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UNDERSTANDING IRAQ’S BASIC HEALTH SERVICES PACKAGE: EXAMINING THE DOMESTIC AND EXTERNAL POLITICS OF POST-CONFLICT HEALTH POLICY

By

Goran Abdulla Sabir Zangana

This thesis is submitted in fulfilment of the degree of Doctor of Philosophy, University of Edinburgh

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2016
Declaration of originality

I, Goran Abdulla Sabir Zangana, declare that the work presented in this Ph.D. thesis is my own and that it has not been submitted for any other degree or professional qualification.

Signed: _________________________________________________________________
UNDERSTANDING IRAQ’S BASIC HEALTH SERVICES PACKAGE: EXAMINING THE DOMESTIC AND EXTERNAL POLITICS OF POST-CONFLICT HEALTH POLICY

Abstract

Background: Iraq is a higher middle-income country with a GDP of $223.5 billion (as of 2014). In the 1970s and 1980s, an extensive network of primary, secondary and tertiary health facilities was built, and the country recorded some of the best health indicators in the Middle East. However, two decades of conflict (both inter- and intra-state), sanctions and poor planning have reversed many of the previous gains. In the aftermath of the 2003 war, the government of Iraq introduced a Basic Health Services Package (BHSP) with a user fee component. International actors often advocate BHSPs as a means of rapidly scaling-up services in health systems that are devastated by conflict. User fees have also been promoted as a way of raising revenue to enhance the financial sustainability of healthcare systems in such contexts. While Iraq is a conflict-affected state, it has retained an extensive healthcare infrastructure and has a ministry of health with considerable financial and administrative capacity. In such a context, the introduction of a BHSP is a notable and distinctive feature of health policy in this setting, and the process through which this occurred have not yet been examined.

Aim: To explore the processes through which the BHSP was conceived and designed in Iraq. It compares Iraq’s BHSP with similar policies in other post-conflict settings. It examines the roles of domestic and external actors and models in the policy’s conception and design. It explores the preferences of internal and external actors about the financing of service delivery through user fees. The study also examines the extent of policy transfer in the formulation of Iraq’s BHSP.
Methodology: The thesis utilises a qualitative case study approach, incorporating analysis of semi-structured elite interviews and documents. Twenty Skype, phone, and face-to-face interviews were conducted between January 2013 and August 2014. Interviewees included former ministers of health, directors of departments of health, academics and officials at donor agencies, bilateral and multi-lateral bodies and consultancies. Documents included 47 official government publications, evaluations, reports, policy briefs and assessments.

Literature review: A search of the literature on health policy making in post-conflict and fragile settings identified three key gaps in existing evidence; first, there is a dearth of published work examining health policy in post-conflict Iraq. Second, the literature focuses mainly on the impact of policy action in post-conflict contexts, largely neglecting the processes through which those policies are introduced. Third, while the literature concentrates on the roles of external actors, it pays limited attention to the role of domestic actors and politics.

Results: Iraq’s BHSP shares commonalities with the other selected countries (Uganda, Afghanistan, and Liberia) in its primary aims, influential actors, interventions included or excluded, and financing principles. However, Iraq’s BHSP also aims at broader, and longer-term, structural reform, while the BHSP in other countries is often motivated by short-term objectives. The MoH in Iraq also appears to assume a prominent role in this case relative to others. Also, Iraq’s BHSP includes a greater number of interventions compared to the other countries.

The Iraq war of 2003 offered the opportunity for wide-ranging structural change in the healthcare system. External actors, especially the WHO, were influential in advocating for a BHSP drawing on the recent experience of a similar initiative in what was in some ways the similar context of Afghanistan. However, the removal of former politicians and the emergence of internal policy actors with considerable technical and financial capacity allowed the domestic authorities to debate, dispute and challenge the recommendations of external actors. Relatedly, some of the internationally distinctive features of the BHSP in Iraq, including user fees, are similar to those that exist elsewhere in the health system.
Most interviewees agreed that the BHSP was a means of enhancing financial sustainability and that it would help to enhance efficiency by targeting resources at population health need. The BHSP, according to some, represented the categories of healthcare that the government should finance, while allowing the private sector to meet demand for other services. However, many domestic actors supported the introduction of user fees as part of the BHSP. Several external actors either distanced themselves from this decision or declared no position, claiming that this was properly a matter for the government of Iraq.

Discussion: While the BHSP’s ‘label’ is new in the context of Iraq, its substantive content is not. The BHSP can be seen as the outcome of the combination of old (existing) technologies and instruments presented in new (and introduced) ways. The existing health system offered ideas, techniques and processes that were maintained and reproduced even if these were packaged in new ways, to create a policy framework which is genuinely novel. External experts highlighted the idea of the BHSP and provided models (such as Afghanistan) on which the policy could be based. Internal decision-makers, however, were active players in policy formulation, not passive recipients who did not question or modify the policy during the process of transfer. On the contrary, it seems that the latter exerted considerable influence. User fees represent one aspect of that continuity.

Ownership of policies by ministries of health in post-conflict is often advocated. However, such involvement introduces the potential for replicating old structures and policies, and may result in a degree of policy incoherence. Policy ideas are likely to change significantly where there is considerable local engagement in policy design and implementation.
Acknowledgments

It would not have been possible to conduct this research project without the help, support and encouragement of a number of individuals, institutions, and family members.

Firstly, I would like to express my sincere gratitude and appreciation to both of my supervisors, Professor Jeff Collin, and Dr Mark Hellowell. It has been an extreme privilege and honour to work with them. I would like to thank them for their commitment to this research and providing stimulating critique and encouraging input.

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I would like to acknowledge the love, support and encouragement of my partner Aveen. This thesis is devoted to our daughter Larisse who was born as the project was coming to its final stages. Last but not least, warm thanks should go to my parents, brothers and sister.
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<table>
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<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BHSP</td>
<td>Basic Health Services Package</td>
</tr>
<tr>
<td>BI</td>
<td>Bamako Initiative</td>
</tr>
<tr>
<td>BPEHS</td>
<td>Basic Package of Essential Health Services</td>
</tr>
<tr>
<td>BPHE</td>
<td>Basic Package of Health Entitlements</td>
</tr>
<tr>
<td>BPHNS</td>
<td>Basic Package of Health and Nutrition Services</td>
</tr>
<tr>
<td>BPHSW</td>
<td>Basic Package of Health and Social Welfare services for Liberia</td>
</tr>
<tr>
<td>CAQDAS</td>
<td>Computer Assisted Qualitative Data Analysis Software</td>
</tr>
<tr>
<td>CDC</td>
<td>Centres for Disease Control and Prevention</td>
</tr>
<tr>
<td>CHWs</td>
<td>Community Health Workers</td>
</tr>
<tr>
<td>CPA</td>
<td>Coalition Provisional Authority</td>
</tr>
<tr>
<td>DALYs</td>
<td>Disability Adjusted Life Years</td>
</tr>
<tr>
<td>DLYs</td>
<td>Discounted Life Years</td>
</tr>
<tr>
<td>DoH</td>
<td>Directorates of Health</td>
</tr>
<tr>
<td>EMRO</td>
<td>Eastern Mediterranean Regional Office</td>
</tr>
<tr>
<td>EPCA</td>
<td>Emergency Post-Conflict Assistance</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential Package of Health Services</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GoI</td>
<td>Government of Iraq</td>
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<tr>
<td>HPSR</td>
<td>Health Policy and Systems Research</td>
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IBRD  International Bank for Reconstruction and Development
ICI  International Compact with Iraq
IDHS-FPA  Integrated District Health System-Family Practice Approach
IFC  International Financial Corporation
IMF  International Monetary Fund
IMR  Infant mortality rates
I-PSM  Iraq Public Sector Modernisation Programme
MDG  Millennium Development Goals
MENA  The Middle East and North Africa
MoPH  Ministry of Public Health-Afghanistan
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1 Introduction

A Basic Health Services Package (BHSP) was introduced in Iraq in 2009. Iraq’s BHSP was introduced in the context of a political change resulting from the Iraq war of 2003. While BHSP has become a familiar feature of health policy in many developing country and post-conflict settings, the Iraq case appears unusual. First, although Iraq is a conflict-affected country, it does not share many of the features of the latter category. The country retained a relatively extensive infrastructure and health system even after the conflict. Second, Iraq’s increasing oil revenues would have permitted the expansion of health services to include more than the minimum services that the BHSP includes. Interestingly, the BHSP for Iraq also included use fees despite the increasing revenues and the share of GDP dedicated to health.

