risk factor surveillance. The national strategy and plan of action for the prevention and control of noncommunicables disease were prepared in line with the global and regional strategies. Collaborative efforts have paid special attention to promoting implementation of the WHO Framework Convention on Tobacco Control and activities for the early detection of hypertension, diabetes and cancer, oral health promotion, prevention of blindness and promotion of healthy lifestyles.

Mental health

Mental health policies and strategies have been established to deliver quality mental health services in general and at primary health care level in particular. However, mental health services coverage is not yet adequate, and human resource availability is insufficient.

Prevention of injuries and violence

Sentinel sites have been established in many governorates to monitor injuries and a multisectoral committee has been initiated to build baseline data on the prevalence and causes of violence and injuries in Iraq. Multisectoral work has started to address the issue of road traffic crashes. Collaborative efforts aim to assist the Ministry of Health in extending injury surveillance to all governorates and in the assessment and development of a prevention programme for domestic violence. Also, the prevention and management of road traffic crashes will be a high priority for WHO collaborative support.

WHO is implementing a project on strengthening emergency medical services. The project has implemented various activities, such as human resource capacity development, construction and equipping of ambulance dispatch centres, construction and equipping of blood transfusion centres and construction and equipping of a national training institute for emergency medical services.

Social determinants of health, environmental health and food safety

All government policies have the potential to affect health and health equity, including those related to finance, education, housing, employment, transport and many others. While health may not be the main aim of policies in these sectors, they have a strong bearing on health and health equity. Policies and programmes embrace all the key sectors of society including the health sector. Areas of WHO interventions are: improvement of nutritional status; environmental health; health promotion and healthy lifestyles; combating health impacts of poverty; and gender mainstreaming.

WHO, together with other partners in the Water and Sanitation Sector Outcome Team, is supporting water quality improvement through the rehabilitation and strengthening of the laboratory network throughout the county.

In the area of food safety, WHO technical support has been channeled through the joint WHO, UNIDO and FAO project on food safety, and on food security with WFP. Although some progress has been made during the past few years in strengthening food safety, a huge challenge still lies ahead for monitoring of biological and chemical standards in food safety.

4.4 Achievements

WHO's collaborating programmes have been successful in assisting the government in development of key policies, strategies and guidelines for various aspects of health in health systems, disease prevention and control, reproductive health and strengthening of primary health care. Major achievements have been seen in malaria control, where the programme is entering the elimination phase. WHO's support has been instrumental in large measure for speedy control of the H1N1 pandemic and cholera epidemics and prevention of further loss of life. In the area of capacity-building, in collaboration with several line ministries and other national partners, WHO has trained a large number of people through training courses, workshops, technical seminars, consultations and fellowship programmes outside the country. In general, WHO achievements are most noteworthy in capacity-building and mobilization of huge funds for the health sector from UN, bilateral and multilateral donors.

4.5 WHO programme strengths

- Excellent relationship with the Ministry of Health and constructive collaboration with all key ministries and national agencies connected with health.
- Track record of technical competence and commitment.
- Close relationship with UN agencies, donors, bilateral partners for coordination and mobilization of resources.
- Presence of a network of national WHO staff inside Iraq, closely involved with the implementation of the programmes at all levels.
- Well qualified dedicated staff, in particular national staff.
- Leadership of the health and nutrition sector and a key member of task forces on a number of priority areas signifies the confidence of the partners.

4.6 Constraints

- Rapid turnover of key senior staff in the Ministry of Health and focal points.
- Heavy reliance on external donor funding.
- Declining interest by donors, especially following the declaration of Iraq as a middle-income country.
- Continued political and security instability and inability of international staff to monitor closely and to travel inside Iraq.
- Difficulties in recruitment and posting of staff in Iraq due to security threats.

4.7 Challenges

- Increasing the presence of WHO international staff in the country given the severe limitations in security-compliant working and living space.
- Supporting the government in development activities under the present security conditions.
- Attracting donors and mobilizing resources, including cost sharing with the Government of Iraq for continuation of collaborative programmes.
- Developing a tracking system to monitor and evaluate the implementation of policies and strategies.
- Stimulating international assistance to focus on implementation at the local level.
- Promoting WHO's role as a leader in view of the UN reform, the integrated mission and the substantive changes in the operating environment for the international community in Iraq.
- Building a cost sharing mechanism with the Ministry of Health.
- Ensuring proper implementation of the International Health Regulations.

SECTION 5. STRATEGIC AGENDA FOR WHO COOPERATION

5.1 Strategic agenda

The strategic agenda for WHO cooperation with the Government of Iraq during 2012–2016 was prepared based on the following.

