National Birth Spacing & Family Planning Strategy

(2021 - 2025)

Republic of Iraq

Ministry of Health

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CONTENTS

ABBREVIATIONS

ANC	Antenatal Care
BS/FP	Birth Spacing/Family Planning
CPR	Contraceptive Prevalence Rate
CSOs/NGOs	Civil Society Organizations/Non-Governmental Organizations
DOHs	Directorate of Health (at governorate level)
FP	Family Planning
GDP	Gross Domestic Product
ICPD	International Conference of Population Development
IRHFPA	Iraqi Reproductive Health and Family Planning Association
IUD	Intra-Uterine Device
KRI	Kurdistan Region of Iraq
LMIS	Logistics Management Information System
MICS	Multiple Indicator Cluster Survey
MEC	Medical Eligibility Criteria (for contraceptive use)
MoH	Ministry of Health
MoHE	Ministry of Higher Education
PDS	Percentage of Demand Satisfied (for FP)
PHC	Primary Health Care
PHCC:	Primary Health Care Centre
PNC	Post-natal Care
PPP	Private – Public Partnership
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDPs	Service Delivery Points
SRH	Sexual Reproductive Health
UN	United Nations
UNFPA	United Nations Fund for Population
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Iraq National Birth Spacing/Family Planning Strategy 2021 - 2025

FOREWORD

The Republic of Iraq is a signatory to the ICPD Programme of Action and UN documents, including the "Sustainable Development Goals" (SDG 3 & 5), that recognise Birth Spacing/Family Planning (BS/FP) as a "*human right"* and are committed to "*enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods*"[1]. Within this context, the Government of Iraq is committed to improving maternal health and recognizes Birth Spacing /Family Planning (BS/FP) as an important element of the efforts as indicated in the RMNCAH strategy 2016-2020[2]. In addition, the Government is fully aware of the beneficial effects FP services have in reducing maternal mortality and morbidity, while improving the health of newborns and children, as well as strengthening child education and empowering women and their participation in national economy. In fact, BS/FP is an effective intervention that helps reduce maternal and infant mortality, as well as improving the health and wellbeing of mothers and their children. An analysis of data plus a review of existing literature from several countries indicates that: *"for each percentage point increase in contraceptive use, the maternal mortality ratio is decreased by 4.8 deaths per 100,000 births. Contraceptive use has potential to improve perinatal outcomes and child survival by widening the interval between successive pregnancies; infant mortality would fall by 10%, and in ages 1-4 by 21%, if children were spaced by a gap of 2 years.*[3] *"*

Moreover, BS/FP is a very cost-effective intervention. Assessments of BS/FP programmes in several countries have shown that investment in BS/FP brings immediate savings in other health care costs like ANC, maternity care, childcare, immunization and in a short period in schooling and education costs. According to the Guttmacher Institute: "*for each additional dollar spent on BS/FP services above the current level, the cost of pregnancy-related care would drop by $2.20 (2.30 USD in Asia, 1.79 USD in Africa, and 4.0 USD in Latin America and Caribbean*[4]*)."* BS/FP also brings additional mid-term cost savings for social services such as childcare, schooling, and the like, which vary from country to country. Beyond the immediate and intermediate savings, it also generates returns by opening opportunities for higher level female education, improvement in women's general health, increases in female labour force participation and earnings, improved child health (above and beyond the benefits of reducing child mortality), increased human capital, and increased per capita GDP. Many of these factors contribute to economic growth. An economic model designed to take all of the foregoing into account and assess the overall cost-benefit ratio of FP, concluded that every dollar invested in BS/FP would bring a benefit of 120 USD, thereby making BS/FP a developmental intervention with the highest economic returns[5].

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[1] ICPD Programme of Action, para 7.12. https://www.unfpa.org/sites/default/files/pubpdf/programme_of_action_Web%20ENGLISH.pdf

[2] RMNCAH strategy outcome 6.1 "By end of 2020, availability & accessibility of FP services are improved."

[3] Cleland J et al. Contraception & Health. Lancet 2012: 380;149-56. https://www.thelancet.com/action/showPdf?pii=S0140-6736%2812%2960609-6

[4] Guttmacher Institute. Adding It Up. 2017. https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017

[5] Copenhagen Consensus. Social, Economic, and Environmental Benefits of Every Dollar Spent.: https://www.copenhagenconsensus.com/sites/default/files/post2015brochure_m.pdf

INTRODUCTION

Iraq development is complex, and is facing acute challenges arising from a series of population-related challenges. These include excessive population growth, a surge in the numbers of young people transitioning into adulthood, soaring rural-to-urban migration, fast growing urban settlements, all of which bring added pressure to bear on urban-based services and even greater demand for employment opportunities, while debilitating the ecological capacities of urban centres.

Total population (in millions)[6]				
	1950	1970	1995	2020
Iraq	**5.7**	**10.0**	**20.1**	**40.2**
Egypt	20.5	34.5	62.3	102.3
Morocco	9.0	16.0	27.0	36.9
Syria	3.4	6.4	14.3	17.5
Turkey	21.4	34.9	58.5	84.3
IR of Iran	17.1	28.5	61.4	84,0

According to UN Population Division data, Iraq's population has increased four-fold over the last 50 years, doubling during the last 25 years (from 10 million in 1970, to 20 million in 1995, to some 40 million in r 2020). The Iraqi population is young, with 14% under age five, and 23% adolescents (10-19 years old). Women of reproductive age (15-49 years) account for 24.4% of the total population. Around 30% of Iraq's population live in rural settings

Socio-demographic indicators	
% Urban Pop.	69.8%
Pop. Growth rate	2.4 %
Total Fertility rate	4 children / woman
Source: Annual Stat. Report, Iraqi MOH 2017	

Past surveys revealed that the country's Total Fertility Rate varied between 3.6[7] & 4.2 children/women[8], and that the Adolescent Fertility rate is still among the highest in the region high (70/1,000 adolescent girls). These rates show significant differences among governorates (annex Table 1/page.)

Taking the above into account, Iraq identified BS/FP as a national development priority for the period 2012 – 2015, as was reflected in the National Population Policy (2014 – MOP), and the Iraqi National Development Plan 2013-2017. With the support of UNFPA, WHO and UNICEF, Iraq's Ministry of Health formulated an integrated RHMNCAH strategy covering 2013-2017. One of the main aims of the strategy was to increase the availability and accessibility of BS/FP services. In line with the newly launched "Global Strategy for Women's, Children's & Adolescents' Health 2016-2030", the Ministry of Health, with support of WHO, UNFPA and UNICEF, conducted a review of the RHMNCAH strategy in 2016, and approved an updated version for the period 2016-2020. However, a series of conflicts and emergencies slowed overall implementation, s particularly aspects related to the Family Planning components.

Consequently, use of modern contraceptive methods has stagnated since 2012 - hovering between 28 % (I-WISH) and 36% (MICS6), with a significant percentage (11-17%) using traditional methods. Meanwhile, surveys showed that the "unmet FP needs" category was around 25%, with its corollary, "satisfied needs for modern FP" registering around 53.8 %. In other words, slightly more than half the women wishing to space or limit their pregnancies were using or had access to modern contraception. This finding alone attests to the weakness of the existing FP programme (see

[6] UNDESA, Population Division (2019). World Population Prospects 2019, Online Edition. Rev. 1
[7] MICS 6 survey (I-WISH), MoP / UNICEF - 2018
[8] Poverty Mapping & Maternal Mortality (PMMM) Survey – MoP / UNFPA – 2013 (based on a sample of 311,000 households)

annex 5/page 32, for difference among governorates).

Considering the above, and the importance of FP for maternal and child health in the context of Iraq's development, the Ministry of Health decided to increase its focus on FP and develop a National Strategy. The strategy is intended to lay the groundwork for development of a National Action Plan complete with budget and specific indicators that will serve as the overall framework for a strengthened FP programme.

At the Health Minister's initiative, with support from UNFPA and WHO, the ministry recently organized a series of consultative meetings and workshops to formulate the strategy and help upgrade the nation's FP services. Participants included programme managers from MoH and other stakeholders, CSOs and medical associations. The workshops not only produced integrated plans within a reproductive health strategy but also a vertical extended BS/FP action plan covering the period 2021 - 2025.

CONTEXT & SITUATIONAL ANALYSIS

As noted, current CPR for modern FP methods remains low (between 28% [9] & 36 [10]%), while unmet FP needs are estimated to be around 25.5% (19.2% in KRI), and satisfied needs for modern FP methods are around 53.8% (34.3 % in KRI). Survey data shows significant disparities of CPR (for modern methods) as follows:

- ✓ Different age groups: Younger women have the lowest CPR (modern or any method).
- ✓ Different governorates: from 17% in Nineveh to 41% in Dhi Qar (details in Annex 5, Page 32)

I-WISH 2011	*15-19 years*	*20-24 years*	*25-29 years*	*30-34 years*	*35-39 years*	*40-44 years*	*45-49 years*
All method	18 %	36 %	53 %	58 %	61 %	56 %	48 %
Modern FP	9 %	19 %	25 %	31 %	38 %	34 %	29 %
% Traditional methods	**50%**	**47%**	**53%**	**47%**	**38%**	**39%**	**40%**

Given the low CPR/modern FP methods, survey data revealed:

- ✓ High Incidence of" Un-Intended Pregnancies": I-WISH survey showed that 24% of pregnancies (during survey period) were un-intended/un-planned, the percentage being higher among women 30 years old and above.

Un-Intended Pregnancy	
15-19 yr	11 %
20-24 yr	16 %
25-29 yr	20 %
30-34 yr	33 %
35-39 yr	46 %
40-44 yr	39 %

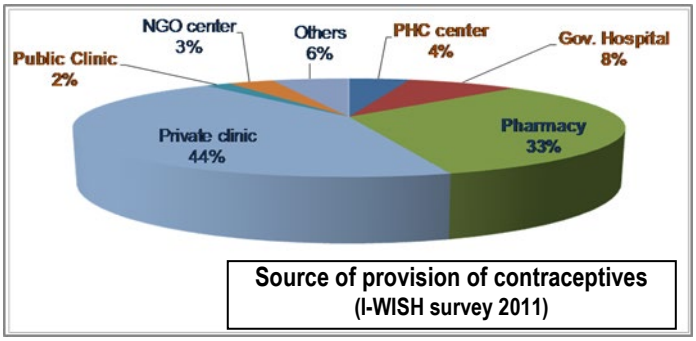
- ✓ High Incidence of Miscarriage/Abortion:
  - The I-WISH survey showed that around 24% of married women had at least one miscarriage/abortion during the five years preceding the survey (28% in KRI)
  - The MoH 2018 statistical report (P101) showed that 16% of inpatient cases being treated in public hospital Obs/Gyn wards were the result of miscarriages, with 60% attributable to obstetric causes and spontaneous abortion.

[9] Iraq - Women Integrated Social & Health survey (I-WISH), MoP / UNFPA - 2011
[10] MICS 6 survey, MoP / UNICEF - 2018

- ✓ High utilization of Traditional methods: Around 30-to-50% of couples use traditional methods, mostly "withdrawal". Although this indicates a desire to space or limit the number of children, it may also explain the high incidence of unplanned/unintended pregnancies, given the unreliability and high failure rate of traditional methods. In other Arab countries, between 3 and 16% of married women and couples rely on traditional methods.

CPRs	Iraq	KRI	Egypt	Morocco	Tunis
All method	40 %	53 %	59 %	71 %	62 %
Modern FP	28 %	28 %	57 %	59 %	53 %
Trad. Methods	11.4 %	25 %	2 %	12 %	9 %
% Trad. methods	**30 %**	**48 %**	**3 %**	**16 %**	**15 %**

- ✓ Private sector as "main source" for modern FP services/commodities): Survey data show that the private sector (clinics/pharmacies/NGOs) is the main source for FP commodities (> 80%), while the public sector accounts for about 15%. Public sector rates show significant regional disparities, as low as 3.4% in Anbar, and as high as 25.4% in Kirkuk. Meanwhile, worth highlighting:
  - Limited role of CSOs and NGOs: Data shows that NGOs/CSOs are a source for only 3.3% of FP users.
  - Public hospitals provide around 50% of female sterilization services.



(Please see *Annex 5 / Page 38 for detailed rates by governorates*)

CAUSAL ANALYSIS – DIRECT & ROOT CAUSES

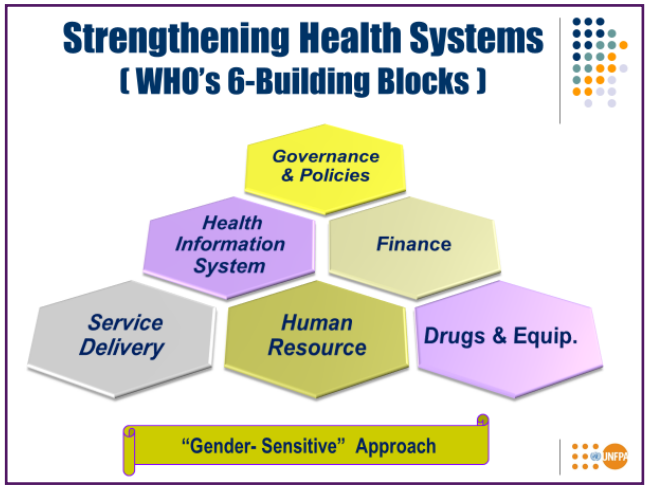
Considering the above, and in line with other countries with low FP utilization, CPR in Iraq (particularly modern FP methods) can be directly attributed to two main direct determinants:

1) Availability, accessibility and affordability of quality modern FP services and commodities.
2) Demand for modern FP methods and cultural barriers

For proper, evidence-based programming, it is necessary to conduct a comprehensive causal analysis to identify the root causes for these direct causes.