Before engaging in a more detailed discussion of the topic of the study, it is necessary to provide some clarifications about the terminologies of the subject. The World Health Organisation (WHO) defines the BHSP as a list of core services that are cost-effective in meeting the most pressing health needs of populations (WHO 2008a). Several distinct, but similar, nomenclatures exist that describe essentially the same concept of packages of basic health services. Uganda uses the terminology Package of basic health services (PBHS). Afghanistan’s Ministry of Public Health uses a similar terminology. Since these various terminologies seem to refer to essentially the same core concept (please refer to chapter five on page 120), we chose to use the term BHSP as an umbrella term to encompass the descriptions above. However, explicit references will be made to the particular terminology when needed.

It is necessary to note here how this research defines and understands internal and external actors. For the purpose of this study, actors are designated as internal or external based on their nationality. Hence, an Iraqi national who worked at an international organisation at the time of the introduction of the BHSP is referred to as an internal actor.

In 2009, the Government of Iraq (GoI) formally introduced a Basic Health
Services Package (BHSP) (Ministry of Health 2009). The Ministry of Health-Iraq (MoH) defines the BHSP as “a minimum collection of essential services that all the population need to have a guaranteed access to” (MoH, 2009:15). It further defines ‘essential services’ as those “that provide a maximum gain in health status (on the national level) for the money spent.....or those services, which if not provided, will result in the most negative impact on health status of the overall population” (MoH, 2009:15). The BHSP recognises user fees as what it calls a sustainable source for financing primary healthcare services. The MoH depicts the BHSP as a step towards the “devolution and decentralization of financial and administrative authorities to the regional and governorate levels” (MoH, 2009: II). It further presents it as a tool to reorient the Iraqi healthcare system from one that is ‘hospital-centred’, ‘capital intensive’ and ‘inefficient’ to a primary healthcare based model which delivers cost-effective preventive and curative services (MoH, 2009:1).

The GoI and the MoH are not the sole actors in the introduction of the BHSP. The BHSP was one of the components of the Integrated District Health System-Family Practice Approach (IDHS-FPA) (Ministry of Health 2009; UNAMI 2007; WHO 2011a).

This chapter will start with setting the scene for this research. It does that by introducing the topic of the study. It then proceeds to provide an overview of the rationale for the research including a description of the puzzle that this study is interested in exploring. The chapter will also outline the structure of the entire thesis. The following section examines in-depth the two main topics of this study; the basic health services package and user fees.

1.1 The Basic Health Services Package
1.1.1 Origins

The origins of the BHSP can be traced to the Comprehensive Primary Health Care Approach, enshrined in the Alma-Ata declaration. The latter approach included services as diverse as education, nutrition, water and sanitation as well as the prevention and treatment of diseases (WHO 1978). The statement was announced at the conclusion of a landmark primary health care event held from September 6 to 12, 1978 in Alma-Ata in Kazakhstan. Three thousand delegates from 134 governments and 67 international organizations attended the
conference. It concluded with the ‘health for all by the year 2000’ declaration (Cueto, 2004). The conference represented the culmination of decades-long criticism of the medically dominated and technology intensive vertical programmes of the late 1950s (Bryant 1969; McKeown 1976; Illich 2000). Those programmes were associated with the United States that was experiencing economic and political difficulties at the time. On the other hand, China’s ‘barefoot doctors’ experience of expanding medical services to rural areas was becoming increasingly popular (Hillier & Jewell, 2013; Sidel, 1972). In parallel, influential organisations (such as WHO and UNICEF) and inspirational leaders within them (including Halfdan T. Mahler and Henry Labouisse) began to formulate jointly alternative primary health approaches to the traditional vertical projects (Djukanovic & Mach 1975). The conference and its organisers reiterated ideas that discouraged excessive reliance on sophisticated technologies, overspecialization of healthcare workers and delinking health and development (Mahler 1975; Mahler 1978). They suggested that those three concepts were not only of limited relevance to developing countries but also harmful to those settings.

The first response to the Alma Ata declaration came almost immediately through what became known as the Selective Primary Health Care (SPHC) approach. Walsh and Warren introduced the idea initially in a paper in 1979 (Walsh & Warren 1979). They presented their idea at a conference organised by the Rockefeller and Ford foundations in Bellagio, Italy (Walsh & Warren 1979; Warren 1988; Cueto 2004). Concerns were raised about the inability of governments to provide comprehensive services (Berman 1982; Unger & Killingsworth 1986; Rifkin & Walt 1986). Statistical tools were proposed to guide the allocation of limited resources to the most cost-effective interventions (Walsh & Warren 1979; Evans et al. 1981; Grosse 1980). The SPHC approach included interventions for five to eight diseases with a particular focus on the health problems of children (Walsh & Warren 1979; Unger & Killingsworth 1986). It excluded water, sanitation, and nutrition that were associated with the comprehensive approach of the Alma-Ata Declaration (Berman 1982; Unger & Killingsworth 1986).

Walsh and Warren suggested that comprehensive primary health as envisioned by the Alma-Ata declaration is not affordable (Walsh & Warren 1979; Walsh 1988; Gish 1982). The affordability concerns of the SPHC arguably heralded an increasingly dominant role for
economics in public health in debates related to primary health care (Lee et al. 2002a; Rifkin & Walt 1986). Walsh and Warren, however, did not directly criticise the Alma-Ata declaration but suggested that an interim strategy such as the SPHC was needed to ensure access to a wider range of services (Walsh & Warren 1979; Cueto 2004). They, therefore, proposed identifying a list of high priority health problems to receive preventive and curative interventions based on criteria such as prevalence, morbidity, mortality and feasibility. The feasibility component underlined the concept of cost-effectiveness in health planning (Berman 1982). Several prominent international actors such as the United States Agency for International Development (USAID) and the World Bank, UNICEF and the Centres for Disease Control and Prevention (CDC), supported the SPHC approach. They did so through the provision of technical manuals, proposals, and funds. UNICEF, one of the strong supporters, operationalised the SPHC approach into what has become known as the GOBI-FFF programme (Growth monitoring, Oral rehydration, Breastfeeding, Immunization, Family Planning, Female Education, Food Supplementation) (Lee et al. 2002a). However, other organizations such as WHO remained sceptical (Unger & Killingsworth 1986; Qadeer 1994).

The selective approach was praised for several claimed advantages. Unger and Killingsworth, for example, attributed the attractiveness of the approach to its ability to achieve tangible results for donors (Unger & Killingsworth 1986). They also highlighted the use of cost-effectiveness tools in the selection of interventions. Moreover, they recognised the ability of the SPHC to establish private markets and, therefore, provide opportunities for the consumption of technologies produced by foreign companies. Others praised what they characterised as a logical and rational approach to priority setting for disease control in developing countries (Gish 1982; Berman 1982; Rifkin & Walt 1986).

However, the selective approach was also at the receiving end of significant criticisms. Gish (1982), for instance, viewed the proposal as a defence of vertical programmes that lacked analytical rigour, confused many concepts relevant to health and ignored the existing health infrastructure of countries (Gish 1982). He considered the notion of selecting a list of health services that are already of high priority for developing countries, as a tool to prevent some people from accessing health care. He further claimed that the proposal lacked
historical perspective or development oriented breadth, was not equipped with a social science endowment and was not appreciative of the local contexts. Berman (1982), on the other hand, focused his criticism on the cost-effectiveness strategy used to prioritize healthcare services (Berman 1982). He stressed that the strategy was not feasible and unacceptable and hence, insufficient. In addition to underlining the technical inadequacies of the approach, Berman highlighted the limited attention to continuity and acceptability of health services by the population. He concluded that a single criterion such as cost-effectiveness was unable to address the complex and multi-faceted issues of primary health care. It is useful to notice that both Gish and Berman were economists who warned against the direct application of economic tools to healthcare (Green & Barker 1988).

Others recognised the potential ability of cost-effectiveness to produce accurate technical results, but also pointed to its modest effectiveness (Janovsky 1996). They attributed such modesty to broader systemic constraints or failures. Janovsky (1996) reported that the development of a minimum package of services through cost-effectiveness would do little to address barriers and system failures arising from economic, cultural, information or power asymmetry factors. Rifkin and Walt (1986), on the other hand, focused on the reductionist approach to health adopted by SPHC and its inability to appreciate the distinction between health and health care (Rifkin & Walt 1986). Similarly, others criticised the medical model underpinning the disease-based outcome measures resulting in the vertical nature of the interventions in the package (Green & Barker 1988).

