A Pilot of Health Interventions to Support Durable Solutions in Iraq

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In this paper, IOM Iraq describes the purpose, design, challenges and lessons of a health intervention pilot in support of Durable Solutions for internally displaced populations in Iraq. Based on this experience, IOM offers reflections on the convergence of humanitarian, development, and peacebuilding perspectives and solutions in durable solutions health programming.

Internally Displaced Persons in Iraq

Close to 5 million internally displaced persons (IDPs) in Iraq have returned to their areas of origin since 2015. As of 2021, only 28 per cent of those areas provide adequate services or facilities to their inhabitants. Approximately 60 per cent of returnees – IDPs who have returned to their area of origin – live in locations where health services are insufficient or inadequate.[1]
Without reliable, high-quality health care returnees and IDPs cannot remain safely and sustainably – let alone thrive – in areas of return or resettlement. With its mission to partner with government and civil society actors to promote the health of migrants and provide emergency health assistance to crisis-affected populations (including IDPs, returnees and host communities), IOM Iraq's Migration Health Division (MHD) expanded its work to contribute to the achievement of durable solutions health objectives for IDPs in Iraq.

Background: Health and Durable Solutions

A durable solution is achieved when IDPs no longer have specific assistance and protection needs that are linked to their displacement.[2] According to the Inter-Agency Standing Committee Framework on Durable Solutions for Internally Displaced Persons,[3] securing a truly durable solution "is often a long-term process of gradually diminishing displacement-specific needs, while ensuring that IDPs enjoy their rights without discrimination related to their displacement." It is, therefore, a complex process that presents human rights challenges, humanitarian challenges, development challenges and peacebuilding or reconstruction challenges.[4]

Unlike development interventions, most of which aim to reach a whole population or country, or humanitarian interventions, which typically focus on life-saving and essential needs for specific vulnerable groups or populations, durable solutions interventions seek to address a wide array of needs for targeted groups (IDPs and returnees) in a broader context. Interventions that are too broad may not address the unique circumstances and needs of IDPs or returnees, while interventions that only target IDPs or returnees miss the opportunity to address the overlapping needs of host community members and could be destabilizing as a result.

Iraq is one of 16 countries where United Nations agencies and partner organizations are piloting the Inter-Agency Standing Committee's Durable Solutions Strategic and Operational Framework.[5] Equitable access to basic services, including health services, is the fourth of eight strategic objectives in Iraq's country-specific durable solutions strategic and operational framework.[6] Activities under this objective focus on restoring and enhancing services through a combination of short- and long-term interventions that include infrastructure rehabilitation, technical assistance and strengthening local and national capacity.

[1] Resolving Internal Displacement in Iraq: Inter-Agency Durable Solutions Strategic and Operational Framework, June 2021, page 18.
[2] www.un.org/internal-displacement-panel/sites/www.un.org.internal-displacement-panel/files/durable-solutions-ferris_1_apr_2021.pdf
[3] IASC Framework on Durable Solutions for Internally Displaced Persons, April 2010
[4] IASC Framework on Durable Solutions for Internally Displaced Persons, April 2010
[5] Durable Solutions for Internally Displaced Persons: Project on Internal Displacement, IASC, April 2010
[6] Resolving Internal Displacement in Iraq: Inter-Agency Durable Solutions Strategic and Operational Framework, June 2021

Pilot Goals and Design

To improve access to health services for IDPs who remained displaced due to the Islamic State of Iraq and the Levant (ISIL) crisis and for returnees in their areas of origin, IOM set three objectives to guide intervention design and implementation in collaboration with the directorates of health (DoH) in four governorates.

1. Restore primary health-care services;
2. Bolster the capacity of Iraq's DoH to effectively manage health services;
3. Improve health literacy among IDPs, returnees and host community members through health promotion and outreach activities.

For each objective, IOM's goal was to support reactivation of Ministry of Health (MoH) services that had been disrupted by the conflict with ISIL and resulting displacement.