I. Availability, Accessibility and Affordability of quality FP services/commodities

For adequate analysis of challenges, affecting the availability and accessibility of FP services, the Causal analysis will adopt WHO's 6-Building Blocks for strengthening health systems, namely:



- ✓ Service Delivery
- ✓ Human Resource
- ✓ FP commodities and Equipment
- ✓ Governance/ Policies/ Coordination
- ✓ Health Information system
- ✓ Financing

A. Service Delivery

Iraq's National Health Policy document[11] states that the country enjoys a good network of health facilities at PHC, secondary and tertiary levels. The MoH annual statistical report for 2019 shows that the national health network comprises 2,808 PHC centres, around 273 public hospitals (both teaching and general), 378 public clinics, and several specialized centres. Several assessments show that PHC facilities are not equitably distributed across governorates, especially when it comes to rural and urban zones. The MoH 2019 statistical report shows that only 738 PHCs of a total of 1,353 (main centres) provided FP and that only 26% of existing PHC centres offer BS/FP services (see annex 7).

Yet studies in many countries and cultures show that nearly 90% of women who recently gave birth expressed a wish to avoid pregnancy for two or more years[13]. Consequently, programmes integrated FP counselling into ante- and post-natal care services, while immediate post-partum FP counselling and services were systematically integrated as part of maternity and post-abortion care.

PHC system [12]	South/ central	KRI
Main PHC centre	1,053	300
PHC/ Sub-centre	825	630
General Hospitals	119	43
Public clinics	119	43
Fam Med. Centres	109	8
Total	**2,466**	**960**
Centres with FP	658	80

However, current data indicates that such opportunities were not exploited in Iraq and that FP services have not been consistently integrated into maternal health services. I-WISH data showed that while ANC coverage is around 90%, only 20% of pregnant women (32% in KRI) got post-natal care after delivery, and only 35% of pregnant women reported getting counselling on birth spacing and modern FP methods during ANC visits.

Missed Opportunity
1.2 million pregnant women/year are potential new FP users

The 2019 MoH statistical report showed that, while institutional delivery is around 86% (91% in KR), and 14.3% of inpatients of OBs/Gyn hospital wards are due to miscarriage, immediate post-partum/abortion FP services and counselling is rarely integrated into maternity and Ob/Gyn wards.

In summary, the low accessibility and affordability of FP services are attributable to:

- Significant low availability of FP services throughout the entire Iraqi public health systems (PHC & Referral levels)
- Misdistribution of public facilities and concentration of private facilities in urban and peri-urban zones.

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[11] hwww.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/iraq/iraqs_national_health_policy_2014-2023.pdf
[12] As per "2019 - MoH's Annual Statistical report,
[13] FP and RH Indicators Database. % of postpartum women with unmet need for contraception. https://www.measureevaluation.Org /prh/rh_indicators/family-planning/family-planning-and-maternal-and-child-health/percent-of-postpartum-women-with-unmet-need-for

- Limited involvement of NGOs in FP service provision (4% of FP users),
- Undue dependence on private sector (fee-charging services) could explain the high levels of unmet need among the lowest wealth quintiles, a significant part of the population that is unable to afford payment for FP methods and services,
- While private sector (for-profit & non-profit) provide services for around 85%[14] of FP users, serious challenges exist when it comes to supporting and monitoring the quality of care provided by private sector.

Access to SRH/FP services during Pandemic & Humanitarian settings

Recent studies during COVID pandemic raised alarm signals related to women's access to existing RH/FP services, and highlighted the crucial importance of adopting women-friendly approaches, such as "Community-Based Distribution" as well as WHO initiative on "Self-Care"

B. Human Resources

According to current legislation and policies, only physicians have the right to prescribe medicines, including hormonal contraceptives (pills andinjectables). Intra-Uterine Devices (IUDs) can only be provided by obstetrician and gynaecologists or medical doctors who receive specific training on IUD insertion/removals. Consequently, as 54% [15] of the public PHC network is run by paramedics (health technician, nurses/midwives), FP services are not available in PHC/sub-centres, and the role of the paramedic in FP service provision is limited to FP counselling. In Iraq, the midwifery workforce comes from a variety of educational backgrounds. Some have three years of midwifery education at nursing schools, others graduate after completing two-year courses at midwifery institutes or after four years study at nursing faculties.

While pre-service training curricula (medical and paramedic) usually include FP, content is limited to didactic training on FP provision and contraception, with no emphasis on the acquisition of practical skills. Moreover, in-service training and capacity building for health providers in RH/FP provision is seldom prioritized or implemented, with most of the training available dedicated to doctors, giving para-medical staff very limited opportunities to upgrade their skills. This is further exacerbated because of the high turnover of doctors switching from the PHC system to a hospital-based approach in order to start their specialization studies.

Current nursing and midwifery leadership needs further strengthening, and should be adequately represented at decision making level in order to advocate for an active role by nurses and midwives in promoting and provision of FP services.

C. FP Commodities & Equipment

In general, all medications and devices are assessed and registered by the MoH Pharmaceutical Department. A National Committee for Drug Selection is responsible for categorizing drugs as essential or non-essential and then further classifying those deemed to be essential medicines into

[14] I-WISH 2011

[15] As per 2019 MoH's -Statistical report,

priority groups I, II, and III based on their "life-saving" effect.

Under this system, "combined pills and progestin-only, long-acting injectable" are rated highest priority in the essential drugs category, while hormonal and Copper T 380A IUDs, which are classified as "devices" and not drugs per se fall into groups II and III. Hormonal "implants" are unavailable in the public sector, and can only be acquired in the private sector.

KIMADIA, the state-owned company responsible for procurement and customs clearance of drugs does so on the basis of quantities determined by the Needs Assessment Department of the Technical Affairs Directorate. Needs are defined jointly with Governorate Directorates of Health. The methodology used for estimating the need for FP commodities is not population-based.

When it comes to procuring FP commodities, KIMADIA faces serious challenges in part because of complex procurement procedures and regulations requiring approval and registration of commercial brands and manufacturing companies. In the case of contraceptives, its low bid, small orders approach more often than not fails to secure a winning response.

Once procured and received, medicines are stored at KIMADIA warehouses, from which each Directorate of Health (DoH) collects its allocation based on plans developed by the Needs Assessment Department. In turn the DoH distribute drugs and commodities to health facilities based on their respective entitlements as determined during the needs assessment exercise.

The FP department of the Public Health Directorate runs an independent, paper-based system to monitor contraceptive distribution to Service Distribution Point (SDP) facilities. However, it is a system in crucial need of a thorough review in order to collect and evaluate data on contraceptive stocks and consumption at the SDP level. This would help avoid overstocking or running out of contraceptives at the SDPs and would be a more reliable basis for replenishing SDPs compared to the current approach).

Finally, While DoHs are encouraged to meet their FP commodity needs through local-level procurement, using their designated budget accounts, FP commodities are rarely prioritized by DOHs, and consequently provision has deteriorated due to lack of supplies.

The private sector has its own channels using a network of distributors and commercial warehouses. Private pharmacists are spread all over the country, to such an extent that there are pharmacies in localities which have no public health facilities.

D. Governance (Policies /Management Coordination)

Governance covers several areas, notably policies, management, planning and coordination.

Policies: Current FP-related institutional policies seriously impede women and couples from access to fee-free health system FP services (PHC and referral systems). These include:

1) Service delivery-related policies – especially those that apply to the integration of FP services across the Iraqi health system and SDPs, including the PHC system (main & Sub-centres), and other SDP outlets like public clinics, hospitals and maternity facilities.
2) Human Resources-related Policies: particularly those that relate to the role of paramedics (health technicians, nurses/midwives) in FP services provision (prescribing & resupplying) and counselling. Policies should also address pre-service training/capacity building of

newly graduated medical and paramedical professionals.

3) FP-Commodities-related policies: Increasing CPR depends on the availability of a wide choice of modern FP methods and commodities, both through the public health system and the private sector. Policies, guidelines and procedures that govern both approval and procurement of modern FP methods and commodities need to be reviewed and updated.

Management/Planning: MOH is responsible for setting standards and monitoring the overall health system, with Governorate Directorates of Health responsible for setting priorities, and the day-to-day management and supervision of health facilities and providers. Within this framework, the FP programme is managed by limited staff at central and sub-national levels. Yet, the success of the FP programme greatly depends on the capacity and skills of governorate-level managers to plan and manage FP services across all health system in their governorates, as well as to carry out regular quality assessments and improvements of existing services.

Coordination: Currently, the FP programme is managed vertically. However, given the multi-dimensional nature of FP programme, successful implementation requires a multi-sectoral/multi-department coordination mechanism, not just at national level but, most importantly, at governorate level. This kind of coordination is key to building a partnership with other government sectors and, , crucially, with the medical private sector, as well as local NGOs, which currently provided services to 85% of FP users[16]

E. Health Management Information System (HMIS)

Health Management Information System (HMIS) supports all health system functions (building blocks) and serves as a proxy for development of health systems. HMIS quality depends on the timeliness and completeness of a bottom-up reporting system (from outlying health facilities up to central level).

HMIS data, supplemented by population-based surveys, a vital registration system and health research, are essential for evidence-based decision making, planning and allocation of resources. For this reason, data analysis and its application should not be confined to central level, but should be shared at governorate and district levels.

F. Financing (Commodities, Equipment & Recurrent costs)

At central level, funds are rarely allocated to FP commodities and equipment. At Governorate level, the allocated budget is rarely used to support FP programming. Currently, the FP programme is dependent mainly on donor contributions which means FP programming remains donor-dependent and donor-driven. However, to ensure sustainability of efforts and investments made at national and sub-national levels, it crucial that:

1) All FP-related commodities and essential equipment should be included in the topmost category of the essential drug list, and, as such, be prioritized in the needs assessment exercise for funding from the central level government budget (the KIMADIA budget).

[16] Source : I-Wish - 2011

Moreover, as and when necessary, additional funding should be mobilized at governorate level through the DOH allocated budget, governors' funds, or charitable CSOs and the private sector.

2) Recurrent costs and investments: Similarly, funds should be secured through the budget lines of the different central Directorates, but, more importantly, at local level through the budgets allocated to Governorate DOHs and through other resources mobilized locally

II. Cultural Barriers & Demand for Modern FP methods

As in true of many similar countries and cultures, the demand for modern FP services and methods in Iraq is greatly influenced by existing cultural barriers, social norms and values, that affecting RH behaviour and practices within the country.

Indicators [17](see Annex 4)		***Iraq***	***KRI***
Women 20-24yr	**married <15yrs**	7.2 %	2.6 %
	married <18yrs	28 %	18 %
Adol. Fertility / 1000 adol.		71	40
Women 15-19r that started Rep. life		13.2 %	9 %
Women 20-24 yr with baby <18yrs		14 %	7 %
Desired Number of children		4.1	3.6
Ideal Birth Interval		2.6 yr	N/A

Demand for FP is roughly defined as the desire of married women seeking to avoid pregnancy for at least two years after giving birth. However, these women may not be prepared or ready to start using modern contraceptives due for various reasons. These include lack of information about contraceptives, such as where to get services and commodities; concerns about safety/efficacy of modern contraceptives; religious concerns; spousal objection or perceptions of same, plus peer pressure and prevailing community norms. Much of the time, women have to deal with a combination of these factors. Surveys data shows the following features and aspects:

- ✓ Persistent incidence of Early Marriage & Teenage pregnancy: Surveys shows that among women (21 - 25years):
  - 30% were married before age 18 (disparities range from 8% in Duhok to 43.5% in Missan);
  - 16% had a baby before age of 18 (disparities range from 3.8% in Duhok to 19.4% in Dhi Qar);

  As a consequence, Iraq's Adolescent Fertility Rate remains high at 70/1,000 (among the highest in the Arab world). Regional disparities are wide, ranging from 119 in Muthana to 22 in Sulaymaniyah;
- ✓ Desired Number of Children: I-WISH showed that the desired number of children is around four (regional variation ranging from 4.9 children in Salaheddin to 3.4 children in Erbil);
- ✓ Moderate birth interval (spacing between two children): The I-WISH survey showed that married women would prefer to have an ideal birth interval of around 2.6 years;
- ✓ Delayed utilization of FP methods during marital life: I-WISH survey showed that, on average, the first use of FP methods among married women was after the birth of their third child;
- ✓ High Rejection/Disapproval of Modern FP methods as shown in surveys:
  - Around half of non-user women (51%) had no intention of using FP in the future (36% in

[17] Source: MICS 6 / 2018 & I-WISH/ / 2011 surveys

KRI), and 25% of respondents indicated their disapproval of FP methods (8% in KRI);

- Around 33% of husbands disapproved/rejected the use of FP methods (12% in KRI);

	Any method	Trad. method	% Trad.
Iraq	40 %	12 %	**30 %**
KRI	53 %	25 %	**48 %**
Egypt	59 %	2 %	**3 %**
Morocco	71 %	12 %	**16 %**
Tunis	62 %	9 %	**15 %**

✓ High Utilization of Traditional methods: as earlier cited, around 30% of FP users adopt traditional methods (mainly withdrawal) -- 48% in KRI. The percentage is higher among younger couples (see table below).

✓ While use of traditional methods indicates willingness to space/limit children, it could:

- Be directly attributed to high rejection of modern FP methods. In other Arab countries, traditional methods are used by 3 to 16% of married women/couples.
- Help clarify high unplanned, unintended pregnancies (24%), stemming from high failure rate of traditional methods

(Refer to Annex 4 / Page 37. for detailed rates by governorates)

	15-19 years	*20-24 years*	*25-29 years*	*30-34 years*	*35-39 years*	*40-44 years*	*45-49 years*
All method	18 %	36 %	53 %	58 %	61 %	56 %	48 %
Traditional FP	9 %	17 %	28 %	27 %	23 %	22 %	19 %
% Trad. Method	**50%**	**47%**	**53%**	**47%**	**38%**	**39%**	**40%**

SUMMARY OF CHALLENGES

Based on above analysis, there are strong indications that the Family Planning programme in Iraq is facing serious challenges, and needs to be reinvigorated. A closer analysis of FP services highlights several challenges that need to be addressed, including the following concerns:

1. Addressing current FP-related policies and legislation will not enhance the availability of FP services through the PHC system since 50% of existing PHC centres (particularly Sub-centres) provide neither FP services nor commodities.
2. There is a need to solve the high-turnover and lack of technical skills of health providers, particularly in rural PHC centres.
3. It is necessary to improve the quality of FP services, both public and private, by providing FP clients with adequate counselling so that they can make informed choices with full knowledge of possible side effects, and services should be equipped to overcome their limited and irregular follow up of FP users.
4. Addressing current verticality of FP programme and its limited linkage with existing maternal and child services, as well as the curative health network, especially hospital maternity facilities, and responding to potential clients' of unmet needs for FP.
5. Ensuring systematic distribution, availability, and provision of at least three modern methods in all PHC centres and other SDPs, particularly in rural and remote areas.
6. Getting other line ministries that deliver community-based services to help promote FP utilization.
7. Strengthening involvement of local SCOs, particularly those delivering health services, in provision of quality RH/FP service, as per national norms and standards.
8. Enhancing partnership, dialogue, and technical support to private sector (clinics and maternity facilities) in promoting and delivering FP, as per national norms and standards.
9. Solving challenges facing FP commodities security system, and its management logistic system,

including those related to forecasting, procurement, warehousing, and distribution

10. Enhancing management, planning and monitoring capacities and skills of programme managers at all levels
11. Addressing unfavourable cultural and social values and norms affecting individual attitudes and behaviours related to marriage, family size and adoption of birth spacing and modern FP methods
12. Ensuring availability of data and monitoring systems, for effective evidence-based planning
13. Further strengthening inter-sectoral coordination at national and sub-national level.