The idea of the SPHC evolved into the concept of a basic health services package (BHSP) which was promoted by the World Development Report (WDR) 1993 (Musgrove 1993; World Bank 1993; Bobadilla & Cowley 1995; Bobadilla et al. 1994). several advantages of the BHSP were proposed in response to the suggested limitations of the SPHC approach. The designers of the BHSP claimed that the latter used comprehensive information such as burden of disease and cost-effectiveness. They also suggested that they were incorporating mortality, morbidity and disability indicators (Bobadilla et al. 1994). Three justifications were also put forward for the clustering of core health services in a package; minimizing costs, enhancing priority setting capacities, and establishing clear boundaries between the private and public sectors (World Bank 1993; Bobadilla et al.
However, one of the principal reasons for such packaging was efficiency considerations by reducing the cost of the package through shared use of 6 services (Bobadilla et al. 1994). Another key objective was to delineate what the state should do and what it should not do arguing for a minimalist role for the latter and advocating a pro-market approach.

As an exercise in coverage and entitlement policies, the BHSP is seen to affect broad health financing goals (Gotsadze & Gaal 2010). Hence, some view it as a policy tool rather than accounting or actuarial exercises (Kutzin, Jakab, et al. 2010). As such, the BHSP typically consists of three dimensions of breadth (the population entitled to the BHSP) scope (the type of interventions covered by the BHSP) and depth (the cost to be paid by the users for financing the BHSP). Figure 1 illustrates these dimensions.

**Figure 1.1: The three dimensions of a benefit package**

![Figure 1.1: The three dimensions of a benefit package](image)

Source: Kutzin et al. (2010)

Similar to the SPHC approach, the BHSP is designed to provide a minimum package of essential services that would be expanded when resources become available (Bobadilla et al. 1994; Bobadilla & Cowley 1995; Bobadilla 1998). Bobadilla and colleagues recommend that “government should ensure universal access to its national package by financing it directly” (Bobadilla et al. 1994:653). However, they also argue for “promoting private expenditure on the clinical interventions in the package” when resources are inadequate (Bobadilla et al. 1994:653). Health services that qualify as ‘discretionary’ are not included in either package and are to be paid for through private sources (Bobadilla et al. 1994). In doing so, the WDR
1993 reframed the debate in health care financing from the early focus on mobilizing additional resources to efficiently allocating existing resources for the funding of a claimed cost-effective package of services (Lee et al. 2002b).

1.1.1 Applications

The WDR 1993 stimulated the introduction of BHSP in many developing countries (Ham 1997; Söderlund 1998). The WDR viewed the BHSP as a ‘recipe’ for reform (McPake 2002) when it suggested that “the policy conclusions of this Report can be tailored to the widely varying circumstances of developing countries” (WorldBank, 1993:156). Packages of essential services were introduced with the support of the World Bank, international organizations, donors, and financing agencies. The World Bank, for instance, prepared a manual to guide policy makers in developing countries on how to develop the package (Brenzel 1993). (Söderlund, 1998) Other supporters included the United States Agency for International Development (USAID), the European Commission, individual European nations, the Asian Development Bank, and UNICEF (Strong et al. 2005; Palmer et al. 2006; Sabri et al. 2007; Ameli & Newbrander 2008; Roberts et al. 2008).

Similar packages of essential services were introduced in post-conflict and fragile states such as Uganda, Kyrgyzstan, Afghanistan, Tajikistan, Liberia, South Sudan and the Democratic Republic of Congo (DRC) (Ministry of Health 1997; Transitional Islamic Republic of Afghanistan 2003; Ministry of Health and Social Welfare 2008; Roberts et al. 2008; Rechel & Khodjamurodov 2010). The aim of the policy in those setting was to scale-up health services rapidly in health systems destroyed by war and conflict. For example, WHO’s Commission on Macroeconomics and Health recommended providing a scaled-down, basic package of priority health services through primary health care facilities and outreach activities in fragile states (WHO 2004). The Organisation for Economic Co-operation and Development (OECD) also states: “state fragility may require a re-design of basic service packages, to make wide coverage feasible under conditions where resources are limited. This may mean combining key services into a package of what is necessary and feasible” (OECD, 2009:8). In many of these settings, the BHSP was provided through contracting with NGOs (Palmer et al. 2006). A more detailed description of the literature on the BHSP in post-conflict countries is provided in the literature review chapter as
part of a broader review of health policy making in such settings.

Almost all of the countries in Central Asia and the former Soviet Union introduced a State Guaranteed Benefit Package (SGBP) (Borowitz & Atun 2007; Rechel & Khodjamurodov 2010). Efficiency justifications dominated the aims for the introduction of the SGBP during the transition from command to market economy. Fiscal shocks, willingness to depart from the previous Semashko model combined with attempts to downsize an inherited extensive infrastructure were among the justifications for introducing SGBP (Kutzin, Jakab, et al. 2010; Kutzin, Cashin, et al. 2010). A deteriorating fiscal space was identified as the principal reason for defining a list of services due to the inability to continue providing previous generous entitlements (Gottret et al. 2008).

The introduction of the BHSP and the user fees component attached to it provides an opportunity to examine empirically those criticisms and concerns. The next section will review the evidence related to user fees.

1.2 User Fees

For the purpose of this section, user fees are defined as those “official fees charged by public health providers for basic as well as higher-level services...” (James et al., 2006:1). Although user fees are a form of Out-of-Pocket Spending (OOPS), outside public settings (WHO, 2010).

1.2.1 Arguments for and against user fees

User fees gained prominence in health policy debates following their introduction in the 1980s in developing countries with the help of organizations and agencies such as the World Bank, UNICEF and USAID (Kanji 1989; Hardon 1990; Russell & Gilson 1997; Ridde 2011). Some suggest that the introduction of user fees was the most prominent component of health sector reforms in developing countries in the 1990s (Creese & Kutzin 1997). In those settings user fees were viewed as a tool to raise revenues, improve efficiency, enhance equity and promote quality at health care facilities (De Ferranti 1985; Griffin 1988; Akin et al. 1987). They were considered as a practical method of raising revenues in resource-poor settings, and a means to improve accountability, governance and staff morale (M. Pearson 2004). Also, user fees were believed to prevent ‘frivolous’ use of services and moral hazard and hence
were thought to enhance efficiency (Gilson 1998). It was suggested that the price signal attached to services provided at public facilities would result in some claimed beneficial consequences. Those suggested benefits included a reduced consumption of unnecessary services and services that are accessed for self-limiting conditions. Other claimed benefits were a reduction in the utilization of costly hospital care and curbing the effects of moral hazard (Sepehri & Chernomas 2001). Some studies supported those arguments by suggesting that demand characteristics were influenced more by quality and proximity than the price of services (Heller 1976; Sepehri & Chernomas 2001). Finally, user fees were suggested as a tool to improve equity when retained revenues are used to broaden coverage and enhance the quality of services offered to the poor (Akin et al. 1987; Litvack & Bodart 1993). Numerous assumptions were made to support this latter claim. Those assumptions were related to the presumed inelasticity of demand and the willingness and ability to pay for health care by consumers. Moreover, supporters of this benefit presumed an administrative feasibility of retention and willingness of governments to relocate resources to serve the poor (Akin et al. 1987; Sepehri & Chernomas 2001).

The introduction of user fees in developing countries stimulated considerable debate and triggered numerous studies about the revenue raising potentials and the impacts of user fees on utilization, equity, efficiency and quality of health services. Many report that user fees are neither an effective nor a reliable source of funding for health systems. Experience in developing countries suggests that user fees were able to raise only 5-7% of the total recurrent health expenditure excluding administrative costs (Gilson 1997; M. Pearson 2004; WHO 2010; McPake et al. 2011). Furthermore, others reported that the administrative costs involved in collecting fees contributed to limiting their revenue raising capacities (Creese 1991). Moreover, several authors suggested that perceiving user fees as a ‘self-financing’ mechanism might lead decision makers to decrease the overall public expenditure on health services (Leighton 1995; Sheiman et al. 2010).

Besides the limited utility of fees in mobilising resources, evidence also suggests negative impacts on service utilisation. For example, a small fee charged for drugs used in de-worming children in Kenya resulted in a decrease in the utilization by 58% (Kremer & Miguel 2007). Attendance of women patients at sexually transmitted disease clinics in the
same country was reduced to 65% following the introduction of user fees (Moses et al. 1992). The attendance of men at those clinics was also reduced to 40% of the pre-user fee level in the same setting. Overall, the utilization of health services at outpatient clinics in Kenya was reduced by 40-50% during a period of introduction, removal and reintroduction of user fees in the country (Mwabu et al. 1995; Mwabu & Wang’ombe 1997). The levy of charges for the registration of patients at district hospitals, health centres, and provincial hospitals resulted in a decrease in utilization of services by 45%, 33% and 27% respectively (Collins et al. 1996). Similar reductions in access to different services in other settings were also observed (Blas & Limbambala 2001; Benjamin et al. 2001; Kipp et al. 2001; Ridde 2003).

