1. Key development issues and rationale for Bank involvement

Over the past six years, Iraq has had five political transitions, culminating in the establishment of a constitutionally-elected government. The country is still not fully stable, with the immediate challenge ahead of upholding the rule of law and building credible, inclusive and sustainable institutions. The ability of the recently established government to include ethnic and religious groups in the political process will be an important factor in determining whether this constitutionally-elected government will improve security and stability, which are preconditions for successful reconstruction.

Violence, while diminished from its peak in 2006 and 2007, still affects some parts of the country, and continues to hinder reconstruction efforts, economic recovery, and institutional reform. Five months after the national elections, the instability has hindered the delivery of basic services to the population by slowing reconstruction efforts, impeding private investment and adding significantly to security costs.

Despite this difficult environment, it has been possible to implement donor-funded projects with some positive results, including the successful closing in February 2010 of the first national project financed through the World Bank Iraq Trust Fund (ITF) – the Emergency Health Rehabilitation Project – as well as the successful closing of the First Emergency Assistance Program for Primary Healthcare in the Southern Iraqi Marshlands (FEAP-PH) managed by the AMAR International Charitable Foundation (AMAR), a UK-based international NGO which has been active on the ground in the region for more than two decades, and financed by the Bank’s Post-Conflict Fund.

Health Sector. The Iraqi health system has suffered the consequences of three major wars, inappropriate policies, poor management, and inadequate resource allocation. During the 1980s, Iraq’s health sector consisted of a highly advanced curative system, but with minimal focus on public health. During the 1990s, funds available for health were reduced by 90 percent and health outcomes were among the poorest in the region, and well below levels found in countries of comparable income. This decline is within the context of an expanding population which has doubled in the past 25 years. The population now stands at 29 million and is growing at about 1.8 percent per year. Over this same period, there has been a serious decline in accessibility and quality of health services. Significant budget cuts, coupled with poor management, neglect, and looting due to recent conflicts, have resulted in a deteriorating health services infrastructure. Training opportunities for health professionals also suffered during this period, and health professionals became isolated from the outside world, with many in fact leaving the country.
**Status of Healthcare in Southern Iraq.** Following the fall of the Saddam Hussein regime in April 2003, much of southern Iraq was confirmed to be in acute need of the most basic of services, including healthcare, education, clean water and electricity supplies, and transport infrastructure. For most areas, the crisis had begun long before the 2003 conflict, but was further exacerbated by it. The Marshland Governorates in particular had by 2003 already suffered from at least two decades of neglect and military action, as well as environmental degradation. As a result, the great majority of the population was internally displaced or became refugees in neighboring Iran or Saudi Arabia. Seven years later, the overall situation in the Marshlands, including the social and political environment has not noticeably improved. Many refugees have returned, putting more pressure on the fragile service structure. The relatively remote location of the Marshlands has also hindered their cause with respect to prioritization of national and international reconstruction initiatives for Iraq. Adult illiteracy rates remain at around 87 percent, the transport infrastructure is patchy and dangerous, electricity supply follows an average pattern of two hours on, five hours off, and most water sources are severely polluted. The Babil Governorate also has suffered the consequences of the past seven years. This governorate has a high level of need, being a heavily populated, ethnically and tribally mixed area which has suffered greatly as a result of some of the worst insurgent violence in 2005-2008.

**Government Program and Reform Objectives.** Nonetheless, with the transition to improved security and political stability, the Government is expected to enter into a period of intensive reconstruction and rehabilitation of the health sector. This will require an articulation of a National Health Strategy which sets national priorities and vision for the health sector, and identifies specific short- and medium-term investment programs and a sector reform agenda.

Under the UNDP coordinated Iraq Public Sector Modernization Programme (I-PSMP), the Government of Iraq (GOI) is undertaking sector reform across several areas of administration, including the health sector. The World Bank is coordinating with other development partners including WHO in the area of health financing and system reform for the GOI to design and implement effective health system reform.

In the National Roundtable on Health which took place in 2009, the Ministry of Health (MOH) identified the following six priority areas for the health sector reform: (i) meeting urgent needs of the population and improving basic health services; (ii) strengthening management of the health system; (iii) developing and implementing a master plan for reconstruction of the health care delivery system; (iv) training and capacity building in public health programs and management of health services; (v) reforming the pharmaceutical sector; and (vi) developing public-private partnerships in the provision of health services. Given the current capacity of the MOH, there will be a need for substantial technical assistance and capacity building programs to translate these broad priorities into actionable programs and measurable results in the short- and medium-term framework.

**Rationale for Bank Involvement**

The Bank, as Administrator of the Post-Conflict Fund, has supported the recently closed FEAP-PH in the Marshlands. FEAP-PH provided support to improve access to quality primary care services in selected health facilities to serve the urgent needs of the Marshlands population. This objective was carried out through rehabilitation and equipping of selected primary care centers, provision of basic equipment and furniture for the centers, support to the women’s health volunteers program, training of primary health center staff, and outreach to the community, including health instruction in the schools. The project, which closed in November 2010, was implemented smoothly, and reached its objectives and fully disbursed funds by the Closing Date.