National Birth Spacing & Family Planning Strategy (2021 - 2025)

Based on Iraq National Health Policy (2014- 2023), the Iraqi National Family Planning Strategy (2021-2025) is expected to serve as a road map in achieving the following global targets:

a) By 2030, ensure universal access to FP services and integration of FP with other programmes.
b) By 2030, achieve the global objective of ending unmet needs for FP.

A. Vision:

By the end of 2025, every woman of reproductive age in every setting realizes her right to physical and mental health and well-being as they relate to her reproductive system and is able to participate fully in shaping a prosperous and sustainable society.

B. Guiding Principles:

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

1. Human Rights-based: Each family reserves the right to determine its size, the number and spacing of its children, as well as its right to access information and receive FP methods that enable parents and would-be parents to decide upon the desired number of their children.
2. Country-led: the State is the principal duty bearer, firstly to deliver FP services, as part of an integrated RH package, as per high quality standards, and free of charge for low-income couples, and secondly to raise awareness of society about the consequences of early and frequent pregnancies with short inter-pregnancy intervals.
3. Multisectoral Collaboration: Promoting birth spacing and modern FP methods poses multi-dimensional challenges, requiring an enabling environment to ensure greater engagement of non-health partners, including other government sectors, and local authorities (including governors).
4. Effective Public-Private Partnership: It is crucial to build a stronger partnership with local CSOs as well as the private health sector.
5. Decentralized Implementation: A decentralized approach must be pursued in strategy management, which lends itself to high efficiency and ownership at governorate level, taking into account local cultural context, challenges and opportunities.
6. Universal and Equity-Driven: The strategy should adopt all relevant measures to minimize gaps and disparities between governorates, and particularly between rural and urban zones.
7. Evidence-Based/Informed: The Strategy design, planning and implementation must be based on and guided by reliable data, generated through the existing health information system, as well as drawing upon national surveys with in-depth analysis.
8. Sustainable: To ensure sustainability of efforts, it is vital to engage not only the different directorates/departments within the MOH, but also to engage other relevant sectors, as well as Iraqi CSOs and the private health sector.
9. Gender-Responsive: Considering the role of husbands, in couples' decisions about the number and spacing of their children, and with regard to use of BS/FP service, necessary

measures and strategies should be taken and implemented to outreach and address men and young males.

C. Target population

Married couples (men and women) in the reproductive age group, and newly-engaged young couples

D. Strategic Logic Framework

Based on earlier Situational and Causal analysis, and building on WHO`s "6-Building Blocks" for health systems, the national strategy will be built by following the strategic logic framework:

Goal/Impact:

Improved well-being of Iraqi women and couples, especially the marginalized and least advantaged, including their rights to exercise RH free of coercion and discrimination

This objective can be best achieved through the following two strategic pillars or outcomes that aim to strengthen and increase:

a) Availability /accessibility to quality BS /FP services (service supply);

b) Demand / acceptability of BS /FP by modern methods.

Outcome 1 (FP service supply):

"By year 2025, improved availability and accessibility of right-based, quality and integrated FP services and modern methods, for Iraqi women and couples, particularly in rural and poor urban zones, and in humanitarian settings"

Outcome 2 (FP demand creation):

***"**By year 2025, increased acceptability and voluntary demand of modern FP methods among women/couples of reproductive ages, particularly in rural and poor urban zones and humanitarian settings"*

The first outcome will be achieved through the following three Outputs /Strategic Objectives:

Output 1.1: *Strengthened governance of National FP Multi-Sectoral Programme (policies, management/planning/coordination and monitoring), at national & local levels, to galvanize political and financial commitments, to ensure effective implementation, and to guarantee client-centred and quality care with expanded choices of modern FP methods*

Output 1.2: *Right-based, client-centred and quality FP services fully integrated across all levels of health care systems (Primary, Secondary and Tertiary) (1ry, 2ry & 3ry), as well as through medical services provided by private sector and charitable CSOs, with priority to rural and poor urban zones and humanitarian settings*

Output 1.3*: Strengthened supply chain management and functional Logistics and Management Information System (LMIS) of FP commodities, including, forecasting, timely procurement and distribution systems to ensure availability and reduce stock shortages of popular choice modern FP commodities and related equipment*

The second outcome will be achieved through the following two Outputs/Strategic Objectives:

Output 2.1 *Expanded community-based outreach interventions targeting married women of reproductive age (15-49 years), particularly in poor urban and rural zones, and in*

humanitarian settings

Output 2.2: *Intensified mass social mobilisation interventions, targeting men and women of reproductive age, to create demand for FP services and modern methods, free of coercion and discrimination*

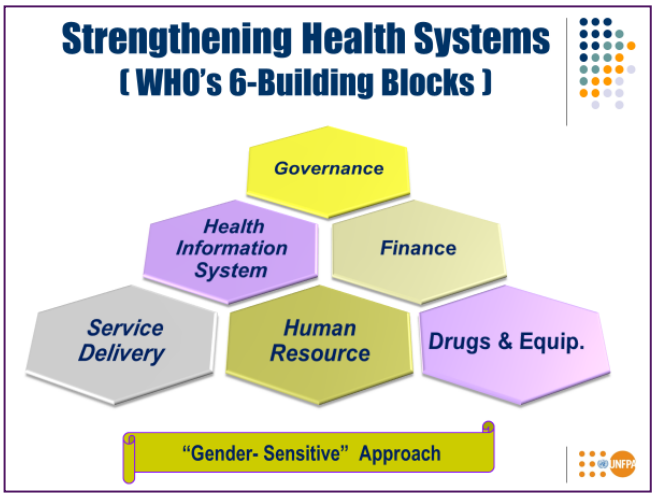
In summary, the diagram describes the overall Iraq FP Strategic Logic framework

E. Linkage to Sustainable Development Goals (2015 – 2030)

The National Birth Spacing and Family Planning Strategy (2021-2025) will directly contribute and accelerate progress towards achieving SDG 3 (targets 3.1, 3.3 and 3.7), related to ending the unmet FP needs by 2030 (a key intervention for many development goals such as improving maternal and child health), as well as SDG 5 (target 5.6), related to access of women (ages 15 to 49) to information and knowledge enabling them to take informed decisions regarding contraceptive use and RH care.

F. Strategic Workplan: Strategic Axes and Major Interventions

Outcome 1: ***By year 2025, Improved availability and accessibility of rights-based, quality and integrated FP services and modern methods for Iraqi women and couples, particularly in rural and poor urban zones and humanitarian settings***



Following the example of WHO 6-Building Blocks, efforts to increase availability of FP services must tackle all the building blocks of the national health system.

The 6-Building Blocks were summarised as 3 Outputs (Strategic Objectives), as follows:

1) Governance and policies /HIS /Financing
2) Service Delivery and Human Resources
3) FP Commodities and Logistic Management Information System

Each of Output has a number of Strategic Axes s and Major Interventions as follow:

Output 1.1: Strengthened governance functions (policies, management/ planning, coordination and monitoring), of the National BS/FP Multi-Sectoral Programme at national & local levels, to galvanize political and financial commitments, ensure effective implementation, and guarantee client-centred, quality care offering expanded choices of modern FP methods

Given the challenges related to "Governance", this output will focus its efforts to the following strategic axes:

- ***Strategic Axis 1.1.1****: "Enhancing existing FP Service Delivery-related policies, regulations, guidelines and financing":* As per 2019 MoH Statistical report, around 1,455 PHC Sub-centres lack posts for doctors, while some 170 main PHC centres have vacant posts for physicians (see annex 7 – Page 42). As per current national FP-related policies, these facilities cannot provide any modern contraceptives, with their role limited to some counselling and referral services. As recommended and endorsed by WHO, task-sharing in FP provision (enabling paramedical staff to provide contraceptive methods) is a vital step to broaden access to and utilization of FP services, and a common approach used by successful BS/FP programmes. The approach helps resolve FP policy-related barriers, especially the following: a) FP service delivery across all health delivery systems (PHC and referral services); b) the role played by different categories of health personnel in FP service provision/counselling/resupply and follow up of clients; c) modern FP commodities and methods that are approved and procured by state budget, and provided free of charge to FP clients; d) allocation of adequate budget for FP commodities and implementation costs.
- ***Strategic Axis 1.1.2****: "Enhancing planning, management and coordination functions and processes of FP strategy, at national & governorate levels (governorate & districts)*: The current strategy promotes a multi-dimensional/multi-sectoral approach for implementation, management and ownership by different implementing partners at the national and sub-national level. Within this framework, efforts will focus on: a) strengthening the skills and capacities of managers for multi-year planning and monitoring; b) enhance the coordination mechanisms at national and sub-national levels (multi-sectoral and inter-departmental); c) set up and operationalize a national reporting system to collect and analyse data on implementation progress of the Iraq FP strategy;
- ***Strategic Axis 1.1.3****: "Improving supervisory and monitoring functions of FP services to ensure quality of care*: Within a human rights-based approach, it is crucial to ensure regular quality assessment and improvement of FP services as per approved guidelines and standards. Axis aims to: a) strengthen the supervisory skills and tools for FP managers at central, governorate and district levels; b) set up and operationalize a quality assessment and improvement system, including an accreditation/award system among FP SDPs, at PHC and referral levels.

- ***Strategic Axis 1.1.4**: "Strengthening M&E process and system through quality statistical and survey data and in-depth research for evidence-based planning and decision making*: To ensure evidence-based planning, management and decision making processes of FP programme, this component will -- a) support and enhance the existing Health Information System (HIS) to regularly collect and disseminate FP-related data; b) advocate and support national surveys and in-depth research (quantitative and qualitative) on social determinants and barriers for access, utilization and behaviour towards modern FP methods, within a gender perspective approach; c) conduct a mid-term review in 2023, and a final evaluation in 2025.

Output 1.2: Rights-based, client-centred and quality FP services fully integrated across all levels of Health Care Systems (Primary, Secondary and Tertiary)), and through medical services provided by private sector and not-for-profit CSOs, with priority to rural & poor urban zones & humanitarian settings

Situational and causal analyses have shown that around 85% of FP clients are served by the private sector (r profit and non-profit), which creates a barrier for low income groups and for those living in rural and remote zones. The low rates recorded for public sector use can be directly attributed to the poor availability of FP services in the current health service delivery systems (PHC and referral levels), as well as to irregular supply and inventory f FP commodities in health facilities.

According to the MoH 2019 Annual Statistical report, only 87% of the main PHC centres are run by doctors (81% in KRI), with limited or irregular stocks of FP commodities, and that sub-PHC centres (1,455) are not authorized to offer FP services, other than counselling. However, not many other health facilities (clinics/hospitals) consistently offer FP services either.

Building on the review and approval of all FP-related policies (cited in the 1st output), this 2nd output should aim to ensure adequate and effective integration of quality FP service delivery across all health delivery systems (PHC and referral levels), as well as in medical services provided by commercial and not-for-profit private services, drawing on these five strategic axes:

- ***Strategic Axis* 1.2.1**: *Integrating FP services and counselling into MCH services in PHC centres, with focus on rural and poor urban zones (including provider capacity):* This Axis aims to ensure effective and systematic integration of FP services into existing maternal health services (ante- and post-natal care) provided by the PHC system (main and sub-centre). To achieve this, the following interventions should be are prioritized: a) Update and disseminate FP training manuals (provision and counselling) for all categories of PHC health providers (main and sub-centres); b) capacity building of MCH providers in FP provision/re-supply/counselling (based on revised policies); c) equip PHCs with required equipment to offer three modern FP methods (including IUDs); d) set up referral FP clinics at district level (main PHC or district hospital) for clients with complications, and provide long-acting FP methods (implants/sterilization); e) integrate FP services into existing curative mobile clinic network for communities in remote areas.

  To offset the low coverage of post-natal care (~20%), this Axis will aim to develop an RH booklet for women. Copies would be available to women in maternity facilities or those making ANC visits as a means of promoting 3-PNC visits, and for raising awareness about

FP services among post-partum women.

Also, in order to help overcome the lack of familiarity newly graduated/recruited medical/paramedical staff in the PHC system (doctors, nurses and midwives) may have in FP provision (and their high turnover), a RH/FP Comprehensive Competency-based Training package will be developed and integrated into the pre-service training of junior medical graduate and graduate midwives (to be delivered during their practicum /internship period).