Several authors and organisations assert that user fees are one of the most regressive methods of financing health services (Ching 1995; McIntyre et al. 2006; WHO 2010). They suggest that fees have deleterious impacts on equity and risk protection goals of health financing systems (Ching 1995; Diop et al. 1995; Mbugua et al. 1995; Gilson 1998; Ridde 2003; Uzochukwu et al. 2004; Schneider & Hanson 2006). Some reported that a ‘poverty trap’ might occur when user fees are combined with OOPS in the private sector (Whitehead et al. 2001). This poverty trap perhaps reflects the regressive nature of user fees and direct payment for health care services in general in comparison to other forms of health financing such as general taxation or social insurance (Wagstaff et al. 1992; Wagstaff & Doorslaer 2000). Others reported that user fees increased regional inequalities and worsen the distortions in resource allocation (Dahlgren 1991; Reich 1995; Mills 1991). While exemptions, retention at local levels, and community participation were intended to ameliorate the regressive nature of user fees, some reported the failure of such measures to achieve equity goals (Gilson 1998; Ridde et al. 2012). The failure of exemptions and waivers were attributed to the absence of mechanisms for targeting the poor or the vague or inaccurate nature of those mechanisms (Mills 1991; Willis & Leighton 1995; Gilson & Mills 1995; Russell & Gilson 1997; Ridde et al. 2012). Others attributed such failures to the inability of weak institutions in developing countries to effectively implement exemptions and waivers (Dahlgren 1991; Abel-Smith & Rawal 1992).

Reliable evidence appears to be lacking about the quality improving effects of retained fees (Lagarde & Palmer 2011; Lagarde & Palmer 2008). Several authors noted that the
retention of user fees at local facility levels was not associated with considerable improvements in the quality of services (Creese 1991; Nolan & Turbat 1995; Russell & Gilson 1997). Others reported that user fees may harm the quality of services as a result of obliging patients not to comply with the required dose of medications for example (McPake et al. 1993). The latter, in those authors opinion, would imply a bigger financial burden on patients. Finally, others suggest that user fees may deter patients from using preventive instead of ‘frivolous’ services (Yoder 1989).

Claims about the efficiency-enhancing effects of user fees are not substantiated by the available evidence either. Opponents of user fees suggest that numerous assumptions are made to justify the efficiency-enhancing effects of user fees (Musgrove 1986; Sepehri & Chernomas 2001). They note that users are unable to distinguish between necessary and less required services (Stanton & Clemens 1989; Abel-Smith & Rawal 1992). Furthermore, they are also sceptical about claims that user fees can reduce demand for unnecessary services while at the same time not affecting necessary care. Those observations were supported by evidence suggesting a reduction in the utilization of essential services when fees were charged (Moses et al. 1992; Awofeso 1998). Moreover, some argue that providers, rather than patients, often make decisions about service provision, therefore, charging consumers implies penalizing the latter for decisions that they do not make (Barer et al. 1993). Besides, it is mostly the affluent segment of the population that uses unnecessary services and user fees have a limited effect in preventing this population from service utilization (Yoder 1989). Finally, opponents suggest that there are other costs involved in accessing health care besides user charges such as opportunity costs related to time, resources lost to travel and informal payments (Abel-Smith & Rawal 1992; McPake et al. 1993). These costs do prevent, opponents argue, any unnecessary or frivolous use of services.

1.2.2 The role of international actors in user fee policies

Some multilateral, bilateral and international organizations and agencies played a prominent role in advocating the introduction of user fees in developing countries. The World Bank, for example, played a leading role in promoting user fees through advice and/or conditionality (Gilson & Mills 1995; Okuonzi & Macrae 1995; Nolan & Turbat 1995; Colclough 1997). In its first major report dedicated to health in 1987, ‘Financing health services in developing
countries: an agenda for reform’, the World Bank advocated levying user fees for public health services (Akin et al. 1987; Ruger 2005). The World Bank continued to support user fees for optional services in the World Development Report of 1993 (World Bank 1993). It, nevertheless, suggested charging ‘affluent’ people to allow the provision of cost-effective health services to the poor (World Bank, 1993:11). It also recognized the need for waivers and exemptions for the poor (Bitrán & Giedion 2002). In its Health, Nutrition and Population (HNP) sector strategy of 1997, the World Bank stopped supporting user fees (Kim et al. 2002; Ruger 2005; the World Bank 1997). It instead, promoted risk sharing, pre-payment, and exempting preventive services from cost-sharing (England et al. 2001; Bitrán & Giedion 2002). A decade later the World Bank renewed its support for user fees in its revised HNP sector strategy of 2007, where it recognized a need for user fees to curb excessive demand (World Bank 2007). Nevertheless, it offered helping countries that are planning to abolish user fees under certain conditions. In 2009, the World Bank joined the WHO and the British Government to call for free services at the point of use at the UN general assembly (Yates 2009).

UNICEF proposed a particular application of user fees in 1987 in what was later known as the Bamako Initiative (BI) (McPake 2002). The initiative was designed to sustain the drug supply through using fees charged for those drugs at primary healthcare centres (Kanji 1989; Litvack & Bodart 1993). The implementation of BI in 1992-1993 was seen as a response to the initial inconclusive evidence of the ability of user fees to achieve their intended objectives (McPake 2002). Although some argue that UNICEF took WHO by surprise when announcing the imitative, it is also believed that the BI was a joint endeavour between the two organizations (Kim et al. 2002; Lee et al. 2002c). Other agencies, such as USAID, were also influential in launching the BI (Lee et al. 2002c). USAID was a key agency in funding studies and research that suggested the effects of user fees on quality improvement at local facilities and the apparent benefits of such improvement on equity (Litvack & Bodart 1993; Diop et al. 1995; Wolters 1995; Weaver 1995; Chawla & Ellis 2000).

In the light of this accumulating evidence, a consensus on user fees is emerging among various stakeholders. Many organizations and academics suggest that user fees need to be
removed when some preconditions are available (Meessen, Hercot, et al. 2011; Meessen, Gilson, et al. 2011). While the debate about removing or retaining user fees continue (James et al. 2006) many low- and middle-income countries started removing them (Meessen, Hercot, et al. 2011). The experience of those countries provides valuable insight on best practices for implementing the policy.

1.3 Rationale for the research
Despite the prominence of BHSPs in global health debates, surprisingly, studies that specifically examine their introduction in post-conflict, conflict-affected and fragile settings are relatively rare. Existing scholarship on health policymaking in those settings exhibit a series of shortcomings (please refer to chapter three on page 63 for more on the gaps in knowledge). First, we were not able to identify any study that explores the introduction of health policies in the post-conflict setting of Iraq. Second, it appears that the literature focuses on exploring the outcomes of policies rather than the processes through which those policies are introduced. Third, studies seem to concentrate principally on the role of external actors and models without a sufficient examination of the role of domestic factors in health policymaking in such settings.

Given those gaps in the literature, more empirical research into health policymaking in the post-conflict setting of Iraq is clearly needed. Hence, the aim of this study is to explore the processes through which the BHSP was conceived and designed in Iraq. More specifically, the interests and preferences of local and external actors in introducing user fees as part of Iraq’s BHSP deserve a closer examination. Relatedly, the extent to which local precedents and external models contributed to shaping health policies in a post-conflict setting perhaps requires further clarification. Finally, the study also examines the extent of policy transfer in the formulation of Iraq’s BHSP. It recognises that policy transfer can offer a useful framework for studying the adoption of a policy that has similar equivalents in other settings.

The introduction of the BHSP in Iraq and the role of international and local actors in the process also deserve a closer examination. In conflict-affected contexts, the BHSP is predominantly designed to rapidly scale-up services in health systems devastated because of
conflict. While Iraq is a conflict-affected state, it has retained an extensive healthcare infrastructure and has a ministry of health with considerable financial and administrative capacity. For example, Iraq is a higher middle-income country with a per capita GDP $6,862.50 (as of 2013) (World Bank 2015). In the 1970s and 1980s, an extensive network of primary, secondary and tertiary health facilities was built, and the country recorded some of the best health indicators in the Middle East (for more on the context of Iraq, please refer to chapter four on page 83). Moreover, as of 2010, Iraq was spending US$167 per capita on health. In such favourable conditions, it is puzzling that Iraq chose to introduce a BHSP that includes only minimum services and is not expanded to include other health services as recommended by the WDR 1993 (World Bank 1993; Bobadilla et al. 1994). Limiting the BHSP to minimum services is intriguing because the WDR recommended the expansion of the package to include essential services beyond the minimum in middle-income countries that spend at least US$62 per capita (Bobadilla et al. 1994). In such a context, the introduction of a BHSP is a notable and distinctive feature of health policy, and the process through which this occurred have not yet been examined.

