

Community Health

Policy and Implementation Landscape Mapping in the Middle East and North Africa Region 2024

Iraq Country Brief





1. Community health in Iraq

						
Community health policy in place	Community health workers recognized as part of the national health workforce	Total number of community health workers currently deployed	Formal linkages between community health and other sectors	Inclusion of community health workers in emergency preparedness plans	Domestic funding available	Community engagement mechanisms in place
No	No	No	No	No	No	No

1.1 Country context

The Republic of Iraq, located in the Middle East, boasts a total population of 43 million.¹ The Federal Republic is divided into 18 governorates each made up of a number of districts, sub-districts, and villages and recognizes one autonomous region (Kurdistan).² Having faced significant turmoil in the past decades that created a complex socio-political landscape shaped by conflict, political instability and economic challenges, the country is now at a pivotal point in its development history with numerous challenges and opportunities ahead.³

The Ministry of Health (MoH) oversees the public health care system, which has shifted towards the provision of essential services through a network of primary health care centres (PHCCs), each serving a population of about 10,000-45,000 individuals. Many of the services provided are curative, though fragmented intergovernmental coordination and budgetary constraints hinder systematic progress. The country further grapples with a shortage of qualified health workers and medical supplies, inefficiencies and poorly maintained health facilities which impede access to universal quality health care. As the country transitions from an emergency to development setting, the government of Iraq, in collaboration with international organizations, is seeking ways to rebuild and improve health care services for the population as a whole.⁴

1 United Nations (UN) (2024). World Population Prospects. Population Growth. Retrieved from <https://ourworldindata.org/population-growth#explore-data-poverty>

2 European Union Agency for Asylum (EUAA) (2022). Country guidance: Iraq. Retrieved from https://euaa.europa.eu/sites/default/files/publications/2022-06/2022_06_Country_Guidance_Iraq.pdf

3 World Bank (2022). Iraq: An Overview. Retrieved from <https://www.worldbank.org/en/country/iraq/overview>

4 WHO (2019). Comprehensive assessment of Iraq's health information system 2019. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020. Licence: CC BY-NC-SA 3.0 IGO.

1.2 Overview of community health

An overarching community health policy or strategy at the national level is lacking and community health workers (CHWs) are not part of the formal national health workforce in the country. Vertical programmes and initiatives on community health are carried out by international institutions and NGOs, especially in (former) camps for internally displaced persons (IDP) or refugees. CHWs are recruited in the context of these programmes but are not officially linked to the national health system. The MoH employs male and female health promoters who primarily operate at the PHCC level. They are not based in communities but do, however, conduct scattered community outreach on an ad hoc basis.



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2. Health systems pillars

2.1 Governance and accountability

- A community health policy or strategy and national system that supports effective functioning of community health programmes does not exist, but community health-related concepts are mentioned in the National Health Policy 2014-2023 and the Basic Health Services Package (BHSP) (2010).
- The BHSP mentions plans for community health houses staffed by male and female CHWs. It also mentions that CHWs will provide information, education and communication activities, distribute contraception, micronutrient supplementation, growth monitoring and immunization support. These plans have not been operationalized for various reasons, including security concerns and COVID-19.
- Health promoters within the Health Promotion Department of the Ministry of Health are part of the PHC system and conduct some community work. CHWs hired by international organizations work closely with or sometimes within PHCCs.
- There is limited engagement of other ministries (e.g. education, youth) in current work conducted by health promoters in communities.
- International organizations working on community health have their own strategies. They do need approval from MoH before working in the field and receive reporting templates to be filled in and sent to MoH on a monthly basis.

2.1.1 Community engagement

- Some community health engagement occurs through health committees at the PHC level, which include participation of religious and community leaders. Effectiveness of these depend on the commitment of committee members and PHC managers. While some committees are able to successfully engage communities, others are less successful. Vertical community health programmes initiated by international organizations use various mechanisms (e.g., regular meetings, trainings) to engage communities in their work. The types of mechanisms differ by organization and are not streamlined by the government.
- Participation in decision-making varies; some units within MoH include health promoters whilst NGOs usually do not.



2.2 Health management information systems

- The Health and Vital Statistics Department is in charge of the national information system (WHO, 2019). The platform currently used is DHIS-2, which is under expansion to other areas such as nutrition, maternal and newborn child health, and HIV.
- Data at PHCC level is collected by health promoters, which is then transferred to the district level, Directorate of Health and MoH. Community level data carried out by health promoters are analysed and used for decision-making.
- All community health data are not entered into DHIS-2 and indicators differ across programmes and interventions. Data collection is hindered by a lack of supplies, such as laptops, at the PHCC level.
- Data from NGO CHWs is not systematically shared with MoH and not included in HMIS. Granularity of the data shared differs between organizations. Some share detailed information whereas others do not report or only provide limited information.

2.3 Medicines and health commodities

- A national standard list of supplies for use by CHWs does not exist.
- CHWs employed by international organizations receive the needed medicines and health commodities from the respective organizations they work for.