Community Selection

In 2022, IOM MHD ("IOM" from here forward) identified communities for intervention based on three key inputs: vulnerability analysis using Displacement Tracking Matrix datasets and other relevant sources, field assessment findings and community consultations. Communities with the following indicators and conditions were more likely to be selected: high numbers of actual/anticipated returnees and/or IDPs; significant damage to public infrastructure and private homes/shelters; barriers to livelihood opportunities; scarcity of water and electricity; absence of actors providing recovery and stabilization services; high concentration of vulnerable groups, such as female-headed households; and expressed health needs. Based on these criteria as well as on operational capacity and feasibility, IOM selected six communities for health interventions.

Objective 1: Restore primary health-care services

Inefficient health workforce distribution is a major obstacle to ensuring everyone in Iraq benefits from the national health system's essential package of health services. Lack of female health-care workers (HCWs) exacerbates this problem, making it more difficult for women to access health services – especially maternal, child and reproductive health care (see Box 1).

IOM worked with DoH to increase the availability of general practitioners, obstetricians/gynecologists, pediatricians and lab assistants to provide essential health services. Efforts included reviewing the HCW distribution, identifying areas with a surplus of nurses and redeploying some nurses to areas with insufficient HCW coverage to meet the need for basic health services such as (leishmaniasis treatment; see Box 2). Decisions about which gaps to prioritize at each location were informed by health facility needs assessments and discussions with the DoH.

In locations where DoH determined that it was not feasible to assign specialists permanently, IOM and DoH agreed to fund their deployment for a three-month period. During that time, these physicians provided on-the-job training to general practitioners on key topics such as the national guidelines for managing childhood illnesses and noncommunicable diseases in collaboration with DoH focal points for each program.

Where there was a lack of female HCWs, IOM supported the hiring and compensation of female HCWs for the first three months, after which period the DoH would retain these positions. Recognizing the MoH's responsibility for health workforce distribution and oversight, IOM and the DoH advocated with the MoH to ensure staffing needs continue being met after the project. As of April 2023, the DoH had retained all HCWs hired with IOM's support through the pilot.

health care. Given the power of social determinants of health to influence health outcomes, it is critical for health-care providers to consider patients' environment and lived experiences in order to intervene successfully. This is true for all people who present for care, including returnees and IDPs. Box 3 describes how IOM trained HCWs working on person centred care.

In addition to delivering technical and financial support for HCW hiring and allocation, IOM trained HCWs on person centred In locations that needed it, minor rehabilitation to primary health-care infrastructure such as (latrines, ramps, pharmacy) was completed to improve accessibility for persons with disabilities, older adults and other vulnerable groups, thereby contributing to a health-care system that is safer and more welcoming to all. In accordance with national guidelines, IOM also provided essential medical equipment and commodities that were not available, worked with the MoH to improve distribution of medications and supplies, and trained HCWs on pharmaceutical management practices.

Box 1: Reinitiating Maternal and Child Health Care

The need: The ISIL crisis disrupted maternal and child care (MCC) services in many communities, including Baaj and Hathra.
The intervention: In collaboration with the DoH, IOM supported the restoration of MCH services in two primary health-care facilities in Baaj and Hathra. The DoH, IOM and health facility staff reviewed MoH guidelines for MCC and created an incremental approach to restoring those services, including assigning dedicated staff to MCC service delivery and procuring necessary supplies and equipment such as (ultrasound machines and essential commodities). Health promoters organized outreach visits to inform communities of the available services and encourage their uptake. Recognizing that lack of referral services contributed to a significant number of pregnancy-related complications and deaths, IOM supported the servicing and maintenance of two ambulances.
The longer-term impact: MCC services are available, and ambulances will continue to be available 24/7 to transport women and children to Mosul Hospital for advanced care.

Objective 2: Bolster the capacity of the DoH to effectively manage health services

Regular supervision of primary health-care centres by DoH personnel is mandatory; however, supervisory visits had become irregular, thereby limiting DoH oversight and the health centre's accountability. To address this gap, IOM and the DoH conducted 21 joint supervisory visits using the MoH's standard tools and checklists to monitor performance, identify areas requiring remediation, provide on-the-job-support to HCWs, and advocate for action to address systemic challenges affecting health-care quality.