- ***Strategic Axis 1.2.2**: Integrating quality "Immediate Post-Partum/-Abortion FP services in all hospital maternities and PHCs with Labour rooms"*: Some 1.1 million Iraqi women get pregnant each year, of whom around 84% deliver in health institutions (68% in public, 16% in private institutions). Around 60,000 women are hospitalized for miscarriage/abortion[18]. This Axis aims to integrate immediate post-partum FP counselling and services on a systematic basis into maternity facilities by: a) Developing guidelines, standards and training manuals for integrating the provision of immediate post-partum/-abortion FP; b) strengthening the capacity of the different health providers working in hospital maternity units and PHC labour rooms; c) securing relevant FP commodities and equipment for hospital maternity facilities.
- ***Strategic Axis 1.2.3**: Integrate FP services in services of Popular Public Clinics*: The existing 378 public clinics provide different services for around four million clients (more than 50% women)[19]. However, unverified information shows that very few of these clinics were capable of delivering FP services and commodities. This strategic Axis would aim to: a) Develop and approve orientations/regulations to integrate FP services into popular public clinics; b) strengthen the capacity of selected FP personnel in provision and counselling: c) secure relevant FP commodities and equipment for these clinics.
- ***Strategic Axis 1.2.4**: Strengthen "Public-Private Partnership" mechanisms with private sector (clinics, maternity facilities and pharmacies to increase access and use of quality FP services)*: Currently, private sector clinics and maternity facilities secure FP services and commodities for around 85% of FP users. This Axis aims to enhance the partnership with the private health sector in order to secure quality FP services by : a) Setting up a functional Public-Private Partnership (PPP) mechanism with private clinics, pharmacies, maternities at governorate level, to promote FP provision; b) capacity building by DOH of private providers in how to ensure quality FP service (GPs & pharmacists), possibly on a cost-recovery basis; c) Setting up and implementing a quality monitoring system (accreditation and awards system) for services provided by private sector (based on WHO and national standards).
- ***Strategic Axis 1.2.5**: Support and Follow up local CSOs (providing medical services) to*

[18] 2019 – MoH's Annual Statistical Report
[19] 2019 - MoH's Annual Statistical Report

integrate and provide FP services, mainly in rural and poor urban areas: Data of I-WISH survey shows that local/charitable NGOs provide FP services to merely 3.6% of FP users (varying from 0.5% in Anbar to 12% in Qadissyah), with limited choices of modern FP methods and commodities. This Axis aims to strengthen partnership and provide support to local NGOs to integrate FP services into their existing medical services, particularly those operating in remote rural and poor urban zones, through the following: a) Develop partnership framework with local CSOs (offering medical services); b) Capacity building for health providers (doctors and nurses) working in CSOs clinics; c) Set up and implement a quality monitoring system (accreditation/award system) for services provided by CSOs, based on WHO and national standards.

Output 1.3: Strengthened Supply Chain management and functional Logistics and Management Information System (LMIS) of FP commodities, including, forecasting, timely procurement and distribution systems to ensure availability of the modern FP commodities and related equipment.

The low CPR of modern FP methods (28-36%) and the weak share of the public sector as a source for FP commodities (<15% of all users) can be directly attributed to the irregular supply and frequent absence of FP commodities in health facilities, as well as to the poor availability of FP services in current health service delivery systems (PHC and referral levels).

Within this scope, and building on review and approval of FP-related policies, particularly those related to FP commodities (see 1st output), this 3rd Output would aim to secure an effective and regular supply of large choice of FP commodities, across all health - Delivery systems (PHC and referral levels), and for private sector (both profit and non-profit), by following these Strategic Axes:

- ***Strategic Axis 1.3.1:*** *Ensuring high level national commitment and coordination for RH Commodity Security (RHCS):* Given the multi-partnership nature of FP service delivery, commitments and coordination among all involved partners is crucial to ensure regular supply and distribution of FP commodities to all SDPs (public and private). This can be achieved by: a) Setting up RHCS High Committee with all relevant stakeholders, including NGOs and private sector; b) developing an RHCS strategy, including listing FP commodities in the highest category of essential drugs;
- ***Strategic Axis 1.3.2:*** *Strengthen Procurement & Supply chain of FP commodities:* This will be achieved through the following: a) Develop/approve/review an overall supply chain system and plan, including forecasting and "pull-based" distribution systems; b) Capacity building of FP managers at governorate and district level, in forecasting, storage and timely distribution of FP commodities; c) Capacity building of KIMADIA managers & staff in timely procurement of FP commodities; d) Renovate and equip storage facilities at all levels; e) Develop an FP commodities' social marketing programme, including a distribution system for private sector (clinics, maternity facilities and pharmacies) and CSOs(on a cost-recovery basis).
- ***Strategic Axis 1.3.3:*** *Strengthen logistics management functions of MOH to ensure contraceptive availability:* This will be achieved through the following: a) Develop and

implement complete e-LMIS for timely collection/reporting on consumption data and distribution of FP commodities at all levels; b) capacity building for all concerned staff on proper utilization of e-LMIS for FP commodities; c) develop and implement a functional supervisory system to monitor RHCS functions at all levels.

Outcome 2: By Year 2025, Increased acceptability & voluntary demand of modern FP methods among women/couples of reproductive age, particularly in rural & poor urban zones, & in humanitarian settings

As highlighted in earlier situational & causal analysis, increasing adoption of "Birth Spacing" and higher utilization of available modern FP services, among women and couples, are facing serious behavioural and cultural-related barriers and challenges. While some of these behavioural challenges could be attributed to lack of awareness and information about FP methods, but most importantly others are also related to misinformation and erroneous misconception, including cultural believes, as well as erroneous myths and rumours about modern FP methods.

To achieve the above-mentioned outcome, the FP strategy will adopt "Two tracks", firstly through "Community-based Out-reaching" for married women individually and in groups, and secondly through "Mass Social Mobilization and Community Engagement", with particular focus on Male/husbands involvement and sensitization. Within this perspective, the FP strategy would aim the following Two Outputs / Strategic Objectives, as follows:

Output 2.1 Expanded Community-based Out-Reach interventions targeting married women at reproductive age (15-49 years), particularly in poor urban & rural zones, and humanitarian settings

Since several years, several "Community-based Outreach interventions were implemented by MoH and other ministries, such as MoLSA, and in close collaboration with Local NGOs, for different scope and perspective, including women rights & health, as well as combating Gender based violence. Building on these efforts, this output aims to expand and integrate Birth Spacing messages and promoting use of modern FP methods among married women. Particular focus will be given to current pregnant women, and new mothers (those who recently delivered their babies), as well as "Newly-Engaged / To-Be-Wed" young couples. Within this context, this output will have the following strategic Axiss, and their respective major interventions:

- ***Strategic Axis 2.1.1:*** *Integrate FP promotion in outreach interventions of MoLSA & Local NGOs working on women social issues (empowerment, combating GBV, early marriage, etc.):* Currently, several ministries, jointly with local NGOs, are engaged to promote women rights and combating Gender-based violence, through "Community-based Women Outreach Workers" (CbWOWs), who conduct regular house visits within their own communities. Building on these efforts, necessary support will be provided to these partners to expand and integrate behavioural change around "Birth Spacing & promoting modern FP methods" through their CbWOWs within their Communities. The following are main interventions: a) Develop guidelines, training manuals & didactic materials for Community-based Women Outreach volunteers (CbWOVs) to promote Birth Spacing & FP among married women; b) Capacity building of Cb/WOVs (MoLSA & local NGOs) on promotion of Birth Spacing &

modern FP methods; c) Provide regular follow up & substantive support to Cb-WOVs (MoLSA & local NGOs).

- ***Strategic Axis 2.1.2:*** *Support MoLSA & Local NGOs to setup "Women Social Centres" (Safe Spaces) in rural, poor urban zones & in humanitarian settings, and promoting Birth Spacing and utilization of modern FP methods*: As part of the national Strategy on "Combating Gender-based Violence", MoLSA, jointly with local NGOs, established "Women Social Centres/Safe Spaces" to provide Psycho-Social Support for GBV survivors, and promote women rights and development. Taking advantage of these efforts, these partners will be supported to expand and integrate behavioural change around "Birth Spacing and promoting modern FP methods" through existing and new "Women Social Centres/ Safe Space": a) Develop & review content & didactic materials of "Women Capacity Package" on women empowerment skills, including RH/FP issues, combating GBV, Early Marriage/Pregnancy; b) Capacity building & follow up for teams of MoLSA & local NGO social workers to deliver the "Women Capacity Package"; c) Secure operations & monitoring of Women Social Centres in poor urban & rural zones, with effective referral to nearest FP services.

  Finally, to ensure community engagement / support and the financial sustainability of above-mentioned main interventions, the strategy would and community engagement, the strategy would explore engaging private sector at local level (Governorate or district levels) to provide needed financial support for "Cb Women Outreach Workers" and "Women's Social Centres"

- ***Strategic Axis 2.1.3:*** *Integrating & Scale up FP promotion into existing MoH Community-based Initiatives (CBIs)*: Similarly, to Strategic Axis 2.1.1, and building on MoH current CBIs Programme, the strategy aims to integrate "promoting Birth Spacing & modern FP Methods within the CBI's outreach component, with particular focus on pregnant women, new mothers (who recently delivered their babies), as well as newly married couples. Main interventions include the following: a) Capacity building & didactic materials for Community-Based Women Outreach volunteers to promote Birth Spacing & modern FP methods among married women in their communities; b) Provide regular follow up to Cb-WOVs; c) Set-up operational linkage bet-ween Birth / Marriage registries & Cb-WOVs, for outreaching / targeting new mothers & newly married adolescents (<18yrs)

- ***Strategic Axis 2.1.4****: Promoting & delivering "Pre-marital Education Courses" for "Engaged / Newly married couples" on Birth Spacing/ FP, and other social & RH issues*: Currently, the MoH is promoting and providing support to a "Pre-marital Testing" Programme, for "Newly-engaged couples". Building on these efforts, partnership will be developed with relevant government entities (MoYS / MoLSA / ……) and local NGOs, to setup a multi-dimensional / comprehensive "Pre-marital Education" courses, firstly to provide necessary SRH information, but most importantly behavioural skills to ensure a successful and responsible family life. Main interventions include: a) Develop & review curriculum/ didactic materials for Pre-marital counselling courses; b) Train & follow up multi-disciplinary team of master trainers & trainers/ animators at governorate & district levels; c) Define & implement promotional strategy for "Pre-Marital Education" courses; d)

Follow up quarterly sessions of Pre-marital courses at district level.

Output 2.2: Intensified Mass Social Mobilisation interventions, targeting men & women at reproductive age, to create demand for FP services & modern methods, free of coercion & discrimination

Considering the pro-natalist socio-cultural norms, prevailing in Iraqi cultural values and norms, Community Mobilization & Engagement are key elements for any social change and adoption of behavioural change to cultural norms & social values. Community Engagement does not only enable dissemination of information but also helps alleviate or reduce cultural/social barriers, such as cultural & social barriers affecting adoption of "Birth Spacing" and utilization of modern FP methods. Within this context, the FP strategy would create & use different platforms, such as use of Mass media (audio-visual and Mobile social media) as well as engaging opinion leaders (religious & community leaders), particularly to ensure male/husbands engagement & involvement. Within this context, this output will have the following strategic Axis, and their respective major interventions:

- ***Strategic Axis 2.2.1****: Engage & follow up religious leaders to positively address BS & FP, correct cultural mis-concepts & norms affecting women health*: As exposed earlier, I-WISH showed that while 23% of Iraqi Women and 30% of husbands have cultural objections to use modern FP methods, due to some erroneous cultural mis-conceptions. Within this context, religious leaders & preachers (male & female – Da'eyat Dinyat) could play a crucial role to promote "Birth Spacing" and dissipate erroneous believes about modern FP methods. Within this context, the following are some of major interventions: a) Develop training & Didactic materials, and map medium/large mosques in targeted governorates; b) Capacity building of Religious Leaders (male & Female) on Birth Spacing, RH/FP issues, as well as combating GBV, early marriage / pregnancy, ……; c) Setup & implement a regular follow-up system for trained Religious leaders; d) Integrate training materials into pre-service training curricula of Imams & Preachers (male & female – Da'eyat Dinyat);
- ***Strategic Axis 2.2.2****: Strengthen Health Edutainment multi-faced media campaign (digital & audio- visual/ printed) to educate public on Birth Spacing & Modern FP methods*: Experience from many countries shows that combining FP with audio-visual entertainment (such as soap operas, or songs) have been effective in adopting new behaviour. Surveys data show that nearly 99% of households own television, more than 90% of women watch television at least once in a week, and that two thirds of women own a mobile phone). These create important opportunities for outreaching couples (men & women) with messages on Birth Spacing, but most importantly to address also erroneous misconceptions believes about modern FP methods. Within this context, the following are some of major interventions: a) Conduct Formative research to segment target audience, around concept of Birth Spacing small family, Early marriage & Adolescent Pregnancy (< 18yrs); b) Advocating for "Corporate Social Responsibility" with private & public TV channels, and mobilizing TV anchors/ producers to integrate FP messages in existing TV programs; c) Mobilizing & networking among celebrities & media/ public figures as "Change Champions" on FP, harmful practices (early marriage/childbearing); d) Supporting Public Areas Branding (posters, billboards, roundabout, etc.) in main public areas; e) Developing

"Social Media" mobilization/ awareness raising through multiple online platforms ("Mobile Social Media" – Twitter, Facebook, ……)

G. Implementation Modalities:

Considering the Multi-sectoral nature of the proposed FP strategy, the Iraq Ministry of Health will be assuming the overall Coordination of implementing the strategy, both at national and governorate levels, through Directorate of Public health at central level, and through its DoHs at governorate level.

As described earlier, the strategy will be implemented by several directorates of MoH, as well as several ministries (MoLSA, Ministry of Endowment, MoYS, ….). In addition, some components will require collaboration and direct involvement of National NGOs and professional associations, both at national and local levels.

Within this perspective, the Ministry of Health will establish a Programme Steering Committee (PSC), where all implementing partners (IPs) from both national & subnational levels, will be represented, as well as representatives from other relevant sectors (MoLSA, Ministry of Endowment, MoYS, ….), national professional associations (medical & pharmaceutical, nursing/midwifery, …) as well as selected national NGOs, universities and other UN Agencies.

This committee will meet at annual basis to: a) conduct an Annual Review of all Strategy Outputs, where annual progress reports will be discussed and approved; b) provide strategic orientations and recommendations for future plans; c) approve proposed Annual Work Plans (AWPs). In addition, it will be also responsible for organizing and approving the Mid-term evaluation (year 2022) and Final Evaluation of the strategy in early 2024;

Moreover, a Technical Committee (TC) will be put in place, with representatives from all Partners contributing to FP Strategy results/components (outcome/Outputs). The TC would meet periodically, at quarterly or semi-annual basis. These meetings will monitor implementation of AWPs, ensure harmonization of efforts among IPs, as well as sharing information, best practices and lessons learned.