- Key health and development challenges confronting the country as analysed by WHO in full consultation with the government, national stakeholders and development partners.
- National policy and strategies for socioeconomic development and the national strategic health plan.
- Contributions to health development by other development partners and identified challenges and gaps in health sector cooperation.
- WHO's past and current cooperation.

5.2 Strategic priorities

The strategic agenda includes 9 strategic priorities for WHO technical assistance to Government of Iraq during the period 2012–2016.

- Reproductive health
- Health system
- Human resources for health
- Health information system
- Noncommunicable diseases and conditions
- Communicable diseases
- Social determinants of health, cooperation and partnerships and communication
- Environment and food safety
- Health promotion

A set of "key objectives" and strategic approaches have been formulated for each strategic priority. The key objectives outline the role of WHO in addressing that priority, reflecting WHO's comparative advantage and WHO's role as policy adviser and convener. The strategic approaches indicate key areas for action by WHO for each of the key objectives and are based on WHO's core functions.

Strategic priority 1. Reproductive health

Main focus: Strengthening women's and family health through scaling up the national reproductive health programme

Strategic approaches

- Improving women's and family health as an important part of the primary health care package and ensuring necessary capacity, infrastructure and resources.
- Developing strategies and plans and implementing extended family planning services at primary health care centres and hospitals.
- Producing skilled personnel and ensuring access to quality basic and emergency obstetric and newborn care to reduce high-risk deliveries outside health facilities.

Strategic priority 2. Health system

Main focus: Strengthening capacity in the Ministry of Health for health system governance, reforming and revitalizing health care delivery, health care quality, patient safety, health financing, public private partnership and health system research.

Strategic approaches

- Consolidating the existing policy instruments into a broad based and encompassing national health policy to guide the development of the health system and health sector.
- Developing a national health strategy and identifying specific short-term and medium-term investment programmes and reform agenda.
- Supporting the development and establishment of public health law.
- Decentralizing the health system and assisting in the implementation and expansion of the basic health service package based on a family practice model.
- Supporting the modernization of the health system by reviewing and upgrading norms, standards and protocols, ensuring the establishment of health care quality assurance, improving the accreditation system and increasing patient satisfaction with the care they receive.
- Strengthening public–private partnership by assisting in regulation and facilitating the rational expansion and development of the private sector in a phased manner.
- Establishing a functioning and a sustained national health account and developing a fair health financing system including social and private insurance options.
- Improving the management of medicines and health technologies including rational use of medicines, quality assurance and dispensing.
- Strengthening national and governorate capacity for health system research.

Strategic priority 3. Human resources for health

Main focus: Establishing/upgrading a system and a comprehensive long-term plan for production and management of human resources for health.

Strategic approaches

- Strengthening existing national efforts for review of human resources for health.
- Developing a long term system and plan for production and management of human resources based on national health policy/strategy and comprehensive review.

- Developing plans and strategies for strengthening the capacity and the curriculum of health and medical professional health workers, universities, schools and teaching institutions.
- Upgrading the accreditation systems for health personnel and teaching institutions.
- Establishing or upgrading continuous medical education and career development for health staff.
- Addressing, on a priority basis, the existing severe shortage of health professionals and minimizing the current massive attrition rate of staff.

Strategic priority 4. Health information system

Main focus: Upgrading and developing a comprehensive national health information system for the health sector.

Strategic approaches

- Consolidating the current status of information, collection, production and dissemination at all levels.
- Developing mechanisms and procedures to train staff on developing health information as a basis for planning and policy development
- Developing a health management information system to include the health information system and modular sub-information systems such as for human resources for health, medicines, social determinants of health, etc, in order to generate information for decision-making, policy-setting and reporting.
- Developing strategies and methods for reconciling discrepancies in health information reported by different sources and assuming custody of health information for the health sector and health interface with other sectors.
- Continue upgrading the health information system incorporating data from communicable disease surveillance systems, risk factors and noncommunicable disease surveillance and disease registries.

Strategic priority 5. Noncommunicable diseases and conditions

Main focus: Supporting implementation of the plan of action for noncommunicable diseases and cancer.

Strategic approaches

- Integrating noncommunicable disease prevention and control into the agenda of the national development plan and facilitate the adoption of integrated policies and programmes by all sectors that will help in control of noncommunicable diseases.
- Strengthening the capacity of the health system at all levels to be able to implement the national plan of action for noncommunicable diseases that has been developed based on the WHO global and regional plans.
- Developing and conducting research and study protocols on lifestyle, diet and physical activity.