The proposed Second Emergency Assistance Program for Primary Care (SEAP-PH) is sequenced as a follow on project to the FEAP-PH and would build on its project framework to scale up the project...
activities, including expanding them to Babil (Babylon) Governorate to the north with a focus on vulnerable groups such as pregnant women and children, as well as those suffering from tuberculosis which has become a growing problem. The proposed project would seek to further strengthen the primary care network in the southern Marshlands which has been supported for the past two years by FEAP-PH, and would extend this support to Babil Governorate, as well. The primary care services would be supplemented by outreach activities which would be responsive to the needs of the under-served.

As a result of initial dialogue with the Bank, the MOH approached the Bank in October 2004 and again in July 2005 concerning support for improvement of primary care services for the population, in particular, with regard to maternal and infant health. Improvement of these services remains an urgent priority for the Government.

The proposed project is aligned with the Government’s National Strategy for Poverty Reduction (2009) which includes as a basic goal improving the health status of the poor. A key output indicator of this goal is “primary health care centers are improved and accessible by the poor”. Primary healthcare remains one of the most badly needed services in the marshlands, Babil and elsewhere in Iraq, with indicators such as the incidence of communicable disease and child mortality rates still at very high levels, and people succumbing to preventable diseases. Primary healthcare services are particularly critical for the poor and isolated populations as these services are often the only services available. Without access to adequate primary healthcare services, the marshlands people are liable to seek treatment instead at the closest hospital, even for minor health problems, severely overloading southern Iraq’s tertiary care system.

The project is consistent with the objectives of the Bank’s Human Development Strategy for Iraq, including helping to stem the deterioration of health services, in terms of infrastructure, human resources, and management. It builds logically on the support being provided through the other Bank-supported human development projects to restore key services to the most vulnerable in the society, and will contribute to getting Iraq back onto the track of achieving the MDGs.

The Bank has been actively involved in the Iraq health sector for the past seven years, during which time it has provided support to the recovery of the health system through three national projects: the Emergency Health Rehabilitation Project (EHRP) financed through the ITF, which became effective in December 2004 and closed in February 2010, the Emergency Disabilities Project (EDP) also financed through the ITF, which became effective in November 2005 and is expected to close in December 2010, and the Regional Health Emergency Response Project (RHERP) in the Kurdistan region of Iraq (Governorates of Erbil, Dohuk, and Sulaimaniyah). The Bank through it Post-Conflict Fund, has also financed two projects managed by international NGOs: the Karama Hospital Burn Unit Rehabilitation Project, implemented by Premiere Urgence, a European NGO, and financed jointly with the Swiss Government, and French Cooperation.

2. Proposed objective(s)

The overall objective of the proposed project is to increase access and quality of basic health services for vulnerable groups, including pregnant women and children, through improved partnerships between public healthcare service providers and community-based health services. This objective would be achieved through: (i) improving service delivery and community outreach, including civil works rehabilitation, provision of essential equipment, furniture and supplies, and outreach activities to communities; and (ii) health education and promotion of behavior change, including training of medical professionals in provision of primary health care, and training of school instructors and the women volunteers involved in providing information to the community on basic health and hygiene practices; (iii) improving the monitoring of health status of the population and building the capacity of the ministry and local authorities for regional and local planning in the health sector; and (iv) project management support.
The proposed project would aim to achieve the following outcomes: (i) sustain present capacity and further increase availability of quality primary health care services, based on international best practice, in the southern Iraqi marshlands; (ii) expand the present project’s primary health care activities into Babil Governorate; (iii) enhance the skills of Iraqi primary health care professionals in southern Iraq through regular training and continuous professional development; (iv) increase the level of health awareness among communities within the catchment areas of AMAR’s primary health care services; (v) increase the capacity of the Ministry of Health (MOH) and local health authorities and secure their increased ownership of primary health care activities within the areas covered by the project.

The project cost is estimated at US$1.2 million, and the project implementation period will be two years. Effectiveness Date is expected to be April 15, 2011, and the Closing Date would be May 31, 2013.

3. Preliminary description

The project would have four project components, namely: (i) Improving Service Delivery and Community Outreach; (ii) Health Education and Promotion of Behavior Change; (iii) Monitoring of Health Status and Engaging Local Health Authorities; and (iv) Project Management.