At yearly basis, each Implementing partner (IP)will prepare a detailed Annual Work Plan (AWP), based on finalized and endorsed current framework. These AWPs will be finalized and approved within the annual meeting the PSC. By end of each calendar year, each IP will prepare a progress report of activities implemented, and constraints for non-achieved annual targets.

H. Monitoring and Evaluation

The success of any strategy depends on regular monitoring of indicators to measure the progress in the implementation of the interventions and achieving the targeted results. The monitoring and evaluation system ensures the realization of Outcomes and Outputs, and consequently allowing the assessment of progress towards the desired impact which is the ultimate aim of the National Birth Spacing / Family Planning Strategy (2021 – 2025).

Within this perspective, Monitoring and evaluation will be undertaken in line with the national Health policy (2015-2030), and will be based on following parameters:

1. Result-base management logical framework which include the Impact, outcome and output indicators,
2. At output level, operational activities will assess the progress and development over time.
3. Setting standardized progress reports to ensure monitoring and evaluation of activities and outputs
4. Setup a data base of necessary information and data firstly for evidence-based planning, and to assess progress for stakeholders and decision makers
5. Conduct annual monitoring & evaluation exercise, as well as mid-term and final evaluation.

Within this perspective, Ministry of Health, with support of UNFPA & WHO, will be responsible for: a) setting up the necessary M&E mechanisms and tools, as well as for conducting reviews to ensure continuous monitoring and evaluation of the National FP Strategy, with the view of ensuring accountability, transparency and integrity.

All collaborating partners will provide periodic reports on the progress, achievements and results of their respective components, outlining the challenges faced during implementation, as well as resource utilization as articulated in Annual Work plan (AWP).

The present Strategy includes three instruments which will guide and facilitate the monitoring and evaluation of the Strategy, namely:

a) Strategic Framework & Macro Action Plan (Annex 1): This plan identifies annual targets for each output, including its related strategic Axis and respective key interventions. These process indicators represent CPAP yearly milestones and will serve to assess progress towards planned outcomes and outputs targets. They will be reviewed and updated annually based on approved AWPs.

b) Strategy Results Indicators (Baseline & 2025 Targets) (Annex 2): This table contains a set of Indicators (Goal / Outcomes / Outputs), with Baseline & expected targets for 2025. Majority of these indicators had a baseline value; others will be established during the first year, based on some surveys or Government periodic statistics. Data collection of these indicators will be assured regularly, and will be managed through a data base, which will be harmonized by the Ministry of Health.

c) Strategy M&E Plan/Calendar (Annex 3): This plan/calendar defines monitoring & evaluation activities, such annual reviews, Mid-term and Final Evaluation. In addition, it will also include surveys, research and data collection systems that will provide the values for the Outcomes and outputs indicators. In addition, this calendar includes the following M&E processes:

   1) Regular Strategy Coordination meetings: Quarterly meetings will be essential with all implementing partners to monitor progress of AWPs and facilitate coordination among partners and information exchange.
   2) Annual review: Jointly with WHO & UNFPA, Ministry of Health will conduct annual review meetings for all Strategy components, to assess progress towards achieving outputs, draw lessons learned, best practices & raise recommendations for way forward.
   3) Mid Term Evaluation (Year 2023): to assess progress & achievements of National FP

Strategy and priorities.

4) Final Evaluation of National FP Strategy – (Year 2025)

I. Critical Factors of Success

1. It is critical that Decision makers at central and local levels alike should demonstrate earnest political buy-in and commitment to efforts made to address current challenges facing "Birth Spacing/Family Planning programme, and its impact and repercussion on women & children overall health, and rapid population growth. This political commitment has to be a sustained, long term expression of interest that is neither transient nor elective.
2. It is critical to reach consensus within the society around shared responsibility of all relevant stakeholders for addressing challenges, which cannot be possibly handled by a single government institution and which require a Multi-sectoral collective action. Therefore, the dynamic engagement by organisations of the civil society and the private sector is a centrepiece in implementing the national FP Strategy. Coordination becomes of paramount significance to avoid duplication of efforts and prevent wasteful use of resources.
3. It is critical to bring about positive changes into the value system that is unpropitious to development. These changes should encompass favourable norms of fertility that promote the culture of a small family and appropriate birth spacing, and gender-sensitive norms.
4. It is critical to create space for introducing and applying creative innovations that can proportionately respond to magnitude and complexity of issues and problems, with an emphasis being placed on demonstrating renewed commitment towards implementing the traditional solutions that have proven to be successful in other developing countries of comparable contexts.
5. It is critical to have in place a vigorous monitoring and evaluation system with focus on the programs and activities relating to population and family planning on the local and central levels. This will be supplemented with a robust component for social science research with focus on the need to develop research studies and policy briefs to inform the implementation of the Iraq National Family Planning Strategy.

CONCLUSION

This document should be used together with other important national documents such as Iraq RMNCAH Strategy (2016- 2020) and National Health Policy. Moreover, the Strategy provides an overall operational vision, as well as main targets (indicated below under indicators) and key interventions. There are further steps for it to become operational.

Strategy will be operationalized through development and implementation of budgeted Action Plans. Suggested steps for development of this plan and implementation of them ,i.e. a Roadmap can be found in the Annex of this Strategy together with strategic objectives (impact, outcome and outputs) with indicators (See Annex I , Annex II and Annex III).

Many mid-income countries (Brazil, Colombia, Dominican Republic, Guatemala in Latin America, Indonesia in Asia Pacific, and Iran and Turkey from the region) have been able to increase CPR rates by 1-1.5 points annually, in nineties with the help of robust programs adopted to country context and respecting human rights. After the turn of millennia countries like Rwanda and Ethiopia which have much lower GDPs and weaker health systems than Iraq have achieved even higher increase rates. This is a realistic target for increasing CPR, responding to unmet demand for FP.

Annex 1: Strategic Framework & Macro Action Plan 2021 - 2025

Outcome 1: ***By year 2025, Improved availability, accessibility and affordability of Right-based, Quality and Integrated FP services & modern methods, for Iraqi women/couples, particularly in poor urban & rural zones, & in humanitarian settings***

Output 1.1: ***Strengthened Governance functions (policies, management/ planning/ coordination & monitoring) of National BS / FP Multi-sectoral Programme, at national & governorate levels, to galvanize political & financial commitments, ensure its effective implementation, and guarantee Client-Centered & Quality care with expanded choices of modern FP methods***

Strategic Axis	Major Intervention	Responsible party	Collaborating Partners	Time Frame				
				Y1	Y2	Y3	Y4	Y5
Strategic Axis 1.1.1: Enhancing existing FP Service Delivery-related policies, regulations, guidelines and financing	Review & disseminate policies of FP service delivery at all health delivery levels (1ry, 2ry & 3ry care levels), particularly at PHC system (Main PHCs & Sub-PHCs)	Health Policy dep.	MCH Dep. (Bg/ KRI) Tech. Affairs. Dir.	X		X		
	Update & disseminate existing guidelines & standard of practice for FP service provision for all Health services levels (1ry, 2ry & 3ry), based on WHO guidelines	MCH Dep. (Bg & KRI)	Tech. Affair Dep. Consult. committee	X		X		
	Advocacy & review policies to expand roles (on "Task sharing" basis) of Gen. Practitioners & paramedics (med. Assistant/nurses/midwives), in FP Provision/ Re-supply/ Counselling	MCH Dep. (Bg & KRI)	Tech Affair Dir. Job Descript section	X		X		
	Update national policy, guideline & protocols linked to FP commodities (WHO guidelines)	MCH Dep (Bg & KRI)	Tech. Aff. Dep.	X		X		
	Advocacy for new modern FP methods & products, based on WHO guidelines	MCH Dep (Bg & KRI)	KIMADIA, Consult. Committees		X		X	
	Advocacy to allocate necessary budget FP strategy (contraceptives & running costs)	Planning Dir.			X	X	X	X
Strategic Axis 1.1.2: Enhancing planning, management & coordination functions & processes of FP Strategy, at national & governorate levels.	TA & workshop to develop tools, training materials & capacity building of RH/FP managers (governorate & district levels) to effectively plan, manage & monitor FP service delivery	Planning Dir.	MCH Dep (Bg & KRI)	X	X	X	X	
	Setup & follow up an FP Technical committee, with all MOH's Deps. involved in FP programme at national & local levels, to coordinate & harmonise actions	Public Health Dir. MCH Dep. (Bg & KRI),	Planning Dir., DoHs	X	X	X	X	X
	Setup & follow up inter-ministerial Pop/FP Committee, at national & governorate level", to develop / review a 3-year costed multi-sectoral FP Action Plan	PH Dir. / Planning Dir.	MCH dep.(Bg/KRI) DoHs	X	X	X	X	X
	Setting & operationalise an overall national monitoring & reporting system to collect & analyse data on implementation progress of Iraq FP Strategy	Planning Dir.	MCH Dep. (Bg/ KRI) Min. of Plan		X	X	X	
Strategic Axis 1.1.3: Improving supportive supervisory & monitoring functions for FP services to ensure quality of care	Develop tools / check lists & training materials to enhance supervision of FP services	MCH Dep. (Bg & KRI)	Quality ……, DOHs	X		X		
	Capacity building & follow up of FP managers / supervisors at governorate & district levels	MCH Dep. (Bg & KRI)	Quality ……, DoHs		X	X	X	X
	Setup and operationalize a quality assessment & improvement system, including an accreditation / award system among "FP SDPs, at PHC & referral levels	MCH Dep. (Bg & KRI)	Quality ……, DoHs			X	X	X
Strategic Axis 1.1.4: Strengthening M&E process & system through quality statistical & survey data & In-	Review & make necessary adjustment of existing Health Information System (HIS) to ensure collection of needed data for FP programme & service indicators	Statistic dep. / Planning Dir	MCH Dep.(Bg /KRI)	X		X		
	Conduct quantitative surveys, In-depth analysis & qualitative research to define social	MCH Dep. (Bg & KRI)	CSO / MoP,	X	X	X		

Output 1.1: Strengthened Governance functions (policies, management/ planning/ coordination & monitoring) of National BS / FP Multi-sectoral Programme, at national & governorate levels, to galvanize political & financial commitments, ensure its effective implementation, and guarantee Client-Centered & Quality care with expanded choices of modern FP methods								
Strategic Axis	**Major Intervention**	**Responsible party**	**Collaborating Partners**	**Time Frame**				
				Y1	**Y2**	**Y3**	**Y4**	**Y5**
depth research for Evidence-based planning & decision making	determinants for FP demand & use among couples & women		Univ. Res. centres					
	Conduct Mid-Term review (2023) and final Evaluation (2025)	Pub Health Dir, UNFPA	Planning Dir.			**X**		**X**

Output 1.2: *Quality Right-based, Client-centred & Quality FP services full integrated across all levels of Health Care Systems (1ry, 2ry & 3ry), as well as medical services provided by Private sector, and charitable Civil Society Organizations, with priority to rural & poor urban zones, and humanitarian settings*								
Strategic Axis	**Major Intervention**	**Main Responsible party**	**Collaborating Partners**	**Time Frame**				
				Y1	**Y2**	**Y3**	**Y4**	**Y5**
Strategic Axis 1.2.1: Integrating FP services & counselling into MCH services in PHC centres, with focus on Rural & Poor urban zones (including capacity of providers)	Update & disseminate FP training manuals (provision & counselling) for MCH providers in PHC system (main & sub-centres)	MCH Dep. (Bg / KRI)	DoHs	**X**		**X**		
	Capacity building of MCH providers in FP provision / re-supply / counselling	MCH Dep. (Bg / KRI)	DoHs	**X**	**X**	**X**	**X**	**X**
	Equip PHCs with required equipment to offer 3 modern FP methods (incl. IUD)	MCH Dep. (Bg / KRI)	KIMADIA, DoHs	**X**	**X**	**X**	**X**	
	Set up "Referral FP clinics" at district level (main PHC or district hospital) for clients with complications, & to provide Long Acting FP methods (Implants / Sterilization / ……)	MCH Dep. (Bg / KRI)	DoHs		**X**	**X**	**X**	
	Develop & disseminate a "Women RH Booklet" during ANC visits & in maternities to promote a "3-Post Natal Care" visits as "Entry point" for FP Promotion	MCH Dep. (Bg / KRI)	Tech. Aff. Dir / Ir RHFP ass.	**X**	**X**			
	Integrate FP services into existing "Curative Mobile Clinics" for communities in remote areas	PHC Centres Dep.	MCH Dep., DoHs		**X**	**X**	**X**	**X**
	Integrate a competency-based Comprehensive training package on RH/FP, into Pre-service training of Junior medical graduate & graduate Midwives	MCH Dep. (Bg / KRI) Univ. Hospitals	Med. Syndicat	**X**	**X**	**X**	**X**	**X**
Strategic Axis 1.2.2: Integrating Immediate Post-Partum /-Abortion FP services in all hospital maternities & "PHCs with Labour rooms"	Develop guidelines, standard & training manuals for integrating provision of "Immediate Post-Partum/-Abortion FP" services in maternities	Tech. Affair Dep., MCH Dep. (Bg / KRI)	DoHs	**X**		**X**		
	Capacity building on "Immediate Post-partum/-abortion FP" counselling & services for different health providers working in hospital maternities & PHC Labour rooms		DoHs	**X**	**X**	**X**	**X**	
	Securing relevant FP commodities & equipment for Hospital maternities		KIMADIA, DoHs	**X**	**X**	**X**	**X**	
Strategic Axis 1.2.3: Integrate FP services in services of Popular Public Clinics	Develop & approve orientations/regulations to integrate FP services into "Popular Clinics"	Pop. Clinics dep.	MCH Dep. (Bg/ KRI)	**X**		**X**		
	Capacity building for selected providers of Popular Clinics in FP provision & Counselling		MCH Dep. (Bg/ KRI)	**X**	**X**	**X**	**X**	
	Securing relevant FP commodities & equipment for Popular Clinics		KIMADIA	**X**	**X**	**X**	**X**	**X**
Strategic Axis 1.2.4: Strengthen "Public-Private Partnership"	Setup functional Public-Private Partnership (PPP) mechanism with private clinics, pharmacies, maternities at governorate level, to promote FP provision among their clients	Ir RHFP association	Med & Pharm Ass. MCH Dep (Bg / KRI)	**X**	**X**	**X**	**X**	