- Developing a multisectoral approach to promoting healthy lifestyles including tobacco control, healthy diet and physical activity.
- Developing a comprehensive programme for disability including care of persons with disabilities.
- Mobilizing the necessary programme to train primary health care and general practitioners and health workers to provide basic mental health care at the first level of health care, giving special attention to services for post-traumatic stress syndrome.
- Establishing community-based mental health care to be supported by primary health care centres and local level health workers and community women volunteers.
- Strengthening the existing comprehensive programme for road traffic crashes and injuries prevention, including monitoring and surveillance of road traffic crashes, road and car safety, monitoring of domestic and other injuries, in partnership and coordination with the relevant government departments such as traffic police, transportation and road ministry, municipalities, etc.
- Assessing the situation with regard to domestic violence and, in collaboration with all other sectors and the UN system and other external partners, developing a national strategy, plan and programme on violence against women.

Strategic priority 6. Communicable diseases

Main focus: Maintaining the progress achieved and further strengthening the control of communicable disease and national preparedness for dealing with epidemic and pandemics.

Strategic approaches

- Accelerating implementation of the Stop TB Strategy through expanding and enhancing implantation of the DOTS strategy, strengthening capacity of the national tuberculosis programme and other partners, improving surveillance and supporting operational and epidemiological research.
- Strengthening communicable disease surveillance and response system at all levels in line with the International Health Regulations.
- Maintaining Iraq free of malaria.
- Ensuring the elimination of schistosomiasis.
- Maintaining the national response to HIV towards universal access to HIV prevention, care and treatment.
- Ensuring preparedness to deal with pandemics related to influenza.
- Strengthening the zoonotic diseases prevention and control programme.
- Ensuring proper implementation of the IHR through building the needed core capacities at different levels including points of entry.
- Undertaking strong advocacy for the urgent improvement of water supply and sanitation and hygiene conditions with the concerned sectors in government, municipalities, local government and the general public.
- Strengthening programmes for emergency preparedness and response for outbreaks of cholera and other waterborne infectious diseases.

Strategic priority 7. Social determinants of health, cooperation and partnerships and communication

Main focus: Assessing, documenting and promoting an intersectoral approach and health in all policies to tackle social determinants of health and health equity.

Strategic approaches

- Improving partnership mechanisms and linkages between the Ministry of Health and health-related sectors and building the capacity of the Ministry to assume a stronger health advocacy role and presence for influencing policies and actions of other sectors (environment, nutrition, human rights, gender, etc.).
- Developing Ministry of Health capacity and outreach to involve communities, nongovernmental organizations and civil society organizations in health development actions.
- Expanding community-based initiatives for applied health promotion, concentrating on hygiene and water and sanitation, healthy lifestyle, health literacy and self care.
- Advocating and launching health in all policies throughout government, ministries and institutions.
- Developing the capacity of the Ministry of Health for monitoring equity in health outcomes.
- Promoting gender-disaggregated data in support of human rights.

Main focus: Supporting the Ministry of Health to take a leading role in strengthening partnership with external development partners.

Strategic approaches

- Strengthening the capacity and the role of the Ministry of Health to mobilize, manage and ensure sufficient funding for health.
- Strengthening Ministry of Health interaction with all external assistance and foster harmonization and coordination of external assistance by the Government of Iraq, under principles of the Paris Declaration.
- Collaborating closely with all health stakeholders, particularly the major donors.

Strategic priority 8. Environmental health and food safety

Main focus: Strengthening the capacity of the Ministry of Health to fulfil its regulatory and advocacy role for healthy environment and surveillance of health impacts of environmental health hazards and conditions.

Strategic approaches

- Strengthening the capacity of the Ministry of Health to undertake evidence-based advocacy and promotion for improvement of environmental health services and conditions.

- Developing and ratifying the legislation empowering the governance role of the Ministry of Health for health impact surveillance and its enforcement authority in case of severe hazards to human health.
- Continuing support to the National Committee for Global Warming for health aspects.
- In partnership with others, strengthening national capacity at all levels for surveillance of drinking-water quality, human waste management, and management of hazardous and medical waste and domestic refuse.
- Strengthening the linkages between environmental agencies and disease surveillance systems, particularly for diseases related to water and sanitation.

Strategic priority 9. Health promotion

Main focus: Strengthening national capacity for health promotion and communication.

Strategic approaches

- Developing the capacity of the Ministry of Health for health communication, especially the use of media.
- Strengthening the health education and health promotion programmes of the Ministry of Health.