Component 1: Improving Service Delivery and Community Outreach. This component is designed to increase access to and capacity of primary health services in the Marshlands and Babil Governorate, and to improve quality of services. Activities would include: (i) rehabilitating and operating twelve existing Primary Healthcare Centers (PHCCs) (eight in the Marshlands and four in Babil Governorate), including upgrades to PHCCs through the purchase of new medical equipment for the MCH departments and laboratories in the project area, and continuing support to the operation of the four PHCCs rehabilitated under the First Emergency Assistance Program for Primary Healthcare (FEAP-PH); (ii) establishing and operating four tuberculosis-dedicated mobile clinics in Basra, Maysan, Thi-Qar and Babil Governorates with the improvement of patient database and the use of WHV to monitor patients at the community level; (iii) training Iraqi health professionals in primary healthcare in the project area, with emphasis on preventive care services, including immunization, birth monitoring (and MCH services more broadly), and diagnostic care, as well as on the management and treatment of disease, and emergency/rapid-response strategies and techniques, including community surveillance, to protect against health threats such as avian flu and polio; (iv) continuing support to AMAR’s existing Women Health Volunteer (WHV) Program which will be substantially increased in size and scope. Besides the 360 current WHVs, an additional 240 female volunteers will be recruited from the communities served by the twelve PHCCs mentioned above. These volunteers will receive regular training in preventive healthcare techniques, including basic hygiene and good nutrition, and will visit up to 50 families each in their respective communities to disseminate the new knowledge they have gained; and (v) continuing the operation of the three mobile primary healthcare facilities (Mobile Health Clinics) supported under the FEAP-PH to maintain their community outreach coverage of the remote areas. The objective is to provide access to primary healthcare for the most isolated populations as well as individuals who are disabled or otherwise unable to reach a health facility.

Component 2: Health Education and Promotion of Behavior Change. This component is designed to increase and improve health knowledge in the project area, with particular emphasis on children. This component will support two programs: (i) carrying out the Health Education in Schools (HES) Program; and (ii) carrying out the Health Education in the Community (HEC) Program. These programs are designed to increase and improve health knowledge in the Marshlands and Babil with particular emphasis on children. The two programs will play a key role in promoting behavior change among members of the communities which it reaches. The Health Education in Schools program under the proposed project will be expanded to include eight primary schools and four secondary schools in Babil Governorate in
connection with the additional four PHCCs to be supported by the project. Through the ‘Health Education in the Community Program,’ 69 teachers and 3 teaching supervisors will each deliver four health education sessions per month at public meetings for local communities held in and around the PHCCs. The sessions, which will reach approximately 3,500 local community members on a monthly basis, will discuss health issues directly relevant to local communities and will raise awareness of local health facilities available. The health advice delivered to local communities through formal verbal health education sessions will be supplemented by the printing, publication and dissemination of Health Education leaflets, posters and digital media to further enhance health awareness activities. The health activities under this component will be supplemented by the health education activities of the WHVs and the Mobile Health Clinics described above in Component 1, thereby disseminating health knowledge to isolated and remote communities in the project areas.

**Component 3: Health Monitoring and Engaging Local Health Authorities.** This component is designed to establish key baselines and trends to improve monitoring of the health of the targeted population and utilization of health services, with a view to facilitating local and regional planning and appropriate and timely allocation of resources by health authorities and other decision-makers. Two sets of activities will be supported: (i) enhancing diagnostic capacity through increasing the quality and usage level of the laboratory facilities; and (ii) carrying out activities aimed at increasing effectiveness of collaboration between AMAR and the MOH, including information exchange, joint development of health materials, training of MOH personnel, and joint development and implementation of a health database program to cover the marshlands and Babil Governorate. These activities have been successfully launched under the First Emergency Assistance Program for Primary Healthcare which closed on November 22, 2010, and will be further developed with this project.

**Component 4: Project Management.** This component is designed to strengthen AMAR’s capacity for project management, monitoring and evaluation through provision of goods, consultants’ services (including project audit and training), and provide financial support and resources to manage and coordinate project activities. The project will provide support and resources for management and coordination of project activities. AMAR will be responsible for coordinating the activities of this project through a Project Management Team which will be based in AMAR’s Basra office, with oversight by the AMAR Iraq Country Manager, based in Baghdad, and by a Project Board of Trustees based in the London office, which will provide strategic direction and monitor project progress and reporting. The in-country Project Management Team (PMT), which will be headed by a Senior Project Manager, will include financial, procurement, implementation, and Monitoring and Evaluation/IT specialists. Project implementation personnel in the project Governorates will report to the PMT on a regular basis. The team will in turn report regularly to the Project Board in the London office. For monitoring and evaluation of project results, the PMT in Basra will collate data on project activities and prepare reports measuring achievements against project activities, in coordination with the London Office team. The London office will ensure that reporting requirements for the project are met.
4. **Safeguard policies that might apply:**
The works programs are very modest and limited to the upgrading and refurbishing of existing PHCCs created under the first project, for a total cost estimated at US$24,000. There is no requirement for an Environmental Management Plan (EMP), however, Attachment 2 of the Environmental and Social Screening and Assessment Framework (ESSAF) will be included as part of the technical specifications of civil works, goods and services contracts.

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5. **Tentative financing**
Source: ($m.)
Borrower 0
World Bank Iraq Trust Fund 1.2

**Total** 1.2

6. **Contact point**
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