Output 1.2: *Quality Right-based, Client-centred & Quality FP services full integrated across all levels of Health Care Systems (1ry, 2ry & 3ry), as well as medical services provided by Private sector, and charitable Civil Society Organizations, with priority to rural & poor urban zones, and humanitarian settings*								
Strategic Axis	**Major Intervention**	**Main Responsible party**	**Collaborating Partners**	**Time Frame**				
				Y1	**Y2**	**Y3**	**Y4**	**Y5**
mechanism with private sector (clinics, pharmacies to increase access of quality FP services	Capacity building of Private providers in provision of "Quality FP service" (GP & Pharmacists	Private Sector Section		**X**	**X**	**X**	**X**	
	Set up & implement "Award system for Private providers that provide quality FP services				**X**	**X**	**X**	**X**
Strategic Axis 1.2.5: Support & Follow up local CSOs (providing medical services) to integrate & provide FP services, mainly in rural & poor urban areas	Develop partnership framework with local CSOs (offering medical services) to integrate FP services into their existing medical services	IrRHFP association, DoHs,	MCH Dep.(Bg/ KRI)	**X**	**X**	**X**	**X**	
	Capacity Building of health providers (doctors & nurses) working in CSOs clinics			**X**	**X**	**X**	**X**	
	Develop adequate monitoring & accreditation system for CSOs' clinics providing FP service				**X**	**X**	**X**	**X**

Output 1.3: *Strengthened "Supply Chain" management & functional Logistics Management Information System (LMIS) of FP commodities, including, forecasting, timely procurement & distribution systems to ensure availability & reduce stock outs of modern FP commodities & related equipment*								
Strategic Axis	**Major Intervention**	**Main Responsible party**	**Collaborating Partners**	**Time Frame**				
				Y1	**Y2**	**Y3**	**Y4**	**Y5**
Strategic Axis 1.3.1: Ensuring high level national commitment & coordination for RH Commodity Security	Setup & follow up RHCS High Committee with all relevant stakeholders, including NGOs & Private sector	KIMADIA	MCH Dep. (Bg/KRI) Tech Affair Dir	**X**	**X**	**X**	**X**	**X**
	Develop RHCS strategy, including inclusion of FP commodities into highest category of essential drugs list	KIMADIA	MCH Dep. (Bg/KRI) Tech Affair Dir	**X**		**X**		
Strategic Axis 1.3.2: Strengthen Procurement & Supply chain of FP commodities	Develop/ approve/ review an overall "Supply Chain" system & plan, including Forecasting & "Pull-based" distribution systems	KIMADIA,	MCH Dep. (Bg/KRI) Technical Aff. Dir.,	**X**		**X**		**X**
	Capacity building of FP managers at governorate & district level, in Forecasting, Storage & timely Distribution of FP commodities	KIMADIA	MCH Dep. (Bg/KRI) DoHs,	**X**	**X**	**X**	**X**	
	Capacity building of KIMADIA managers & staff in Timely procurement of FP commodities	UNFPA, KIMADIA	MCH Dep. (Bg/KRI)	**X**	**X**			
	Renovate and equip Storage Facilities at all levels	KIMADIA	DOHs		**X**	**X**	**X**	**X**
	Develop a "Social Marketing" programme, including a distribution system, of FP commodities for private sector (clinics, maternities & pharmacies), & CSOs (Cost-Recovery basis)	Ir RHFPA Ass. / MCH Dep.(Bg/KRI	Med & Pharm Ass., DoHs	**X**	**X**	**X**	**X**	**X**
Strategic Axis 1.3.3: Strengthen logistics management functions of MOH to ensure contraceptive availability	Develop & implement complete e-LMIS for timely collection/ reporting on consumption data & distribution of FP commodities at all levels	KIMADIA	MCH Dep. (Bg/KRI) DOHs	**X**	**X**			
	Capacity building of all concerned staff (at all levels) on proper utilisation of e-LMIS for FP commodities			**X**	**X**	**X**	**X**	
	Develop & implement a functional supervisory system to monitor RHCS functions at all levels				**X**	**X**	**X**	**X**

Outcome 2:	***By year 2025, Increased acceptability and voluntary demand of modern FP methods among women / couples of reproductive age, particularly in rural and poor urban zones, and in humanitarian settings***								
Output 2.1:	***Expanded Community-based*** **Out-Reach interventions targeting married women at reproductive age, particularly in poor urban & Rural zones, and in humanitarian settings**								
Strategic Axis	**Major Intervention**	**Main Responsible party**	**Collaborating Partners**	**Time Frame**					
				Y1	**Y2**	**Y3**	**Y4**	**Y5**
Strategic Axis 2.1.1: Integrate FP promotion in outreach interventions of MoLSA & Local NGOs working on women social issues (empowerment, combating GBV, early marriage.)	Develop guidelines, training manuals & didactic materials for Community-based Women Outreach volunteers (CbWOVs) to promote Birth Spacing & FP among married women	MoLSA Local NGOs	MCH Dep.(Bg/KRI), Ir RHFP ass.	**X**		**X**		
	Capacity building of Cb/WOVs (MoLSA's & local NGOs') on promotion of Birth Spacing & FP			**X**	**X**	**X**	**X**	
	Provide regular follow up to Cb-WOVs (MoLSA & local NGOs)				**X**	**X**	**X**	**X**
Strategic Axis 2.1.2 : Support MoLSA & Local NGOs to setup "Women Social Centres" (Safe Spaces) in rural, poor urban zones & in humanitarian settings, and promoting Birth Spacing and utilization of modern FP methods	Develop & review content & didactic materials of "Women Capacity Package" on women empowerment skills, including RH/FP issues, combating GBV, Early Marriage/Pregnancy	MoLSA, Local NGOs	MCH Dep.(Bg / KRI)	**X**		**X**		**X**
	Capacity building & follow up for teams of MoLSA's & local NGOs' social workers / facilitators to deliver the "Women Capacity Package"			**X**	**X**	**X**	**X**	
	Secure operations & monitoring of Women's Social centres in poor urban & rural zones, with effective referral to nearest FP services			**X**	**X**	**X**	**X**	
	Conduct fund mobilisation with local private sector to follow up "Women's Social Centres"				**X**	**X**	**X**	**X**
Strategic Axis 2.1.3: Integrating & Scale up FP promotion into existing MoH Community-based Initiatives (CBIs)	Capacity building & didactic materials for Community-Based Women Outreach volunteers to promote Birth Spacing & modern FP methods among married women in their communities	Health Promotion Dep	MCH Dep.(Bg / KRI) DoHs	**X**		**X**		
	Provide regular follow up to Cb-WOVs	DoHs	Health Prom. Dep..	**X**	**X**	**X**	**X**	
	Set-up operational linkage between Birth / Marriage registries & Cb-WOVs, for outreaching / targeting new mothers & newly married adolescents (<18yrs)	MCH Dep (MoH)	MoLSA, DoHs			**X**	**X**	**X**
Strategic Axis 2.1.4: Promoting & delivering "Pre-marital Education Courses" for "Engaged / Newly married couples" on Birth Spacing/ FP, and other social & RH issues	Develop & review curriculum/ didactic materials for Pre-marital counselling courses	MoYS./ MoCY NGOs	MCH dep (Bg/KRI) MoLSA	**X**		**X**		
	Train & follow up multi-disciplinary team of Master Trainers, & Trainers / animators at governorate & district levels			**X**	**X**	**X**		
	Define & implement promotional strategy for "Pre-Marital Education" courses			**X**		**X**		
	Follow up quarterly sessions of Pre-marital courses at district level			**X**	**X**	**X**	**X**	**X**

Output 2.2:	**Intensified Mass Social Mobilisation interventions, targeting men & women at reproductive age, to create demand for FP services & modern methods, free of coercion & discrimination**								
Strategic Axis	**Major Intervention**	**Main Responsible party**	**Collaborating Partners**	**Time Frame**					
				Y1	**Y2**	**Y3**	**Y4**	**Y5**
Strategic Axis 2.2.1: Engage & follow up religious leaders to positively address Birth Spacing & FP, correct cultural mis-concepts & norms affecting women health.	Develop training & Didactic materials, and map medium/large mosques in targeted governorates	Min. of Religious Affairs	MCH Dep., Media Dep	**X**		**X**		
	Capacity building of Religious Leaders (male & Female) on Birth Spacing, RH/FP issues, as well as combating GBV, early marriage / pregnancy, ……			**X**	**X**	**X**		
	Setup & implement a regular follow-up system for trained Religious leaders				**X**	**X**	**X**	**X**
	Integrate training materials into Pre-service training curricula of Preachers / Imams					**X**		
Strategic Axis 2.2.2: Strengthen Health Edutainment multi-faced media campaign (digital & audio-visual/ printed) to educate public on birth spacing and modern family planning	Conduct Formative research to segment target audience, around concepts of Birth Spacing small family, Early marriage & Adolescent Pregnancy (< 18yrs)	Media Dep.	Univ. Research centres	**X**		**X**		
	Advocating for "Corporate Social Responsibility" with private & public TV channels, and mobilizing TV anchors/ producers to integrate FP messages in existing TV programs	Media Dep.	MCH Dep (Bg/KRI)	**X**	**X**	**X**		
	Mobilizing & networking among celebrities & media/ public figures as "Change Champions" on FP, harmful practices (early marriage/childbearing)	Media Dep.	MCH Dep (Bg/KRI)		**X**	**X**	**X**	
	Follow uping Public Areas Branding (posters, billboards, roundabout, etc.) in main public areas	Media Dep.	MCH Dep (Bg/KRI)		**X**	**X**	**X**	
	Developing "Social Media" mobilization/ awareness raising through multiple online platforms ("Mobile Social Media" – Twitter, Facebook, ……)	Media Dep.	MCH Dep (Bg/KRI)		**X**	**X**	**X**	**X**

ANNEX II: Monitoring Matrix & Indicators (Goal - Outcomes - Output/Strategies)

Results	Indicators	Baseline		Target		
		Value	Source	2025	2030	Source
Goal / Impact	Total Fertility rate	4.2	PMMM-2012	3.5	3.0	Census or Demographic Surveys
	Adolescent Fertility rate / 1000 adolescent girls	70	MICS 6 (2018)	60	50	
	Maternal Mortality	TBD	Census 2021	0.9%/yearly decrease	9%	

Outcomes	Indicators	Baseline		Target 2025	
		Value	Source	Value	Source
Outcome 1: (Availability of FP services	CPR for modern FP methods	28 - 36 %	I-WISH/ MICS 6	> 45%	National Survey
	Satisfied needs for Modern FP methods	53.8 %	MICS 6 (2018)	75 %	National Survey
	Unmet needs for modern FP methods	24.3	I-WISH (2011)	15 %	National Survey
	Un-Intended Pregnancy	24.2 %	I-WISH (2011)	15 %	National Survey
	% of Public sector share as source of FP commodities	15%	I-WISH 2012	> 50%	National Survey
	% of FP SDPs (PHCs & others) that DID NOT witness "Out-of-Stock" of FP commodities during current year	TBD	DoH Annual Reports	80 %	DoH Annual Reports
Outcome 2: Demand of Birth Spacing / Modern FP methods	CPR for Traditional methods	12 – 17%	I-WISH/ MICS6	8 %	National Survey
	Desired Number of Children	4.1	I-WISH 2012	3	National Survey
	Desired Spacing period between children	2.6 yrs	I-WISH 2012	3 yrs	National Survey
	Women (15-19 yrs) became pregnant < 18yrs	12.6 %	MICS 2018	9 %	National Survey
	% of new mothers that do NOT intend to use in future	~ 50%	I-WISH 2012	< 25 %	National Survey
	Women Objecting on FP methods	23 %	I-WISH 2012	12 %	National Survey
	Husbands objecting on FP methods	30 %	I-WISH 2012	20 %	National Survey

Outcome 1:	***By year 2025, Improved availability, accessibility and affordability of Right-based and quality integrated FP services & modern methods, for Iraqi women/couples, particularly in poor urban & rural zones, & in humanitarian settings***					
Output 1.1:	***Strengthened Governance functions (policies, management/ planning/ coordination & monitoring) of Iraq BS/FP Multi-sectoral Programme, at national & governorate levels, to galvanize political & financial commitments, ensure its effective implementation, & guarantee Client-Centered & quality care with expanded choices***					
Strategic Axis	**Indicator**	**Baseline**	**Target**	**Source**	**Periodicity**	**Responsibility**
Strategic Axis 1.1.1: Enhancing existing FP Service Delivery-related policies, regulations, guidelines and financing	Number of FP-related policies / guidelines reviewed to enhance : a) FP service delivery; b) Human resources; c) FP commodities	0	3	MCH Annual report	Annual	MCH section
Strategic Axis 1.1.2: Enhancing planning & management functions & processes, and coordination at national & governorate level	Number of Governorates that formulated "3-year FP Action Plan"	0	18	MCH Annual report	Annual	MCH section
	% implementation of Governorates Yearly action Plan	0	100 %	DOH's annual report	Annual	MCH section
Strategic Axis 1.1.3: Improving Supportive Supervisory & Monitoring system & functions for FP SDPs	% of DOHs that implemented a Quarterly monitoring / supervision plan to all districts and SDPs in their respective areas	0	100%	DOH's annual report	Annual	MCH section, DOHs
Strategic Axis 1.1.4: Ensuring availability of quality statistical & survey data, and In-depth research for advocacy and Evidence-based planning & decision making	# of Quantitative surveys & qualitative research on social determinants for FP demand & use among couples & women	0	1 survey / 4-5 research	MCH Annual Report+ Ministry of planning	4-5 years	MCH section
	% implementation of M&E plans at governorate level	0	100%	DOH's annual report	Annual	MCH section, DoHs