SECTION 6. IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR WHO

Given the prevailing conditions inside the country and even beyond in the Region, the implications of the CCS on WHO at all levels are massive. A country in transition moving from emergency through recovery to a development requires solid and sustained efforts in maintaining the momentum of rebuilding the nation's health system. A country where the loss of human capital due to protracted instability in the social sector, particularly health, was profound requires appropriate technical support to revive the human resources of the health system. A country with limited public health regulatory capacities in service delivery and health technology including pharmaceuticals sector needs tremendous technical know-how and expertise to strengthen access to essential medicines and consolidate the regulatory function. It is expected that the state of emergency and violence will probably reduce in intensity, yet remain a major challenge and indeed a significant obstacle to national development in the short term.

A critical area in the overall reconstruction is to maintain ongoing national efforts in health sector development with a focus on increasing coverage, increasing qualified health professionals, strengthening delivery of integrated primary health care services, promoting decentralization approach, addressing determinants of health to reduce growing inequity, and reformulating national health policy with the purpose of providing strategic directions and workable strategic plans in line with the CCS. Another important area which is vital to health sector development is creating a common platform for all development partners with attention to aid effectiveness and the principles of the Paris declaration. Coordinating the efforts of large number of donors and health supporting agencies requires sustained efforts by the Ministry of Health.

There are many other priority areas, nonetheless WHO should agree and position itself to those fundamental priorities described above. The implications of the CCS process at different WHO levels are described below:

6.1 Country level

In close partnership with other UN agencies and donor community, WHO has been able to deliver various health projects that were designed to modernize and consolidate the national health care delivery system. The Organization enjoys a close relationship with the Ministry of Health at central level, with Kurdistan Region and with other governorates.

The country staffing level will be reviewed based on the requirements subsequent to the move to Baghdad.

WHO country staff with profound expertise in health systems are currently supporting collaborative programmes. Given their experience in Iraq, some staff have the institutional memory of the organization at country level which is an added value to overall WHO technical input to Iraq programme. However, there are key programmatic areas where long-

term staff are required to ensure comprehensive support to the health sector. In addition, there are important areas where only WHO can provide the necessary technical support, such as in updating public health law and legislation. Thus, the Organization needs to shoulder this responsibility and deploy skilled professionals in this area. The country office should be adequately equipped to facilitate the transfer of knowledge and expertise between Iraq and other countries in the Region, other WHO regions and headquarters. For example, during the current biennium Iraqi national teams have been exposed to study tours in neighbouring countries and technical forums on health system development have been organized outside the country involving other development partners such as the World Bank, United Nations agencies and some academic institutions.

WHO has to play a major role in promoting partnership with key health supporting agencies such as UNICEF, UNFPA, WFP, ICRC, IFRC and donors including the EU, DFID and USAID. The country office needs to develop a convening authority and bring these agencies together in order to ensure alignment with national strategic plans and harmonizing their external inputs. This may require additional international staff to assist ongoing efforts in promoting partnership and in enhancing aid effectiveness and donor coordination. Additionally, WHO's role is assist the Ministry of Health in ensuring ownership and putting itself in the driving seat.

Under the Iraqi public sector modernization programme, WHO and its partners have succeeded in carrying out diagnostic work to achieve better understanding of the gaps in performance of the health system and its institutional function. A roadmap has been established based on the outcome of the countywide assessment. The roadmap outlines key action areas in modernizing the sector for the coming two years. In this regard, WHO has to redouble its efforts during the next biennium to assist the government in leading the implementation of the roadmap in partnership with concerned agencies.

Iraq has recently indicated strong commitment to addressing social determinants of health. It fielded a high-level delegation to the World Conference on Social Determinants of Health in Rio de Janeiro in October 2011, where heads of government expressed their determination to achieve social and health equity through action on social determinants of health and well-being through a comprehensive intersectoral approach. This is a major undertaking where WHO technical support will be critical.

6.2 Regional level

The Regional Office has been deeply engaged with the country office and headquarters in delivering technical assistance to Iraq. The WHO-supported programmes are expanding, as are the challenges. It is vital to have continuous support from the Regional Office, particularly in capacity development on health systems, in supporting programme evaluation and in facilitating logistics. The Regional Office needs to focus on the following in the next two years.

- Assisting the country office in translating the public sector modernization programme roadmap into action

- Assisting the country office in launching the implementation of the basic health services package
- Supporting the development of national health policy
- Providing necessary support to refining the existing health sector strategic plan
- Assisting in assessing principles of aid effectiveness based on the Paris Declaration
- Supporting the process of developing a national strategy for social determinants of health and health equity
- Assisting in fielding necessary expertise in Ministry of Health regulatory function and updating Iraq public health laws and legislation.