As Iraq resumed HCW professional development activities disrupted by the COVID-19 pandemic, and looked to address the high HCW turnover that resulted from the pandemic, investing in capacity-building for all cadres of health professionals was needed. In addition to the trainings supported by IOM, and at the request of the DoH, training rooms were rehabilitated and equipped in Baghdad and Ninewa (Hathar Primary Health Care Centre) to enable the DoH to conduct trainings in-house.

Box 2: Restarting Leishmaniasis Treatment in Baaj and Hathra

The need: Cutaneous leishmaniasis, a parasitic disease transmitted by sandflies, causes skin lesions that can result in life-long scars, disfiguration and social stigma. People living in Baaj and Hathra did not have access to treatment due to the lack of skilled HCWs and medication.
The intervention: IOM worked with the DoH to establish leishmaniasis services by sending physicians from Baaj and Hathra to Mosul for training and certification; reallocating nurses either from within their current health facility or between health facilities to support service delivery; and providing essential medication and supplies for a six-month period.
The longer-term impact: With leishmaniasis care established in Baaj and Hathra, their primary health-care centres will be included in the national programme for neglected tropical diseases and should now receive necessary supplies from the MoH on a regular basis.

Objective 3: Improve health literacy among IDPs, returnees and host community members through health promotion and outreach activities

Health promotion interventions are essential for IDPs and returnees. These interventions can increase healthy behaviours reduce the risk of disease outbreaks and promote social cohesion by bringing together different segments of the population – for example, returnees and host communities – around common interests.

Working with Health Promotion Officers at the DoH and health facilities, IOM identified Community Health Promoters from the target communities to improve linkages with health facilities through outreach activities. A long-term goal of efforts such as these is to rebuild people's trust in the Iraqi health system as it continues to recover from multiple crises.
DoH and IOM also collaborated to respond to Iraq's 2022 cholera outbreak with risk communication and community engagement activities aimed at preventing acute watery diarrhoea and promoting food and water safety.
To leverage the strengths of civil society organizations (CSOs) and encourage their involvement in health issues, IOM trained CSOs to organize health workshops for youth. In addition to addressing relevant health topics, the workshops provided a space for youth, including returnees and host communities, to interact with one another.
Finally, outreach activities were used to inform returnees, IDPs and host populations – including hard-to-reach groups – of available services and refer them to the closest health facility for preventive and curative services.

Box 3: Person centred Care Training

IOM developed a training to provide HCWs with person centred care perspectives and skills. The training focused on identifying and responding to implicit bias, delivering trauma-informed care, safeguarding patients' rights (including confidentiality), involving patients in health-care decisions and working in ways that are conflict-sensitive. Pre- and post-assessment of trainees found modest-to-large improvement in attitudes and beliefs related to person centred care.
IOM's hope is that this short-term goal of improving HCW-patient interactions by instilling greater awareness and sensitivity to patients' lived experiences in HCWs will contribute to a longer-term goal of rebuilding trust between communities and health-care providers.

Success Factors

Set clear expectations and roles

Meeting early with the DoH about project goals and scope was critical to the success of this pilot. IOM teams set clear expectations for the types and levels of support the organization would be able to provide. Doing so was especially important because Iraq is adapting to significant changes in international donor priorities and funding levels as focus shifts from humanitarian emergency response to post-emergency stabilization. Furthermore, the DoH had become accustomed to short-term support that did not meaningfully address how they would sustain progress following project completion. IOM worked with DoH teams to: (a) clearly define the role of each actor, and (b) prioritize interventions that the DoH identified as important and feasible to invest in the long term, beyond the pilot timeframe.
At the end of the pilot, the DoH demonstrated strong ownership of the activities they had co-designed and co-implemented with IOM.