2.4 Health workforce

- Types of workers who conduct community health-related activities:
 - *Health promoters* working for the Health Promotion unit at the MoH. Although they perform community outreach and link communities to PHCCs, they differ from CHWs in that community work is not their main role and is only conducted in an ad hoc manner. They are also not based in their own communities per se and operate mainly at the PHCCs. There are currently 3,000 health promoters in the country.
 - *CHWs* hired by NGOs and international organizations for short-term projects, especially within IDP and refugee camps. Different types of CHW cadres are defined and employed, including CHWs, junior CHWs, community health volunteers (e.g. during COVID-19) and community mental health workers. These are not formally part of the national health workforce. They define their own selection criteria and roles and responsibilities for CHWs which varies depending on the programme. Some of these efforts were integrated with primary health care services, but with closing of the camps much of this work has ceased.
 - *Community Health Volunteers* (e.g. university students or community members) provide short-term support to community health initiatives conducted by the MoH. These are not formally integrated into the system and only for ad-hoc situations, such as during emergencies. They are trained and receive incentives rather than salaries.
- Collaborations between MoH health promoters, PHCCs and NGOs have supported short-term community health initiatives, but the sustainability of these have been a concern.
- Supervisory visits are conducted by MoH staff to assess the performance of the health promoters.

2.5 Service delivery

- There is no comprehensive package of services delivered at community level and no specific method to measure quality of care.
- Health promoters engage with communities to raise awareness about health issues, promote healthy behaviours, and educate people on disease prevention. They actively promote vaccination, maternal and child health, nutrition, hygiene, and other public health priorities. They serve as a link between the community and the PHCCs. They identify individuals who need care and refer them to appropriate services. They also assist in delivering basic services, such as immunizations, health screenings, and distributing health supplies. Their work is based on emerging needs, not on a specific package of health messages.
- International organizations contribute through implementation of vertical programmes at community level based on the priorities they set. Their community health programmes include health education and connecting community members with services on gender-based violence, child protection and mental health and psychosocial support.
- Mobile clinic outreach services in- and outside camps are provided by a variety of organizations (e.g. WHO, UNICEF, MSF, Iraqi Red Crescent Society, Premiere Urgence Internationale, etc.). Much of this work has stopped due to the closing of the camps.

2.6 Partnerships and financing

- There is no specific national budget for community health, but the health promotion department at the MoH does have its own budget and the government does fund some trainings and initiatives on community outreach organized by the different units.
- There is limited to no involvement of the private sector in community health, but increased interest has been voiced to the MoH.
- The main external funders include(d) INGOs and UN agencies (through donor support). The type of support include(d) the provision of supplies, training and capacity building, and CHW remuneration.

2.7 Cross cutting issues

2.7.1 Emergency preparedness

- In terms of emergency preparedness, there is no formal integration of community health at national level. That stated, community health volunteers are sometimes engaged by the MoH during emergencies to provide relevant services at community level.

2.7.2 Refugees and Internally Displaced Persons (IDPs)

- The majority of community level work has occurred in the context of refugee and IDP services. CHWs were employed by NGOs to provide community-level services in former camps.
- Refugee/IDP communities were able to access services not only within the camps (while these were in operation), but also outside of the camps, if emergency care was needed.

Insight: Community health in camps

- Efforts by international organizations (e.g. NGOs, UN agencies) have focused on vertical community health programmes in camps for IDPs and refugees, primarily by employing CHWs. There was a preference for employing female CHWs in camps, with many being IDPs or refugees with medical backgrounds. These workers received pre-service training to provide the services targeted by the organization. In all cases, approval from the Ministry of Health was needed prior to engaging in communities. After approval was granted, the Ministry of Health sometimes provided support in terms of guidelines and training and disseminated reporting templates. Stakeholders noted a need for improved communication skills and refresher courses for those working in communities in order to strengthen persuasive preventive health messaging.
- Referrals in camps were often conducted by medical mobile clinics staffed by various health care professionals. Patients were referred to clinics/hospitals set-up by the international organization or in specialized cases, to government facilities. Specific forms were reportedly used by each organization to manage the referral process. Major funders of community health-related activities included national and international NGOs, UN agencies, and bilateral/multilateral donors like International Medical Corps, Health Alliance International, Iraqi Red Crescent Society, World Health Organization and UNICEF. With the closure of camps, the roles of CHWs have diminished, as their work was primarily linked to these temporary settlements. While CHWs played a crucial role in camp-based community health services, the discontinuation of these services with camp closures highlights the need for sustainable, long-term community health strategies.



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3. Conclusions

3.1 Challenges

- Budget constraints make it difficult to set-up formal community health mechanisms and introduce a new cadre of paid community health workers.
- There is insufficient cross-sectoral awareness on the necessity and benefits of community health in Iraq.
- Recent and/or current community health programmes are dependent on external aid, leading to poor sustainability of health service provision.

3.2 Enablers

- There is political willingness to create a community health unit and start formalizing community health.
- The role of some primary health care workers, such as PHCC staff or health promoters could be expanded or strengthened to better cover community health-related activities (e.g. as supervisors or trainers).
- Recent developments have made the environment safer and more enabling for the establishment and expansion of community health.

3.3 Priority policy directions

- Establish a multi-sectoral committee that will be in charge of strengthening community health and develop a national community health policy. The committee could also be charged with the development of CHW job descriptions, roles and responsibilities, training curricula, monitoring field work, among others. Ensure buy-in from the Ministry of Finance by including them in the multi-sectoral committee.
- Update the Public Health Law so that it is aligned with the new proposed community health programme.
- To ensure sustainability of the proposed community health programme and successful implementation of the policy, the policy should be accompanied by a costed plan so that a sustainable system can be set-up, including fair wages, regular training and supervision.
- Given the existing financial constraints, existing knowledge and experience should be built upon and used in the development of a formal community health. This should include finding best ways to engage existing health promoters and available PHCC staff in training and/or supervising CHWs, engaging other government ministries (e.g. Ministry of Education and the Ministry of Youth), in the set-up of a community health.
- Facilitate knowledge exchange sessions and/or a mission abroad to learn from best practices and lessons learned on community health in neighbouring countries.

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