6.3 Global level

Headquarters has been fully engaged in Iraq health sector reconstruction since it started and its contribution remains critical to the national process. Apart from its technical role, input from headquarters is needed to assist in mobilizing resources for the country, in facilitating logistics and in sharing global experience on health sector reforms in post-conflict settings.

Annex 1

IRAQ FACTS AND FIGURES

Area	Indicator	Figure	Unit	Year	Source
Demographic	Total population (est.)	32.3	million people	2009	COSIT Population Estimates[24]
	Total female (est.)	16	million people	2009	COSIT Population Estimates
	Total male (est.)	16.2	million people	2009	COSIT Population Estimates
	Population (female)	49.5	%	2009	COSIT Population Estimates
	Population (male)	50.4	%	2009	COSIT Population Estimates
	Population urban	21.88	million people	2009	COSIT Population Estimates
	Population rural	10.4	million people	2009	COSIT Population Estimates
	Urban population	67	%	2009	COSIT Population Estimates
	Rural population	33.5	%	2007	COSIT Population Estimates
	Population under 15 years old	43.1	%	2007	COSIT Population Estimates
	Population 15–24 years old	20	%	2007	COSIT Population Estimates
	Population 15–64 years old	54.1	%	2007	COSIT Population Estimates
	Population over 64 years old	2.8	%	2007	COSIT Population Estimates
	Fertility rate	4.3	number of children per woman	2006	MICS[25]
	Estimated yearly population growth rate	3.4	%	2009	MoH 2009
	Crude death rate per 1000 Population	4	Per 1000 population	2009	MoH 2009
	Crude birth rate per 1000 Population			2009	MoH 2009
Economic	Real GDP growth rate	9.8	%	2008	IMF Country

[24] *Population estimates of Iraq for 2007*. Ministry of Planning and Development Cooperation, Central Organization for Statistics and Information Technology (COSIT), Directorate of Manpower and Population Statistics, (2007. Unless otherwise stated, all population estimates are from this source.

[25] Data from UNICEF/COSIT/KRSO/Ministry of Health Multiple Indicator Cluster Survey (MICS) 2006, cited in UNICEF, COSIT, KRSO, Ministry of Health, *Iraq: Monitoring the Situation of Children and Women – Multiple Indicator Cluster Survey 2006 Final Report: Volume 1* (2007). Unless otherwise stated, all statistics from MICS 2006 are from this source.

Area	Indicator	Figure	Unit	Year	Source
	(projected)				Report 08/383[26]
	GDP	97.2	US$ billion	2008	IMF Country Report 08/383
	GDP per capita	3198	US$	2008	IMF Country Report 08/383
	Crude oil export revenues (over GDP)	66.4	%	2008	IMF Country Report 08/383
	Crude oil export revenues (over total GoI revenues)	85.8	%	2008	IMF Country Report 08/383
	Consumer price inflation	14	% annual change	2008	IMF Country Report 08/383
	Unemployment rate: total over 14 years	15.3	%	2008	COSIT Labour Force Survey[27]
	Unemployment rate: females over 14 years old	19.6	%	2008	COSIT Labour Force Survey
	Unemployment rate: males over 14 years old	14.3	%	2008	COSIT Labour Force Survey
	Unemployment rate: males aged 15–29	24.7	%	2008	COSIT Labour Force Survey
	Labour force participation: population over 14 years old	46.8	%	2008	COSIT Labour Force Survey
	Labour force participation: females over 14 years old	18	%	2008	COSIT Labour Force Survey
	Average wage (IQD)	348 000	Iraqi dinar/month	2007	IHSES[28]
	Average wage (US$ equivalent)	277	US$/month	2007	IHSES
	Value of imports	1.328	billion Iraqi dinars	2002	COSIT Annual Abstract of Statistics 2006–2007
	Value of exports	49.781	billion Iraqi dinars	2006	COSIT Annual Abstract of Statistics 2006–2007

[26] International Monetary Fund, *Iraq: Second Review Under the Stand-By Arrangement and Financing Assurances Review – Staff Report; Staff Supplement; Press Release on the Executive Board Discussion; and Statement by the Executive Director for Iraq*, IMF Country Report No. 08/383 (2008).

[27] Data from COSIT Labour Force Survey 2008, extracted by the Inter-Agency Information and Analysis Unit unless otherwise stated.