The decision to introduce the BHSP, therefore, entailed forgoing some other alternative approaches in providing primary healthcare services. One such alternative is the comprehensive primary health approach. The latter would have been a more preferred option if one considers the background of Iraq’s health system (please refer to chapter four on page 83) and the favourable financial context presented above. However, Iraq chose to introduce a more selective primary health care approach.

The adoption of user fees and co-payments as a sustainable source of financing the BHSP in Iraq is also puzzling in light of the information presented above and two other groups of local and global developments. Locally, a growing share of Iraq’s Gross Domestic Product (GDP) is allocated to health. In 2003, Iraq was spending only 2.5% of its GDP on health (UNAMI 2007). The total health expenditure increased to 3.3% of GDP in 2008 and again to 5% of GDP in 2010 (WHO 2011b; WHO 2015). Soaring oil prices and subsequent economic growth facilitated such increases (Gunter 2011). It also appears to reflect a political commitment in part of the GoI to health and health care. The government’s expenditure on health as a percentage of the general public spending has increased by
more than 76% between 2007 and 2010 (3.4% in 2007 to 6% in 2010) (WHO 2011a). Therefore, in this context, the reliance on user fees to co-finance a primary health care programme is novel and worthy of further investigation.

Furthermore, the adoption of user fees for financing the BHSP is not consistent also with contextual and historical trends in health financing in the country. Historically, the experience of Iraq with user fees demonstrates an inverse relationship between economic prosperity and the importance of charges for funding health care (Please see chapter four on page 83). Iraq experimented with user fees during economic downturns, sanctions, and wars (WHO 2006). These represented exceptions to the rule of providing services free of charge at the point of use (Garfield 2003; Tawfik-Shukor & Khoshnaw 2010). This pattern, however, does not hold in financing the BHSP, where user fees are introduced at a time of economic growth. Moreover, the Constitution guaranteed every citizen equal access to health care services (Iraqi Parliament 2005). The constitution guarantees access to essential health services through 26 articles and provisions (WHO 2011a). The adoption of user fees, however, potentially undermines the principle of guaranteed access by raising financial barriers to such access. Therefore, those contextual factors suggest that user fees would be an unlikely health-financing tool to mobilize resources in the Iraqi context.

Globally, a growing body of evidence appears to propose a consensus about the removal of user fees in developing countries (for more on this please refer to the user fees section above). Considering this evidence, many international organizations, academics and advocates support the removal of user fees when some preconditions are available (Yates 2009; Meessen, Hercot, et al. 2011). Advocates propose the removal of user fees as one of the quick mechanisms for achieving the Millennium Development Goals (MDGs) (Sachs & McArthur 2005). The World Health Organization, in particular, appears to oppose user fees in its official reports and resolutions as part of its advocacy for universal coverage in developing countries (Robert & Ridde 2013). It is interesting to notice that WHO has been technically supporting the BHSP in Iraq that includes a user fee component (Ministry of Health 2009). The identification of user fees, therefore, raises important questions about the roles and preferences of internal and external actors in designing and formulating health policies in Iraq.
Since the introduction of Iraq’s BHSP and its user fee component is inconsistent, and at times contradictory, with evidence and with economic and historical trends, it attracts intellectual curiosity. Hence, this study aims at exploring the processes through which the BHSP and its financing methods were introduced in Iraq. The primary objectives of this research are the following:

1. Examine the extent to which Iraq’s BHSP is similar to or different from equivalent policies in other post-conflict countries.
2. Identify and analyse the origins of, and the mechanisms through which, Iraq’s BHSP was designed and analyse the extent to which the BHSP has been shaped by the preferences of and tensions among the actors involved.
3. Identify and analyse the views of various internal and external actors on the system-wide effects of the BHSP.
4. Explore the lessons for health policymaking in conflict-affected settings that can be drawn from a better understanding of the transfer of the BHSP to Iraq.

The next section outlines the structure of the thesis.

1.4 Structure of the thesis
This thesis is organised into nine chapters. Following the introduction, chapter two outlines the conceptual and methodological framework for the study. The chapter discusses the research paradigm and justifies the use of the adopted approaches. It then proceeds to address the methods used to collect and analyse data. The chapter will also examine the literature review strategy. Finally, the methodological limitations and ethical considerations will be addressed.

Having outlined the methodologies of the research, chapter three assesses two main bodies of literature. The first set is the literature on health policy making in post-conflict, conflict-affected and fragile settings. The second set includes the policy transfer literature and attempts to apply the transfer framework to this study. The chapter concludes with an overview of the findings of the literature review and the gaps that this study attempts to fill.

Chapter four outlines the geographic, demographic, political economy and health system context of Iraq. The background chapter set the scene for the examination of the
policy process of introducing the BHSP. It also attempts to explore the contextual factors that might influence the introduction of Iraq’s BHSP. It starts with a basic assumption that any piece of policy is not introduced in a vacuum, and the context of the country has an influence on the process of introducing such policies.

Chapter five is the first results chapter. It examines the extent to which Iraq’s BHSP is similar to or different from equivalent policies in other post-conflict countries. The chapter will explore the similarities and differences between Iraq’s BHSP and equivalent policies in other settings.

Chapter six presents findings that shed light on the extent to which internal and external factors (including players) have contributed to shaping the BHSP. The chapter uses findings from interview, documents data and specific secondary data to explore the external and domestic origins of the BHSP.

Chapter seven present the views of external and internal actors with regards to the extent to which the BHSP was intended for and contributed to system-wide changes. The chapter uses findings from documents and interview data to explore the views of internal and external actors on topics such as user fees, insurance, standardisation, decentralisation and privatisation. Having presented the empirical results of the study, then Chapter eight briefly summarises those findings, interprets them and discusses their significance in light of existing knowledge.

Finally, chapter nine presents the major conclusions of this study.
This chapter presents the conceptual and methodological framework for this research. The chapter begins with discussing the research paradigm and methodology adopted in this study and offers justifications for the use of the particular adopted approaches. It attempts to do that in relation to the empirical case of the study. It then proceeds to address the methods used to collect data. Examining the data analysis aspects of the research will be highlighted next. Finally, the methodological limitations and ethical considerations will be addressed before proceeding to conclusions.

The chapter will also examine the literature review strategy. The description of the literature review strategy is presented here because it is part of the methodological procedures of the research. Also, because the literature review was an important source of data for this research. Similar to the other methods of collecting data through interviews or documents, gathering, synthesising and presenting data from the literature should also be through a systematic method.

### 2.1 The Research Paradigm

Put simply; the research paradigm is the way that the researcher choose to view the world (Gilson 2012). There is a host of lenses through which the researcher can look at the world. This spectrum of what can be termed a knowledge paradigm ranges from positivism to relativism passing through critical realism (Gilson 2012). Situating the study in a particular knowledge paradigm has implications for all aspects of the research. The paradigm will influence the selected empirical case. It also has impacts on the nature of questions, methodology, design and ultimately the findings of the research.

This study adopts a relativist (interpretive/social constructionist) worldview. In this paradigm, the social phenomenon is perceived as ‘co-constructed’ through the interactions among and between different actors (Agger 1991; Shiffman 2009). The assumption here is that the phenomenon does not exist or operate in isolation or independently from social actors. The phenomenon is perceived as constructed, changed and adapted through a continuous process of interaction and interpretation among and between the actors (Gilson
2012; Lincoln 1992). In short, the relativist worldview assumes that the phenomenon evolves through a continuous re-interpretations applied to it by actors.

In adopting relativism, this study acknowledges yet explicitly rejects the positivist paradigm. The positivist understanding assumes the existence of ‘facts’ and ‘objects’ that operate independently from human understanding and interpretation (Gilson 2012). According to the positivist worldview, facts and objects can be measured and observed without interference in their inherent ‘law’ of cause and effect. Hence, positivism aspires to ‘discover’ those facts and the laws that govern them.

There are numerous reasons that this research departs from the positivist approach and takes a relativist stance. First, this research does not view the health system merely as a vehicle to deliver technological solutions to independently existing health issues. Health systems, rather, are seen as embedded in social and political contexts. They, therefore, are influenced by and are affecting the underlying legacies, values, norms and interests (Sheikh, Gilson, et al. 2011). Second, this research views health policies and health systems as a social construct made up largely from values and resulting behaviours (Lincoln 1992). Health policies (and systems) are perceived as dynamic and socially constructed (Smith, Mitton, et al. 2009). In this understanding, health policy actors base their decisions on the knowledge that is derived from interpretations they acquire throughout their daily experiences in the system (Blaikie 1991). Finally, the positivist approach tends to focus on what intervention works rather on how and why certain interventions operate in a particular context (Gilson, Hanson, et al. 2011). This study is interested in the latter set of questions rather than what works.