Output 1.2:	***Quality, Right-based and Client-centred FP services fully integrated across all levels of Health Care Systems (1ry & referral), as well as medical services provided by Private sector, and charitable Civil Society Organizations, with priority to rural & poor urban zones, and humanitarian settings***					
Strategic Axis	**Indicator**	**Baseline**	**Target**	**Source**	**Periodicity**	**Responsibility**
Strategic Axis 1.2.1: Integrate FP services & counselling through MCH services (ANC & PNC) in PHC centres, with focus on Rural & Poor urban zones (incl. capacity of health Providers)	% of Main PHCs that offer 3 modern FP methods (including IUD) & FP Counselling / Governorate	TBD	100%	MCH DATA	Annual	MCH Section
	% of Sub-PHCs (managed by doctors) that offer 3 modern FP methods (incl. IUD) / Governorate & FP Counselling / Governorate	TBD	100 %	MCH DATA	Annual	MCH Section
	% of Sub-PHCs (managed by Med. Ass.) that provide "Resupply" of hormonal methods (Pills & Injectable) and condom & offer FP Counselling	TBD	50 %	MCH DATA	Annual	MCH Section
	% of districts hospitals that have "Referral FP services (out-patient clinics)	TBD	50 %	MCH DATA	Annual	MCH Section
Strategy 1.2.2: Integrate Immediate Post-Partum/ Abortion FP services in maternities	% of maternities that offer "Immediate Post-Partum FP counselling & Services	TBD	75 %	MCH DATA	Annual	MCH Section
Strategic Axis 1.2.3: Integrate FP services	% of Public clinics that offer 3 modern FP methods (other than condom)	TBD	75 %	Public clinics	Annual	Pop. Clinics dep

Output 1.2:	***Quality, Right-based and Client-centred FP services fully integrated across all levels of Health Care Systems (1ry & referral), as well as medical services provided by Private sector, and charitable Civil Society Organizations, with priority to rural & poor urban zones, and humanitarian settings***					
Strategic Axis	**Indicator**	**Baseline**	**Target**	**Source**	**Periodicity**	**Responsibility**
in services of Popular Public Clinics	and including IUD resupply			reports		
Strategic Axis 1.2.4: Strengthen partnership with Private sector (clinics, maternities & pharmacies) to increase access & use of quality FP services	# Governorate DOH that established PPP with private clinics & pharmacies	0	12	DoHs report	Annual	IRHFP Assoc. / Pharm. Assoc. / Medical Assoc.
	% of Private clinics & maternities that signed PPP with DoH to promote FP services / governorate	0 %	25 %	DoHs report	Annual	
	% of Private pharmacies that signed PPP with DoH to promote & sell "Social Marketing FP commodities (Pills, Injectable, condoms, ……	0 %	25 %	DoHs report	Annual	
Strategic Axis 1.2.5: Support & follow up local CSOs (that provide medical services) to integrate & provide FP services in underserved rural & poor urban areas	% of CSOs clinics that offers FP services in existing medical services	TBD	> 75 %	DoHs report	Annual	NGOs+MCH Section

Output 1.3:	*Strengthened "Supply Chain" management & functional Logistics Management Information System (LMIS) of FP commodities, including, forecasting & last-mile monitoring to ensure availability & reduce stock outs of modern contraceptives & related equipment*					
Strategic Axis	**Indicators**	**Baseline**	**Target**	**Source**	**Periodicity**	**Responsibility**
Strategic Axis 1.3.1 Ensuring high level national commitment & coordination for RH Commodity Security	# of Meeting of the RHCS High Committee / Year	0	2 / year	Annual FP report	Annual	MCH section. KIMADIA
	# of FP methods approved & included into "Essential Drug List"	6	8			
	# of FP methods procured by KIMADIA	2	8			
Strategic Axis 1.3.2: Strengthen procurement & Supply chain of FP commodities	% of Forecasted Commodities procured by KIMADIA (preferably by each approved FP method)	TBD	100%	Annual FP Report	Annual	Tech. Affairs dep, KIMADIA
Strategic Axis 1.3.3 Strengthen logistics management functions of MOH to ensure contraceptive availability	% of Governorate & districts that have an "Operational LMIS"	0 %	100 %	Annual FP Report Tech. Affairs Report	Annual	Tech. Affairs dep., KIMADIA

Outcome 2:	***By year 2025, Increased acceptability and voluntary demand of modern FP methods among women / couples of reproductive age, particularly in rural and poor urban zones, and in humanitarian settings***					
Output 2.1: *Expanded & intensified community-based* Out-Reach interventions (group or One-to-One) targeting married women at reproductive age,						
Strategic Axis	**Indicators**	**Baseline**	**Target**	**Source**	**Periodicity**	**Responsibility**
Strategic Axis 2.1.1: Integrate FP promotion in outreach interventions of MoLSA & local NGOs working on women social issues (GBV, early marriage)	% of Districts that have One NGO that provide FP Outreach awareness through home visits	0 %	50 %	MoLSA annual report	Annual	MOLSA-Women aff. Dir. / with MoH
	# of women outreached for Birth Spacing/Modern FP methods through home visits	0	TBD	MoLSA annual report	Annual	
Strategic Axis 2.1.2: Support MoLSA & Local NGOs to setup "Women Social Centres" (Safe Spaces) in rural, poor urban zones & in humanitarian settings, and promoting Birth Spacing and utilization of modern FP methods	% of districts where an NGO established a "Women Social Centre" that promote Birth Spacing/ FP in targeted governorates	TBD	50 %	MoLSA annual report	Annual	MOLSA, DOH
	# of women frequenting WSC & informed on FP.	0	TBD	MoLSA / CSOs annual report	Annual	MOLSA, DOH
Strategic Axis 2.1.3: Integrating & Scale up FP promotion into existing MoH Community-based Initiatives (CBIs	% of districts where existing MoH CBIs integrated / included "Birth Spacing / modern FP methods into their respective interventions	TBD	50 %	MCH & CBI annual report	Annual	MCH dep. & CBI sections
Strategic Axis 2.1.4:: Promoting & delivering "Pre-marital Courses" for "Engaged / Newly married couples" on Birth Spacing/FP, & other social & RH issues	% of Districts that offer a "Pre-Marital course" regularly (as needed) (possibly quarterly), in targeted governorates	0	25 %	MoYS / MoLSA / CSOs	Annual	MoYS / MoLSA
	% of newly married couples that attended Pre-marital courses	0	25 %	MoYS / MoLSA / CSOs	Annual	MoYS / MoLSA

Output 2.2: Intensified Mass Social Mobilisation interventions *to create demand for informed & voluntary FP services & modern methods, free of coercion & discrimination*						
Strategic Axis	**Indicator**	**Baseline**	**Target**	**Source**	**Periodicity**	**Responsibility**
Strategic Axis 2.2.1: Engage & support religious leaders to positively address Birth Spacing & FP, cultural mis-concepts & norms affecting women health	% Mosques that deliver "regularly" messages on Birth Spacing in Friday prayers & other religious teaching activities	0	25 %	تقرير ديوان الاوقاف	Annual	ديوان الاوقاف
	% of Districts where at least one mosque is regularly delivering messages on Birth Spacing during prayers & religious teaching activities	0	75 %	تقرير ديوان الاوقاف	Annual	
Strategic Axis 2.2.2: Strengthen Health Edutainment multi-faced media campaign (digital/audio- visual/ printed) to educate public on birth spacing	Estimated Number of people reached with FP messages through Mass media	NA	4 million	Media Dep. report	Annual	Media Dep.
	# of Mass Media channels engaged in FP promotion	NA	3 channels	Media Dep. report	Annual	Media Dep.

Annex 3: Monitoring and Evaluation Plan / Calendar

	Year 2021	Year 2022	Year 2023	Year 2024	Year 2025
Surveys/studies	I-WISH, In-Depth studies on FP determinants	Policy-related research & Policy Brief on FP	In-Depth studies on FP determinants	Policy-related research & Policy Brief on FP	------
Monitoring systems	M&E monitoring framework for Nat. Strategies	Assess & review of data collection system (HIS,LMIS)	Support related databases	Assess & Review M&E framework of Nat. Strategies	Support related databases
Evaluations	------	------	Thematic Mid-Term evaluation		Final evaluation
Reviews	Annual review	Annual review		Annual review	Annual review
Monitoring / Support activities	Regular monitoring field visits with relevant partners	Regular monitoring field visits with relevant partners	Regular monitoring field visits with relevant partners	Regular monitoring field visits with relevant partners	Regular monitoring field visits with relevant partners
	Joint Quarterly meetings with all IPs of each component	Joint Quarterly meetings with all IPs of each component	Joint Quarterly meetings with all IPs of each component	Joint Quarterly meetings with all IPs of each component	Joint Quarterly meetings with all IPs of each component
M&E capacity-building	Result Based M&E capacity building for partners (national & sub-national level)	------	Refreshing sessions on Result Based M&E skills	------	Assessment for capacity building interventions

Annex 4: Reproductive-Related Behavioural Indicators

	TFR	Adol Birth Rate	Women 20-24 yrs married before age		15-19yrs started Rep. life	20-24 yrs had baby <18yrs	Desired # of children	Average Family Size	Intention use FP in Future		Women disapprove	Husband disapprove	# of children at First use of FP
			<15 yrs	<18yrs	MICS 6		(I-WISH)	(I-WISH)	Yes	No			
Nineveh	3.7	88	7.1	31.5	15.6	14.9	4.5	7.0	17.0	51.0	36.0	39.0	2.6
Kirkuk	2.1	27	5.6	18.1	6.3	7.9	4.5	5.0	31.0	32.0	10.0	13.0	1.9
Diala	4.5	79	5.9	32.1	16.9	16.8	4.1	5.6	32.0	56.0	25.0	30.0	3.1
Anbar	2.5	42	2.8	17.3	15.6	9.6	4.8	7.4	21.0	69.0	39.0	47.0	3.0
Baghdad	3.7	85	7.4	27.9	16.8	14.5	3.9	5.6	25.0	41.0	23.0	37.0	2.6
Babel	3.7	77	8.2	30.6	13.3	16.8	4.1	6.8	39.0	56.0	18.0	31.0	2.7
Karbala	4.0	95	12.6	36.8	15.7	9.7	3.5	5.9	20.0	65.0	21.0	30.0	2.0
Waset	4.0	76	7.9	28.7	15.0	15.9	4.2	6.8	23.0	57.0	32.0	32.0	3.2
Salahaddin	2.6	51	8.1	22.7	13.1	22.3	4.9	7.1	30.0	56.0	27.0	29.0	3.1
Najaf	3.9	112	11.6	37.2	17.8	21.4	3.7	6.4	42.0	31.0	10.0	18.0	2.5
Qadissiyah	3.8	89	6.5	25.3	13.2	14.3	3.9	6.9	34.0	56.0	37.0	59.0	2.5
Muthana	5.1	119	4.9	23.2	22.8	8.4	5.0	7.0	30.0	61.0	16.0	17.0	2.9
Dhi Qar	3.8	47	12.1	34.8	7.9	19.4	4.2	6.9	33.0	58.0	52.0	51.0	3.2
Missan	4.9	93	14.8	43.5	9.7	18.6	4.8	6.8	18.0	55.0	30.0	35.0	2.5
Basra	4.2	76	8.7	33.5	14.7	17.5	4.6	6.7	22.0	51.0	10.0	13.0	2.5
South/Central	**3.8**	**77**	**8.2**	**30.1**	**14.1**	**15.7**	**4.2**	**6.3**	**26.0**	**51.0**	**25.0**	**33.0**	**2.7**
Duhok	3.7	32	1.8	8.1	4.5	3.8	4.2	6.7	41.0	39.0	8.0	10.0	3.0
Sulaimaniyah	2.8	22	1.7	13.5	5.7	7.2	3.5	4.9	47.0	47.0	7.0	10.0	2.0
Erbil	3.1	55	3.4	24.0	12.8	8.3	3.4	4.8	29.0	27.0	9.0	16.0	2.8
KRI	**3.1**	**40**	**2.6**	**18.1**	**8.9**	**7.1**	**3.6**	5.2	**38.0**	**36.0**	**8.0**	**12.0**	**2.5**
IRAQ	**3.6**	**70**	**7.2**	**27.9**	**13.2**	**14.1**	**4.1**	**6.1**	**28.0**	**49.0**	**23.0**	**30.0**	**2.6**

Annex 5: Contraceptive Prevalence Rate & Source of FP Methods

	CPR - All Methods		CPR - Modern methods		Unmet Needs	% satisfied Need for Modern FP	Source of FP methods							
	MICS-6	I-WISH	MICS-6	I-WISH	I-WISH		PHC	Gov. Hosp	Pub. Clinic	**Total Pub**	Priv. Clinic	Pharmacy	NGOs	Other
Nineveh	44.5	34.4	35.1	17.3	24.1	55.5	8.0	7.5	0.0	15.5	76.8	6.3	1.1	0.3
Kirkuk	51.3	26.3	36.5	17.8	33.7	59.2	18.3	7.1	0.0	25.4	56.2	16.3	0.0	2.1
Diala	51.7	42.6	36.0	29.6	20.4	55.2	1.9	3.5	0.7	6.1	43.6	38.4	3.2	8.7
Anbar	57.7	38.2	42.2	32.1	21.4	62.5	1.0	1.1	1.3	3.4	69.6	24.0	0.5	2.5
Baghdad	54.9	38.8	41.2	27.4	25.5	60.0	7.4	7.3	4.5	19.2	45.5	29.6	4.4	1.3
Babel	47.5	37.1	37.8	35.7	29.6	59.3	4.0	13.0	0.7	17.7	47.8	12.9	4.9	16.7
Karbala	56.1	45.6	42.6	33.0	24.7	61.8	8.5	7.2	0.0	15.7	49.6	18.5	4.0	12.2
Waset	52.7	28.8	41.1	24.3	25.8	62.9	1.2	7.6	0.0	8.8	64.2	24.1	0.0	2.9
Salahaddin	51.5	27.3	32.4	25.0	29.9	52.1	1.9	11.8	0.2	13.9	46.1	32.1	1.9	6.0
Najaf	48.0	48.4	36.1	32.7	18.3	56.4	0.0	12.7	0.0	12.7	25.7	47.4	10.4	3.8
Qadissiyah	45.4	47.0	34.5	34.8	21.1	53.5	2.8	9.6	0.0	12.4	23.7	50.3	11.7	1.9
Muthana	45.0	36.9	42.5	35.5	31.2	61.3	2.5	15.2	0.0	17.7	13.3	66.4	2.4	0.2
Dhi Qar	42.5	41.1	34.5	40.7	30.0	54.6	3.0	8.2	1.0	12.2	43.4	40.9	0.7	2.8
Missan	41.6	39.5	41.6	28.1	22.9	66.8	2.7	7.7	0.0	10.4	8.4	79.6	0.0	1.6
Basra	49.5	35.9	39.3	28.9	25.2	58.4	8.9	9.8	0.0	18.7	28.7	43.1	4.0	5.5
South/Central	**49.9**	**37.6**	**38.4**	**27.5**	**25.5**	**58.5**	**5.2**	**8.4**	**1.3**	**14.9**	**44.3**	**32.6**	**3.6**	**4.6**
Duhok	56.9	49.3	27.6	25.1	19.3	41.2	4.5	11.6	2.4	18.5	41.9	28.1	1.3	10.2
Sulaymaniyah	73.3	57.5	25.3	27.6	18.6	31.1	0.4	2.4	3.0	5.8	49.2	38.1	0.9	6.0
Erbil	66.0	50.8	24.9	28.9	19.9	34.1	1.6	7.4	7.9	16.9	36.4	31.1	0.9	14.7
KRI	**66.6**	**53.2**	**25.6**	**28.4**	**19.2**	**34.3**	**1.7**	**6.2**	**4.7**	**12.6**	**42.8**	**33.4**	**1.0**	**10.2**
IRAQ	**52.8**	**39.8**	**36.1**	**28.3**	**24.7**	**53.8**	**4.7**	**8.1**	**1.8**	**14.6**	**44.1**	**32.7**	**3.3**	**5.3**
			incl. LAM											