[28] Data from World Bank/COSIT/KRSO Iraq Household Socio-Economic Survey (IHSES) 2007, cited in World Bank, COSIT, KRSO, *Iraq Household Socio-Economic Survey: IHSES-2007 – Tabulation Report* (2008). Unless otherwise stated, all statistics from IHSES 2007 are from this source..

Area	Indicator	Figure	Unit	Year	Source
Poverty	Population living under the poverty line	22.9	% of total	2007	IHSES
	Number of poor persons	6 883 646	people	2007	World Bank Draft Iraq Poverty Assessment
Budget	Budget projection for 2009	59.5	US$ billion	2009	Iraq National Budget 2009
	Total budget expenditure 2009	58.6	US$ billion	2009	Iraq National Budget 2009
	Budget projection 2010	71.3	US$ billion	2009	Iraq National Budget 2009
	Government expenditure: Pensions	2.5	US$ billion	2008	Iraq National Budget 2008
	Government expenditure: Public distribution system	6.6	US$ billion	2008	Iraq National Budget 2008
	Government expenditure: operational spending	78	% of total expenditure	2009	Ministry of Finance
	Government expenditure: health	6	% of total expenditure	2009`	MoH 2009
	Government expenditure: education	9.9	% of total expenditure	2009	Ministry of Finance
	Government expenditure: security	16.4	% of total expenditure	2009	Ministry of Finance
	Government expenditure: other ministries	38.1	% of total expenditure	2009	Ministry of Finance
	Government expenditure: KRG transfers	12	% of total expenditure	2009	Ministry of Finance
	Government pension expenditure budget (projected)	3.9	US$ billion	2009	IMF Country Report 08/383
	External government debt	31.8	US$ billion	2008	IMF Country Report 08/383
Health	Life expectancy at birth	59	years	2007	UNPD
	Infant (under 1 year) mortality rate	24	number of deaths per 1000 live births	2009	MoH annual report 2009
	Under 5 mortality rate	29.5	number of deaths per 1000 live births	2009	MoH annual report 2009
	Maternal mortality rate	32	number of deaths per 100 000 live births	2009	MoH annual report 2009
	Anaemia prevalence	35.5	%	2006	IFHS

Area	Indicator	Figure	Unit	Year	Source
	among women 15–49 years old (neither pregnant nor breast feeding)				
	Anaemia prevalence among pregnant women 15–49 years old	37.9	%	2006	IFHS
	Anaemia prevalence among breast feeding women 15–49 years old	25.8	%	2006	IFHS
	Low birth weight (below 2500 grams)	5.6 (except KRG)	%	2009	MoH annual report 2009
	Child (18–29 months) immunization rate: tuberculosis	91.4	%	2006	MICS
	Child (18–29 months) immunization rate: polio	98.6	%	2009	MoH annual report 2009
	Child (18–29 months) immunization rate: DPT corresponding vaccines: DPT3	61.5	%	2006	MICS
	Child immunization rate: measles	83	%	2009	MoH annual report 2009
	Fully immunized children (18–29 months)	38.5	%	2006	MICS
	HIV prevalence among adults (15–49 years)	0.2	%	2008	2008 Report on the Global AIDS Epidemic, UNAIDS
	Household water supply: connected to public network	81.3	%	2007	IHSES
	Households with waste disposal services	36	%	2007	IHSES
	Women (aged 15–49) using modern contraceptive methods	32.9	%	2006	MICS
	Pregnant women that received at least one antenatal care visit	84	%	2006	MICS
	Pregnant women that received 4 antenatal care visits	56	%	2006	MICS
	Deliveries by skilled personnel	84	%	2009	MoH annual report 2009
	Deliveries in a health facility	68	%	2009	MoH annual report 2009

Area	Indicator	Figure	Unit	Year	Source
	Acute malnutrition (wasting)	4.7	%	2007	COSIT/WFP CFSVA 2007
	Under weight(general malnutrition)	9.1	%	2007	COSIT/WFP CFSVA 2007
	Chronic malnutrition (Stunting)	21.8	%	2007	COSIT/WFP CFSVA 2007
	Low birth weight	5.6	%	2009	MOH 2009 Without Kurdistan
	Exclusive breastfeeding rate <6 months	25	%	2006	MICS
	Number of cholera cases between 2007 and 2008	2009:6 cases (including zero deaths)		2009	MoH 2009
	Incidence of tuberculosis (TB)	30	Per 100 000 population per year	2009	MoH
	Notifications of smear positive TB cases	46%	%	2009	MoH
	% of deliveries that are at high risk and need advanced medical support	15	%	2007	WHO
	Women facing serious complications during pregnancy	22	%	2009	MoH annual report
	Percentage of female deaths that can be attributed to maternal mortality	6	%	2007	WHO CCS
	% of primary health care centres offering family planning services	<5	%	2007	WHO CCS
	% of children by the age of 12 months that have all recommended vaccinations	<33	%	2007	WHO CCS
	% of the adult population (aged 25–65 years) suffered from raised blood pressure	40.4	%	2006	MOH/WHO Chronic Non-communicable Diseases Risk Factors Survey
	% of population with hyperglycemia	10.4	%	2006	MOH/WHO Chronic Non-communicable Diseases Risk