The choice of the relativist worldview does not arise from an ideological conviction in part of the researcher. Such choice is the result mainly of pragmatic considerations about the empirical case of this research. As described in chapter one, the aim of this research is to explore the process of introducing Iraq’s BHSP. This research does not view the health system in Iraq as an isolated and rigid object. Rather, it views Iraq’s health system as a social construct that is situated within, affected by and affects historical, political and economic contingencies. The relativist paradigm is useful in exploring the complexities of introducing
an ostensibly new policy (the BHSP) in such a social construct (Iraq’s health system). Adopting a relativist approach also helps in examining the views, voices, beliefs and understandings of multiple actors involved in the introduction of the BHSP in Iraq. The assumption here is that Iraq’s BHSP does not exist independently of the values, interests and intentions of those stakeholders who are involved in its introduction. Exploring those values, preferences and interests, are essential for beginning to answer questions related to the introduction of Iraq’s BHSP. In short, this research aspires to provide rich understandings and interpretations of the phenomena through deep exploration.

Adopting a relativist worldview in the field of health policy and systems research is not without challenges. One such challenge is that drawing on the relativist worldview in health research is still in its infancy (Gilson 2012). Research in health service and health care often adopts a positivist stance (Bennett et al. 2011; Sheikh et al. 2011; Gilson et al. 2011). The positivist approach to health research, views health issues as facts that exist independently of the researcher who studies them (WHO, 2012). Empirical inquiry, in this worldview, aims at uncovering causes and consequences that operate as laws in a particular context and that can be generalised to others. It does that through testing hypothesis originating from previous experiences and pre-existing theories (Gilson, Hanson et al. 2011). Also, the dominant actors within the health system including doctors, nurses and other professional health workers often perceive the positivist worldview as given (Gilson 2012). The prevalence of such methods also arises, in part, from the anxiety in part of donors, international organizations and local actors to examine the effectiveness of interventions and benefits of programs in comparison to the costs of those interventions and programs. Therefore, there are relatively few studies that adopt relativism as a knowledge paradigm for their inquiry in Health Policy and Systems Research (HPSR). This research attempts to contribute to the movement toward the involvement of social and political science in HPSR. This research attempts to contribute to the movement toward the involvement of social and political science in HPSR.

2.2 The Research Methodology
The decisions on the selection of a particular knowledge paradigm influenced the methodological choices. This study views methodology broadly as those principles that underpin the approaches to data collection (Dew 2007). More specifically, a methodology is
the “description and explanation of the study that guides and justifies the choice of its methods, clarify their assumptions and outcomes” (Denzin & Lincoln 2000). This research adopts a qualitative approach. In general, qualitative research can be viewed as “a process of understanding...that explores a social or human problem where the researcher builds a complex holistic picture, analyses words, reports detailed views of informants and conducts their study in a natural setting” (Creswell 2007). This definition is consistent with the relativist worldview because the qualitative methodology can “grasp phenomena in some holistic way or to understand a phenomenon within its own context” (Lincoln, 1992:376). Hence, a qualitative enquiry offers the opportunity to explore complex social phenomena while taking into consideration subjective values and beliefs (Creswell 1998; Creswell 2002; Denzin & Lincoln 2000).

The qualitative approach offers several potential theoretical advantages for the field of HPSR and this research in particular. First, in HPSR qualitative approaches can help in developing theories. This advantage is useful in HPSR, an area which is characterized by the infancy of its theoretical underpinnings (Bennett et al. 2011). Second, qualitative data can be used to enhance the understanding of phenomena that are obscured by quantitatively derived objective data. The meanings of otherwise ambiguous or counter-intuitive results obtained from quantitative methods can be questioned and explained through qualitative methods (Miles and Huberman 1994; Robinson, Dolan, et al. 1997). Third, qualitative research and the relativist paradigm it underpins is particularly useful for the policy formulation process that this research considers (Lincoln, 1992). Finally, qualitative methods can be used as a preparation for the conduction of structured surveys and questionnaires, to ensure that respondents understand the concepts and terms used in those investigations (Coast 1999). These advantages were instrumental in the decision to select the qualitative methodology for this study.

Besides (and related to the) the general features of the qualitative methodology described above, the latter deemed appropriate particularly for achieving the aims of this study. First, there is a limited knowledge base to start with in the area of HPSR in Iraq and the wider Middle East and North Africa (MENA) (El-Jardali et al. 2010; Carter & Little 2007). Therefore, qualitative data about the views, preferences, interest and behaviours of
various stakeholders in Iraq will be generated and analysed. Qualitative data about the views, preferences, interest and behaviours of various stakeholders in Iraq will be generated and analysed. Qualitative data about the views, preferences, interest and behaviours of various stakeholders in Iraq will be generated and analysed. Qualitative data about the views, preferences, interest and behaviours of various stakeholders in Iraq will be generated and analysed.

The description of the qualitative methodology provided above offers the opportunity to select from a broad range of study designs and approaches. The literature commonly refers to a host of designs such as case studies, phenomenology (Spiegelberg 1975; Baker et al. 1992), discourse analysis, discourse analysis, discourse analysis (Fairclough 2003) grounded theory (Glaser & Strauss 1967; Baker et al. 1992), and ethnography (Hammersley & Atkinson 2007), ethnomethodology and action research the study (Baker et al. 1992; Leininger 1992). The section below describes the research design approaches adopted in this study.

2.3 The Research Design: A Case Study Approach

The purpose of this section is to address key questions and objectives related to the research design of this study. The section attempts to describe the case under investigation. It offers a definition of case studies, introduce the case study of this research and outlines the boundaries of the case. It then presents certain features of the case study approach that made it appropriate for this study. The section will later offer thoughts on the limitations of this particular case study.

This study adopts a flexible approach. The study did not start with a rigid design. It neither began with a fixed and unchanging set of questions throughout the study. On the contrary, the study’s design, aim, questions, analysis and even results and findings changed throughout the study’s progress. Particular questions were either modified or entirely removed while others were added in the face of new insights from the literature, interviews or documentary findings. The same adaptations were applied to the data of the study in the analytical phase. This constant modification can be seen as an example of what Parlett and Hamilton (1976) call ‘Progressive Focusing’ (Parlett & Hamilton 1972) which is not
uncommon in studies that adopt similar paradigm, methodology and design (Bechhofer & Paterson 2000; Gilson 2012).

So why the decision was made to adopt a case study approach? To answer this question, it is necessary first to define a case study. As defined by Stake (1995) a case study is “the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances” (Stake 1995: xi). Similarly, Morra and Friedlander (1993) suggests that case study is utilised as a “method for learning about a complex instance, based on a comprehensive understanding of that instance obtained through extensive description and analysis of that instance taken as a whole and in its context” (Morra & Friedlander 1999:3). Pope and Mays also argue that the case study “focuses on one or a limited number of settings; used to explore contemporary phenomenon, especially where complex interrelated issues are involved” (Pope & Mays 1995:43). More simply, Ragin and Becker (1992) define a case study as “the analysis of social phenomena specific to time and place” (Ragin & Becker 1992:2).

This research is a case study of Iraq’s BHSP. It is an attempt to learn more about Iraq’s BHSP through extensive description and analysis. The latter is seen as an instance that is ‘taken as a whole and in its context’. We also consider the BHSP as a “specific, complex and functioning thing” (Stake 1995:2). Furthermore, the BHSP in Iraq is viewed as a ‘bounded or integrated system’ (Stake 1995). The ‘important circumstance’ within which the BHSP is situated is the post-conflict setting of Iraq between 2003 (the Iraq war) and the formal introduction of the BHSP in 2009.

Another dimension of the relevant circumstance of this case is the level of analysis. A useful typology to utilise in thinking about the levels of analysis is the micro, meso and macro levels of analysis (Sheikh et al. 2011). Sheikh and colleagues (2011) define those levels as follows: “macro-level analysis analyses the architecture and oversight of systems, meso-level analysis focuses on the functioning of organizations and systemic interventions, and micro-level analysis considers the roles of individuals…and how systems respectively shape and are shaped by their decisions and behaviour” (Sheikh et al. 2011:3). Situating the study at any one of the above levels introduces several particular disadvantages. For example,
the macro-level analysis of structures could be too abstract while the micro-level analysis frequently overlooks the impact of broader structural factors (Evans 2001) The meso-level of analysis likewise can result in overlooking essential features otherwise covered by the micro and macro levels (Fulop, 2001; Mills, 2012; Dowding 1995). This study embraces a pragmatic position towards situating itself at one or more of those levels. It aspires to undertake a multi-level analysis that encompasses elements of each of the levels described above (Evans & Davies 1999). Such a position will arguably assist in capturing and uncovering the potential complexities of policy formulation process.