Annex 6: Skilled Birth Assistance / Post-Natal Care National Surveys (MICS 6 / 2018 & I-WISH / 2011)

	% Delivery in Hospital			% Delivered by			% C-Section (MICS 6)			% C-S IWISH	% Post Natal Care		% Abortion/ Miscarriage (I-WISH)
	Pub. Hosp.	Priv. Hosp	Total	Doctor	Nurse / Midwife	Qualified staff	Elective	Emerg.	Total		MICS 6	I-WISH	
Nineveh	77	7	84	64	28	92	13	11	24	15	21	29	28
Kirkuk	88	2	90	84	11	95	24	10	34	12	35	18	11
Diala	76	9	85	80	18	98	22	15	37	26	14	26	22
Anbar	69	7	76	66	26	91	15	7	22	19	14	41	32
Baghdad	63	20	83	80	17	97	29	9	38	29	26	44	19
Babel	82	6	88	75	19	94	19	11	30	27	15	57	33
Karbala	70	16	87	77	18	95	23	9	32	29	12	48	38
Waset	79	2	81	74	16	89	25	11	35	19	14	21	23
Salahaddin	63	13	76	74	14	88	22	12	34	26	22	50	16
Najaf	80	16	96	90	9	99	24	11	35	28	26	49	24
Qadissiyah	75	19	94	80	17	97	31	9	39	34	7	29	33
Muthana	94	1	95	94	3	97	19	5	24	23	6	38	33
Dhi Qar	79	7	86	48	46	95	21	6	27	20	6	29	25
Missan	75	4	80	70	25	95	16	8	24	13	6	23	20
Basra	85	4	89	46	52	97	18	8	25	10	15	30	23
South/Central	**76**	**10**	**86**	**72**	**24**	**95**	**21**	**10**	**31**	**22**	**17**	**37**	**24**
Duhok	90	8	98	92	7	98	16	18	35	25	18	39	37
Sulaymaniya	69	26	95	95	4	98	33	13	46	26	27	46	29
Erbil	57	29	86	86	11	98	33	16	49	28	41	53	22
KRI	**68**	**23**	**91**	**90**	**8**	**98**	**29**	**16**	**45**	**26**	**32**	**47**	**28**
IRAQ	**74**	**12**	**87**	**75**	**21**	**96**	**23**	**11**	**33**	**23**	**20**	**38**	**25**

Annex 7: Iraq Health Network (as per "2019 - Annual Statistical Report" – Ministry of Health)

	# Health sectors	Main PHC	Sub-PHC	All PHCs	PHC offering FP	% PHC offering FP		PHCs run by			% Run by doctors		Fam. Med. Clinics	Pub. Clinics	Training Health Center	Health Houses	General hospitals
						Main PHCs	All PHCs	Doctors	Para med	Total	Main PHC	All PHCs					
Nineveh	11	93	89	182	13	14%	7 %	120	62	182	129 %	66 %	10	24	1	36	10
Kirkuk	6	65	66	131	45	69%	34 %	68	63	131	105 %	52 %	6	25	1	8	6
Diala	7	62	40	102	48	77%	47 %	64	38	102	103 %	63 %	6	7	1	13	7
Anbar	12	79	103	182	35	44%	19 %	79	103	182	100 %	43 %	2	14	1	85	10
Baghdad	20	213	52	265	161	76%	61 %	237	28	265	111 %	89 %	31	62	10	45	19
Babel	5	48	73	121	33	69%	27 %	59	62	121	123 %	49 %	6	21	1	61	10
Karbala	4	34	28	62	33	97%	53 %	38	24	62	112 %	61 %	8	17	1	20	4
Waset	6	47	31	78	48	102%	62 %	16	62	78	34 %	21 %	3	12	1	38	6
Salahaddin	10	62	65	127	10	16%	8 %	47	80	127	76 %	37 %	1	15	1	30	9
Najaf	6	53	32	85	46	87%	54 %	27	58	85	51 %	32 %	14	14	2	45	7
Qadissiyah	5	42	42	84	42	100%	50 %	43	41	84	102 %	51 %	4	8	1	57	4
Muthana	5	30	40	70	10	33%	14 %	0	70	70	0 %	0 %	4	9	1	6	4
Dhi Qar	9	81	86	167	31	38%	19 %	47	120	167	58 %	28 %	1	28	1	58	6
Missan	4	34	45	79	27	79%	34 %	28	51	79	82 %	35 %	3	13	1	9	6
Basra	10	110	33	143	76	69%	53 %	64	79	143	58 %	45 %	10	28	1	22	11
South/Central	**120**	**1,053**	**825**	**1,878**	**658**	**62%**	**35 %**	**937**	**941**	**1,878**	**89%**	50 %	**109**	**297**	**25**	**533**	**119**
Duhok	7	87	79	166	59	68%	36 %	87	79	166	100 %	52 %	3	18	0	N/A	6
Sulaymaniya	11	115	377	492	2	2%	0.4 %	65	427	492	57 %	13 %	1	29	1	N/A	23
Erbil	7	98	174	272	19	19%	7%	92	180	272	94 %	34 %	4	N/A	1	N/A	14
KRI	**25**	**300**	**630**	**930**	**80**	**27%**	**9%**	**244**	**686**	**930**	**81 %**	**26 %**	**8**	**47**	**2**	N/A	**43**
IRAQ	**145**	**1,353**	**1,455**	**2,808**	**738**	**54.5%**	**26 %**	**1,181**	**1,627**	**2,808**	**87 %**	**42 %**	**117**	**344**	**27**	**533**	**162**
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N/A **Not Available**

Annex 8: Skilled Birth Assistance (as per "20219 - Annual Statistical Report" – Ministry of Health)

	Deliveries 2019											Caesarean Section (CS)			
	Total De-liveries	Public Hosp	%	Private Hosp	%	PHC centre		Non-Heath inst		Inst. De-liveries	% Inst. Deliveries	Total CS	% CS	% Pub hospital	% Private hospitals
Nineveh	83,924	49,100	59%	3,222	4%	556	0.7%	31,046	37%	52,878	63.0%	14,361	17%	22%	99%
Kirkuk	38,778	30,878	80%	2,113	5%	463	1.2%	5,324	14%	33,454	86.3%	13,786	36%	37%	100%
Diala	43,170	31,569	73%	2,141	5%	677	1.6%	8,783	20%	34,387	79.7%	15,775	37%	42%	100%
Anbar	46,688	34,525	74%	1,516	3%	274	0.6%	10,373	22%	36,315	77.8%	13,338	29%	42%	100%
Baghdad	216,824	119,237	55%	69,049	32%	1,109	0.5%	27,429	13%	189,395	87.3%	110,294	51%	41%	88%
Babel	59,439	47,402	80%	7,152	12%	0	0.0%	4,885	8%	54,554	91.8%	24,871	42%	37%	100%
Karbala	41,978	28,212	67%	9,542	23%	0	0.0%	4,224	10%	37,754	89.9%	15,474	37%	26%	87%
Waset	40,491	30,902	76%	1,147	3%	219	0.5%	8,223	20%	32,268	79.7%	14,410	36%	43%	99%
Salahaddin	38,825	19,452	50%	1,507	4%	200	0.5%	17,666	46%	21,159	54.5%	8,153	21%	34%	98%
Najaf	47,923	42,870	89%	4,731	10%	106	0.2%	216	0%	47,707	99.5%	20,601	43%	38%	95%
Qadissiyah	34,984	21,156	60%	9,851	28%	91	0.3%	3,886	11%	31,098	88.9%	17,866	51%	38%	99%
Muthana	26,582	24,791	93%	615	2%	0	0.0%	1,176	4%	25,406	95.6%	9,052	34%	34%	85%
Dhi Qar	59,731	37,038	62%	6,756	11%	4,308	7.2%	11,629	19%	48,102	80.5%	17,739	30%	27%	98%
Missan	35,218	27,500	78%	336	1%	64	0.2%	7,318	21%	27,900	79.2%	6,064	17%	21%	66%
Basra	95,050	79,569	84%	6,522	7%	1,466	1.5%	7,493	8%	87,557	92.1%	26,696	28%	29%	46%
South/Central	**909,605**	**624,201**	**69%**	**126,200**	**14%**	**9,533**	**1.0%**	**149,671**	**16%**	**759,934**	**83.5%**	**328,480**	**36%**	**34%**	**89%**
Duhok	42,332	22,888	54%	12,457	29%	1,652	3.9%	5,335	13%	36,997	87.4%	10,984	26%	30%	--
Sulaymaniya	39,999	29,653	74%	5,814	15%	0	0.0%	4,532	11%	35,467	88.7%	9,564	24%	20%	92%
Erbil	57,345	29,204	51%	20,724	36%	40	0.1%	7,377	13%	49,968	87.1%	28,341	49%	31%	76%
KRI	**139,676**	**81,745**	**59%**	**38,995**	**28%**	**1,692**	**1.2%**	**17,244**	**12%**	**122,432**	**87.7%**	**48,889**	**35%**	**--**	**--**
IRAQ	**1,049,281**	**705,946**	**67%**	**165,195**	**16%**	**11,225**	**1.1%**	**166,915**	**16%**	**882,366**	**84.1%**	**377,369**	**36%**	**33%**	**92%**
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LIST OF PARTICIPANTS

Review to add participants of Workshop in Erbil Workshop (18th - 20th Feb. 2020), as well as KRI participants		
≠	Names	Job Location
1	Dr. Faris Hasan Al-Lami	DG of Public Health Directorate
2	Dr. Raghad Abdul-Ridha	PHC Department/ Public Health Directorate
3	Dr. Majida Kareem Ahmed	MCH section/ Public Health Directorate
4	Dr. Lujain Kadhim Muhammed	MCH section/ Public Health Directorate
5	Dr. Enaam Hassoon Jawad	MCH section/ Public Health Directorate
6	Dr. Rajiha Khaleel Ibraheem	MCH section/ Public Health Directorate
7	Dr. Tayseer Salah Ghaffoori	MCH section/ Public Health Directorate
8	Dr. Thanaa Hussein Salih	School Health section/ youth health manager/ Pub. Health Directorate
9	Dr. Enas Taha Al- Hamadany	IRHFPA
10	Dr. Taghreed Khaleel Al-Haidary	Al-Kindy Medical College/ MOHE
11	Abbas Mudhaffar Faris	Planning & Resources Development Directorate
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19	Pharmacist Sahar Tariq	Need Assessment Department/ Technical Affairs Directorates
20	Pharmacist Rand Ryadh Hasan	KIMADIA
21	Pharmacist Wijdan Hussein Sabah	KIMADIA
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23	Dr. Jaafar Alaa Habeeb	IHAO NGO
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27	Dr. Rafah Yasen Hasan	MCH unit/ Al-Najaf DOH
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30	Fauze Ahmed Muhammed Salih	Ministry of Planning
31	Zainab Ali Hussein	Ministry of Planning
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33	Dr. Hala Abdul Wahab Muhammed	Technical Affairs Directorate
34	Haneen Akram Habeeb	Ministry of Education
35	Rafid Atya Abdul Jabbar	Diwan Al-Waqf Al sinni
36	Farqad Hussein Al-Saady	Diwan Al-Waqf Al Shiei
37	Pharmacist Haider Abdul Ameer	Pharmacy Department/ Technical Affairs Directorate
38	Pharmacist Atheer Adil Murtadha	KIMADIA
39	Dr.Ashwaq Talib Judi	MCH section / Public Health Directorate
40	Dr.Ibtisam Faraj Hssan	MCH section / Public Health Directorate
41	Dr. Battol Ali Ghalib	Baghdad Medical College/ MOHE
42	Dr.Alaa Abide Algani	MCH unit/ Nineveh DOH
43	Dr.Muhammed Hashim	Planning & Resources Development Directorate/ MOH
44	Dr.Muhammed Talib	Technical Affairs Directorates
45	Dr.Sara Kamel Zaidan	IRHFPA
46	Dr.Naima Muhssin Ali	MOH
47	Dr.Atiaf Hassan	IRHFPA

48	Susan Abid Alrazaq	Ministry of Planning
50	Dr.Hajeh Hoshyar Muhammed	Ministry of Health / Kurdistan
51	Dr.Uaz Aziz Saeed	Ministry of Health / Kurdistan
52	Dr.Chemin Taha Yassin	Ministry of Health / Kurdistan
53	Dr.Naela Nariman	Ministry of Health / Kurdistan
54	Dr. Diyar Ibrahim	Ministry of Health / Kurdistan
55	Dr.Ghada Saadalah	Ministry of Health / Kurdistan
56	Dr.Brevian Adnan	Ministry of Health / Kurdistan
57	Dr.Luma Hazim	Ministry of Health / Kurdistan
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