Area	Indicator	Figure	Unit	Year	Source
					Factors Survey
	% of adult population being overweight	66.9	%	2006	MOH/WHO Chronic Non-communicable Diseases Risk Factors Survey
	% estimated lifetime prevalence of any mental disorder	18.8	%	2006/07	IMHS
Education	Net primary school attendance rate among children 6–11 years old	85.8	%	2006	MICS
	Net secondary school attendance rate among children 12–17 years old	40.1	%	2006	MICS
	Literacy rate (15 years and above)	82.3	%	2007	IHSES
Human security	Female-headed households	10.8	%	2006	MICS
	Refugees inside Iraq	39 503	people	2010	2010 UNHCR Country Operations Profile – Iraq
	Registered Iraqi refugees	294 148	people	Oct. 2009	UN Regional Response Plan for Iraqi Refugees-2010
	Refugee returns	16 370	people	July-Dec. 2008	UNHCR Monthly Statistical Update on Return – December 2008
		37 090	people	2009	UNHCR Monthly Statistical Update on Return – March 2010
	Internally displaced persons (post 2006)	1 552 003	people	July 2009	UNHCR Monthly Statistical Update on Return – July 2009
	IDP returns	129 550	people	July-Dec 2008	UNHCR Monthly Statistical Update on Return – December 2008
		167 740	people	2009	UNHCR Monthly Statistical Update on Return – January 2010

Area	Indicator	Figure	Unit	Year	Source
	Area contaminated by landmines and unexploded ordnance	1730	square kilometres	2004–06	Landmine Impact Survey[29]
	Communities affected by landmines and unexploded ordnance	1622	number of communities	2004–06	Landmine Impact Survey
	Population at risk from landmines and unexploded ordnance	1 616 127	people	2004–06	Landmine Impact Survey
Lifestyle	Persons using internet	2.7	% of population	2007	IHSES
	Internet usage among the whole population	14.3	average minutes/week	2007	IHSES
	Internet usage among actual users	528	average minutes/week	2007	IHSES
	Mobile phones	23.5	millions of mobile phones	2008	IHSES[30]
Infrastructure	Persons with all-weather road access to their households	57.2	%	2007	IHSES
	Persons suffering transportation problems: bad roads	25.4	%	2007	IHSES
	Persons suffering transportation problems: traffic congestion	4.8	%	2007	IHSES
	Persons suffering transportation problems: scarce or distant transport	13.3	%	2007	IHSES
	Number of primary health care centres and sub-centres throughout the country	2168	number	2009	MoH annual report 2009
	Number of primary health care centres staffed by at least one medical doctor	1070	number	2009	MoH annual report 2009
	Primary health care centres per 10 000 population	0.67	number	2009	MoH annual report 2009
	Number of main blood banks	17	number	2008	BHSP MOH and WHO

[29] Data from iMMAP Landmine Impact Survey 2004-2006, cited in iMMAP, *Landmine Impact Survey: Republic of Iraq – 2004-2006*. Unless otherwise stated, all data from the Landmine Impact Survey are from this source.
[30] Extracted from IHSES 2007 raw data.

Area	Indicator	Figure	Unit	Year	Source
	Number of physicians nationwide	22.396	number	2009	MoH annual Report 2009
	Number of specialists nationwide	7117 including 905 from MOHE working at MOH Hosp.	number	2009	MoH annual Report 2009
Human development	Gender Development Index	0.584	value	2006	NHDR 2008[31]
	Human Development Index	0.743	value	2004–2006	NHDR 2008
	Seats held by women in national parliament	27.3	%	2006	NHDR 2008
	Female legislators, senior officials, managers	22.4	%	2006	NHDR 2008

[31] *Iraq: 7000 Years of Civilization – National Human Development Report 2008*. Baghdad, Government of Iraq, 2008.

Annex 2

LIST OF TREATIES AND INTERNATIONAL AGREEMENTS

Iraq is Party to the following treaties and international agreements.