The case study approach was used because it has several features that were considered relevant to this research. First, as Ragin and Becker (1992) argue, case studies can and often will invoke various and additional units in their inquiry (Ragin & Becker 1992). Hence, case study designs are arguably more appropriate for exploring policies and interventions that are complex, not discrete and are not easily distinguishable from their external environment (Keen & Packwood 1995; Yin 2014; Yin 2009; Yin 1981). The temporal and spatial boundaries of this case study were useful in introducing structure to the research and its design. However, those boundaries were neither rigid nor were set from the outset of the study. This case study invoked elements from other post-conflict settings and elements of the Iraqi health system before the 2003 conflict. In retrospect, such references seem inevitable given the embeddedness of Iraq’s BHSP within wider historical, political and health system contexts and because of the latter’s complex and less discrete character. Similarly, the existence of elements outside the boundaries of this case is logical given that those boundaries were consolidated in later stages of the research rather than from the outset. Furthermore, making references to elements outside the temporal and spatial limits of this case were useful for enriching and deepening the understanding of the complexities of the case within those boundaries.

Second, other well-known features of case study design were also instrumental in selecting the latter as the methodological approach for this study. For example, Yin (2014) argues that the case study approach is more appropriate for research studies that attempt to address how (and why) questions (Yin 2014). Furthermore, Yin (2014) also claims that a case study is more appropriate when the researcher has a little or no control over the case under
investigation (Yin 2014). It is also believed that the case study approach is more useful in cases that involve a relatively small sample size of involved organizations. We think that the case study of Iraq’s BHSP fulfils both those three conditions and preferences. As described elsewhere, the aim of this study is to tell the story of the BHSP in Iraq and explore how and why it was introduced. On the other hand, we also believe that the researcher has limited or no control over the case under scrutiny. Lastly, we argue that the case study approach is more appropriate compared to other approaches given the relatively small sample size of organisations that are involved in the policy process of introducing the BHSP in Iraq.

Finally, it was realised that the case study approach allowed for the testing and even ‘falsification’ of propositions made by the literature (Flyvbjerg 2006). This is the case perhaps because this approach is flexible enough to allow the study to be “exploratory, explanatory, or descriptive or a combination of these” (Pope & Mays 1995, p.43; Morra & Friedlander 1999). Health policy formulation in the post-conflict setting of Iraq has not yet been explored in-depth in the literature. The examination of the introduction of the BHSP, therefore, offered the opportunity to test propositions made by the literature on health policy formulation in post-conflict settings. The ‘falsification’ of any of the propositions made by the literature through the in-depth study of Iraq’s case can be seen as a significant contribution to knowledge in this field. As such, it is the hope of this case study to explain questions related to introducing health policies in post-conflict settings.

It is probably clear from the above discussion that this research adopted a single case study approach in contrast to multiple cases. According to Yin (2009) and others, the use of a single case study rather than a multi-case design is justified in some circumstances (Yin 2009; George & Bennett 2005). Below are an overview of those justifications as applicable to the case of Iraq’s BHSP (Wilson 2014). First, the single case represents an example of a critical case that is defined as “having strategic importance in relation to the general problem”. (Flyvbjerg 2006:14). It is expected that the single case study of Iraq’s BHSP will offer valuable contributions to a better understanding of the introduction and formulation of policies in post-conflict settings. We argue that the case of Iraq is critical in the sense that it is similar in some aspect to other post-conflict settings but also different in many other aspects. Therefore, Iraq’s case offers the opportunity to test some of the hypotheses that are advanced
in the literature on policy formulation in post-conflict settings. For example, one of the propositions that this research is interested in is the claimed dominant role of international actors in introducing health policies in post-conflict contexts (Macrae et al. 1996; Okuonzi & Macrae 1995). Iraq’s BHSP, we argue, is a critical case because it can offer deeper understandings on such propositions.

Second, we propose that Iraq BHSP perhaps can be viewed as unique or extreme for several reasons; first Iraq is an extreme case of foreign military intervention. Second, it is a unique case in the sense that a period of relative isolation was followed by the influx of large numbers of international actors in the immediate post-conflict period. Third, Iraq has never been studied from the perspective of health policy formulation in post-conflict settings. Finally, Iraq’s case can be seen as unique in the sense that it is a precedent for other countries in the Middle East. Understanding the processes of policy formulation in the post-conflict setting of Iraq could have relevance to future processes in Syria, Libya, and Yemen. Finally, a single case study can also be justified based on its ‘revelatory’ nature. This single case study of Iraq’s BHSP will explore some areas of health policy formulation in a post-conflict setting that were not previously studied.

It is not the aim of this section to present the limitations of the case study approach. These limitations are analysed in more detail elsewhere (Flyvbjerg 2006). However, it is necessary to highlight here some of the challenges of the case study design as it relates to this study. Arguably, case studies are inherently less capable of producing generalizable conclusions (Yin 2014; Yin 2009; Yin 1981; Stake 1995). As such, the inferences from a single case study cannot be understood as a universal truth that is unrestricted by time or place (Gomm et al. 2000). Hence, a case study cannot account for or explain a similar phenomenon in a different context (Stake 1995; Gomm et al. 2000). However, some suggest that generalisations can be inferred from case studies (Blaikie 2010; Mjoset 2006; Flyvbjerg 2006; Winters & MOR 2009). Those generalisations are characterised as tentative or provisional rather than absolute and concrete (Evers & Wu 2007). Furthermore, others argue that the inability of case studies to generalise should not be considered as a weakness of this particular methodology. Rather, those authorities claim that any attempt to generalise beyond a particular case introduces the risks of imposing mistaken inferences.
To summarise, this section defined the case study approach. It then introduced the case of Iraq’s BHSP. The section also presented arguments and justifications for why the case study approach is thought to be appropriate for this research. Finally, it briefly reflected on the limitations of this particular case study.

2.4 The Research Methods

Data was obtained by conducting a literature review, in-depth semi-structured interviews and documents review. This section reports the methods utilised to collect data. It starts with a description of the literature review strategy. It then proceeds to present the interview and document data collection methods. These latter techniques were used strategically for achieving a level of certainty about the explanations that interviews offered (Bechhofer and Paterson 2000). In other words, data triangulation is used to achieve control in the study.

2.4.1 The Literature review strategy

The objective of the literature review was to explore what is known about the introduction of health systems policies in post-conflict settings.

A practical guide for conducting systematic reviews of the literature was used in conducting the literature review (Petticrew & Roberts 2006). A modified version of The Campbell Collaboration protocol for conducting systematic reviews was also used in aiding the review (The Campbell Collaboration 2001). The review started with a search for systematic reviews of the literature that addressed or were closely related to the question under consideration. The following databases were systematically searched:

- The CRD database at the University of York
- The Cochrane Database of Systematic Reviews
- Applied Social Sciences Index and Abstracts (ASSIA)
- Medline

Search strategies such as (Health AND Package OR post-conflict) were used. Several reviews were identified that were only remotely related to the question under consideration (Health Council of the Netherlands 2003; Kruk et al. 2010; Chopra et al. 2012; Witter 2012). The lack of systematic reviews on the introduction of health policies in post-conflict settings
adds to the value of this literature review. However, as shown below, the absence of systematic reviews perhaps reflects the scarcity of research on this particular topic. Nevertheless, the cited systematic reviews helped in guiding the process of literature search that is reported below.

The next step was conducting a comprehensive search of the relevant literature. The followings were used as key words or index terms in the quest: conflict, post-conflict, reconstruction, fragile, transition combined with health, BHSP, BPHS, Basic Packages of Health Services, Basic Health Services Package, health packages, benefit package, user fees and any of the following subject terms introduction, formulation, transfer, translation, diffusion, dissemination, learning, copying, emulation, inspiration, coercion. For example, one of the early searches was the following term: [(conflict OR post-conflict OR reconstruction OR fragile OR transition) AND Health AND “Policy Transfer”].

The starting point for the search was the following databases:

- PubMed,
- Science Direct,
- The Cochrane database
- The University of Edinburgh’s library
- Google Scholar

Those sites and databases, however, probably do not contain all of the relevant literature on the topic under question (Petticrew & Roberts 2006). Therefore, the ‘grey literature’ was also searched. The websites of WHO, the World Bank, and the Health and Fragile States Network were searched for relevant publications. The search also included book chapters, references to other literature reviews and primary studies. Websites such as EThOS, COPAC and theses.com were searched for available theses that were relevant to this study (British Library 2015b; Jisc service 2015; Anon 2015b). Conference proceedings were also searched through the dedicated websites and tools such as BLPC, OpenGrey and PolicyFile (British Library 2015a; Anon 2015a; ProQuest LLC 2015).