Take a flexible and localized approach

Activities within each of IOM's three objectives were co-designed with the DoH teams. This approach enabled IOM and the DoH to tailor interventions to priority needs, as well as the capacity to sustain and eventually scale those interventions. Box 4 provides another example of how IOM and DoH partnered to localize interventions.

Box 4: Reaching displaced children with vaccines

One of the effects of the COVID-19 pandemic on essential health services was the interruption of childhood vaccination programmes. The gap in childhood vaccination is especially pronounced for displaced children, who are missed by government vaccine monitoring systems when they move repeatedly – something that became more common during the pandemic as families lost their livelihoods. In Baghdad, the DoH identified a small population of internally displaced families that had recently moved to the catchment area of the health facility. To support restoration of routine childhood vaccination, IOM supported the DoH to organize an outreach immunization campaign. More than 300 children were vaccinated, provided with immunization cards and registered with a primary health-care facility so HCWs could follow up with their families about future vaccinations.

Leverage existing programmes and longstanding relationships

IOM implemented the pilot in locations where the Organization had been operating for several years. In communities where IOM had not delivered health programming before, IOM had established a presence by providing assistance in other sectors over the years. As a result, IOM had longstanding relationships with both communities and local government authorities. The existing trust enabled open conversations and facilitated discussions about resource allocation and prioritization of activities.

Key Learnings and Way Forward

This pilot revealed several challenges to implementing health interventions in the context of durable solutions. One is the ongoing need for humanitarian interventions in areas of return, which continue to be immense. If left unaddressed, humanitarian needs may undermine progress towards achieving durable solutions for IDPs.

As the country navigates the transition from emergency As the country nagiviates the transition from humanitarian emergency response to a development-focused approach utilizing durable solutions, Iraq needs. durable solutions donors and implementers who understand and are willing to invest simultaneously in humanitarian and development needs – or, at a minimum, who account for the delicate interplay between the two in funding arrangements and programme design. Effective partners will be those who are flexible, attuned to the diversity of needs across Iraq and willing to operate in uncertainty.

Another challenge is maintaining investment in returnees as a priority vulnerable group. Once IDPs return to or resettle to or resettled in a community, the latent assumption is that they do not require further support because they now have access to the community's existing resources. Yet, it is well-established – and this pilot confirms – that displacement is a complex and traumatic experience and, as a result, many IDPs have health conditions or elevated risk for disease that require solutions contextualized to their displacement experience. While access to health services is a priority for the Iraqi government, the MoH allocates most of its budget to the health workforce, pharmaceuticals, and secondary and tertiary care. Investment in primary health care is limited, and variation in availability and quality of primary care services remains high throughout the country. In this context of inadequate primary care and limited government resources, areas of return typically are not prioritized and have considerable unmet needs. Advocacy for returnees' needs must continue alongside efforts to strengthen the national health system overall.

In addition, many IDPs and returnees have become accustomed to seeking and receiving health care in camp settings, where care delivery was less complex and stockouts and staffing shortages relatively limited thanks to international aid (though this is changing as funding for though this is changing as funding for IDP and refugee camps diminishes diminishes). IDPs and returnees have not interacted with the national health system for several years, and they need support learning how to navigate it to meet their needs. Furthermore, communities hosting large populations of resettled IDPs may need additional support to ensure they can serve their populations equitably.

Health promotion is critical to connecting IDPs and returnees with essential health information and services. In doing so, it also has the potential to play a role in reestablishing trust between the Iraqi government and community members. Some returnees are coming home to communities where bonds between HCWs and households remain tenuous or broken due to chronic resources shortages and weak public sector governance. As an arm of health care that involves more community participation and input, health promotion can improve social cohesion between returnees and their community, and between IDPs and their new homes.

Finally, this pilot offers insight into how durable solutions health programmes targeting returnees and IDPs might pave the way for broader health system strengthening efforts rather than compete with or detract from them. Health for durable solutions initiatives can serve as a starting point for addressing longer-term investment in health systems and, in this way, provide a bridge between humanitarian and development work.

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