- International Covenant on Civil and Political Rights (ICCPR, 1976)
- International Covenant on Economic, Social and Cultural Rights (ICESCR, 1976)
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, 1970)
- International Health Regulations (2005) **Ratified in 2007**
- Convention on the Elimination of Discrimination against Women (CEDAW, 1986)
- Convention on the Rights of the Child (CRC, 1994) its Optional Protocols (CRC OP 2007)[1]
- Universal Copyright Convention (1954)
- Hague Convention for the protection of cultural heritage in the event of armed conflict (1954)
- Convention on the Means of Prohibiting and Preventing the Illicit Import, Export and Transfer of Ownership of Cultural Property (1970); the Convention for the Protection of World Heritage (1972)
- Convention for the Protection of Intangible Heritage (2003)
- Anti-personnel Mine Ban Convention (2008)
- Core Conventions of the ILO: C29 (Forced Labor), C 98 (Right to Organize and Collective Bargaining), C100 Equal remuneration, C111 (Discrimination, Employment and Occupation), C138 (Minimum Age Convention), C182 (Elimination of the Worst forms of Child Labor).
- Convention on the Prevention and Punishment of the Crime of Genocide (1948)
- International Convention against Apartheid in Sports of (1985)
- International Convention on the Suppression and Punishment of the Crime of Apartheid (1973)
- WHO' s Framework Convention on Tobacco Control (FCTC); **Ratified by Iraq in 2008**.

Iraq is not yet Party to or has not ratified the following.

- CEDAW Optional Protocols
- ICCRP Optional Protocols 1 and 2
- Committee Against Torture (CAT) and its Optional Protocols
- UNIDROIT Convention on Stolen or Illegally Exported Cultural Objects
- Hague Convention for the protection of cultural heritage in the event of armed conflict Second Protocol (1999)
- Convention on the Protection and Promotion of the Diversity of Cultural Expressions (2005)
- International Convention on the Protection of the Rights of all Migrant Workers (ICRMW)

- ILO Convention 87 Freedom of Association and Protection of the Right to Organise (1948)
- International Convention for the Protection of all Persons from Enforced Disappearance (2006)
- Convention on the Rights of Persons with Disabilities and its Optional Protocol (2006)
- Convention relating to the Status of Refugees (1951) and its 1967 Protocol
- Convention relating to the Status of Stateless Persons (1954)
- Convention on the Reduction of Statelessness (1961)
- Statute of the International Criminal Court of (1998)
- Convention on the non-applicability of statutory limitations to war crimes and crimes against humanity (1968)
- Arab Charter for Human Rights adopted in the Arab Summit in Tunisia in 2004 (new version)

Iraq has not developed a strategy for chemical and waste management in line with the Strategic Approach to International Chemicals Management (SAICM) resulting from the 2002 Johannesburg World Summit. The Government of Iraq currently lacks the information required to assess which Multilateral Environmental Agreements it might sign and ratify and develop adequate capacity, legislation and resources for effective implementation and compliance.

Annex 3

PARTNERSHIPS

Health programme area	Partners	Remarks/issues/needs
Heath system		
Access to service delivery, primary health care	WHO, USAID, UNCEF and EC	Proper coordination needed
Governance	WHO, USAID and UNOPS	More technical inputs needed by partners. Also closer involvement of governorates and local level authorities
Human resources development	WHO, UNICEF, UNFPA and USAID	Coordination and harmonization for development and implementation of human resources for health national plan
Health financing	WHO	Scaling up technical input
Medicines and health technologies	WHO, UNFPA, UNICEF, Global Fund, IMC and Government of Japan	
Health information system	WHO, UNICEF, UNDP and UNFPA	Harmonized and focused joint support strategy is needed to make a comprehensive assessment and strengthening of national health information system for planning, informing and generating evidence for policy and strategy setting
Reproductive health		
Maternal health	WHO, UNFPA, UNICEF, IMC and WFP	Joint harmonized strategy to support the national programme ensuring coordination
Child health	WHO, UNICEF, UNFFPA and IMC	As above
Adolescent health	WHO and UNFPA	As above
Communicable diseases		
Surveillance and outbreak response including pandemics	WHO, UNICEF, FAO	Commitment for long term funding
Malaria, tuberculosis and HIV/AIDs	WHO, UNDP, FAO and members of Joint UN Programme on HIV/AIDS	Expand collaboration with other ministries outside the Ministry of Health and make firm commitment for funding and technical assistance
Vaccine-preventable diseases and neglected tropical diseases	WHO, UNICEF, FAO	Commitment for long term funding