The search through key words and index terms in electronic databases and other websites yielded a total of 1922 documents, articles, book chapters, reports and other
materials (Figure 2.1) presents the process of identifying selected sources and the breakdown of documents contributing to the final literature review report.

**Figure 2.1: Sources contributing to the literature review**

Electronic and Library Search: 7 databases & 9 websites

1922 full text papers and book chapters identified

69 documents were identified as relevant from the title and/or abstract by applying inclusion and exclusion criteria

392 documents identified following the inclusion of relevant citations and references

200 documents following further appraisal of titles and abstracts
The review identified documents were examined for their relevance to health policy making in post-conflict, fragile or conflict-affected settings. The results of that search were screened through their titles and abstracts to decide on which were relevant and met the inclusion criteria. Several inclusion and exclusion criteria were considered in the search strategy. Only materials pertaining to post-conflict settings were selected. The search in the academic literature was limited to English publications only. Documents in Arabic were also included from the grey literature. Studies were not excluded purely based on the geographical locations where they were conducted. Neither were materials excluded depending on the type of the interventions or policies considered. Also, no restrictions were employed depending on the time at which the studies were conducted. Such restriction was deemed unnecessary given that the literature on health systems policies in post-conflict settings is relatively recent. Studies that focused exclusively on interventions during natural disasters were excluded. Natural disasters were excluded because of the assumption that they are not directly relevant to the post-conflict status of Iraq.

Only 69 documents were selected based on the inclusion and exclusion criteria. A further snowballing technique was employed to identify other resources. Snowballing was done through examining the reference list of selected articles. It was also done by searching the citations of selected articles in other studies, reports and documents. A total of 200 documents, journal articles, studies, books and book chapters were included in the final analysis. The identified documents were then divided into two categories studies examining specific policies or interventions, and descriptive studies. Such categorisation was necessary to facilitate the review process given the relatively large size of the data. It was also helpful in aiding the triangulation of evidence between research findings and results from the grey literature. Then the studies from the first category were critically appraised. The appraisal, extraction and synthesis of findings from the identified literature followed prescriptions provided by authorities in the field of qualitative systematic reviews (Petticrew & Roberts 2006; a Pearson 2004). This process was also guided by practical applications to systematic reviews to qualitative research (Stevenson et al. 2004). Findings from the second category were used to triangulate the results of the first category. The process and findings of the appraisal and the synthesis of those findings are presented in the literature review chapter.
2.4.2 Semi-structured interviews

This study collected qualitative data through in-depth, semi-structured interviews (Mason 2002). Interviewing was used as a principal data collection method because it “provided information not recorded elsewhere, or not yet available (if ever) for public release” (Richards, 1996:200). The purpose of the in-depth interviews was to capture the voices, attitudes, perspectives and preferences of the individual interviewees (Coffey & Atkinson, 1996; K. Denzin & Lincolin, 2000; N. Denzin & Lincoln, 2008; Patton, 2015). It was further used to explore the meanings that underpin interviewee’s experience through further probing (Arksey & Knight 1999). The “conversation with a purpose” that occurred during interviews allowed capturing the contextualised knowledge of interviewees (Mason, 2002:62). It also offered the opportunity to explore the dynamics of interactions among social groupings (such as internal and external actors in this case study) (Arksey & Knight 1999). Furthermore, semi-structure in-depth interviewing was employed to get “vivid, warm and contemporary” account from individuals rather than just a “dull, clinical history” from documents or archives (Seldon, 1988:9). Finally, the data collected through interviews were useful in interpreting and triangulating information gathered through document analysis (Richards 1996).

The semi-structured interview guide consisted mainly of open-ended, follow-up and probing questions (Rubin & Rubin 2011). Interview schedules were prepared using mainly open-ended questions (Appendix 1). Schedules also included primary questions and probes. A flexible structure for asking the questions during the interview process was adopted to allow the respondents the autonomy to share their experiences and opinions (Creswell 1998; Creswell 2002; Creswell 2012; Aberbach & Rockman 2002). Probing of provided answers also allowed clarification of responses and further exploration of their meanings (Arksey & Knight 1999). The aim of using open-ended questions and probe was “not to get simple yes and no answers but descriptions of an episode, a linkage, and explanation” (Stake, 1995:65). This format was also used to “elicit depth, detail, vividness, nuance and richness” (Rubin & Rubin, 2011:134). The questions were revised in consultation with the supervisors. They were also discussed with colleagues at Social Policy Seminars conducted at the School of Social and Political Science of the University of Edinburgh. The interview guide was then tested in one pilot interview. Further changes were made given the responses to the questions.
in the pilot interview. A decision was made later to include the pilot interview in the data collected for analysis because the data was deemed appropriate for the purpose of the study.

The participants of the study were chosen based on what they might know to help answer the questions of this research (Aberbach & Rockman 2002). More specifically, the identified individuals were considered as professional elites in their field (Gubrium & Holstein 2001). Potential participants were identified through reviewing documents that highlighted the contribution of particular persons or organizations. Internet searches were also utilised to identify individuals who might have been able to contribute to answering the questions of this research. The internet search included websites of organisations, think tanks, consultancy agencies, academic institutions and government websites. Key individuals were also identified through their academic contributions to the literature on Iraq's health system or the BHSP in Iraq. The researcher’s professional background and connections helped in the identification of and access to key individuals. Finally, every interviewee was asked about other potential individuals that they thought might offer more insight into the topic of the research.

Following the process outlined above a total of 37 individuals were selected to be contacted through emails (Appendix 2). Twenty persons agreed to conduct the interviews. This number of interviewees were deemed adequate for two main reasons. First, they were believed to be knowledgeable and diverse enough to offer a comprehensive response to the questions of the study. Second, the data collected through the interviews were seen as adequate for achieving the aim of the research so that no further interviews were considered as necessary. Interviewees included key national decision makers such as former ministers of health, directors of departments of health, directors of health policy and planning at the departments of health and ministry of health, directors of hospitals and administrators of the health centre where the pilot phase of the BHSP is implemented. The identified individuals also included academics, officials at international organizations, donor agencies, and consultancies. Out of the 20 interviewees, 10 were foreign, and the rest were Iraqis. A total of six interviewees worked at the time of the interviewee in domestic institutions (MoH, Directorates of Health and Universities) while the rest interviewees worked at international organisations. Table 2.1 offers the numbers of the interviewees based on selected categories.
Only five of the respondents were female. The age of the participants ranged from 35 to 65.

Table 2.1 categories of interviewees

<table>
<thead>
<tr>
<th>Categories</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>6</td>
</tr>
<tr>
<td>Bilateral body</td>
<td>3</td>
</tr>
<tr>
<td>Multilateral body</td>
<td>7</td>
</tr>
<tr>
<td>Consultancies</td>
<td>3</td>
</tr>
<tr>
<td>Academia</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

Out of the 20 interviews, only two were conducted face-to-face. Both face-to-face interviews were carried out during conferences that the researcher and the interviewees attended. The rest of the interviews were conducted by either Skype or phone. Most of the participants responded relatively quickly. However, several individuals either cancelled the interviews or postponed them to a later appointment due to their engagement with other duties. Most of the interviews lasted for about an hour and a half while some were a little less or more than an hour. The interviews were transcribed either immediately or within 48 hours. Most of the interviews were conducted in English. However, some has been carried out in Arabic or Kurdish. Those interviews were translated during the transcription process by the researcher. At the conclusion of each interview, the participants were asked for their suggestions about other potential interviewees as well as documents that the participants were aware of and relevant to the purpose of the study.

The quotes from the interview data are referred to through an identification system that includes four pieces of information. The identification system includes the nationality, gender, place of work and the number of the interview. A list of the all the interviews and the identification system used to refer to them is provided below:

- **IM_Ac_1** (Iraqi Male, worked in academia)
- **IM_Md_2** (Iraqi Male, worked at a multilateral donor agency)
- **IF_UN_3** (Iraqi female, worked at UN)
- **nIM_Bi_4** (non-Iraqi male, worked at a bilateral agency)
The Skype/phone interviews were not without challenges or shortcomings (Shuy 2002). There are no agreed-upon standards for conducting elite interviews through Skype or phone (Stephens 2007). There is a relatively limited experience with conducting phone interviews with elites (Wasserman 2000). Furthermore, some of the interviews that we conducted with participants who were based in Iraq were interrupted due to problems with internet connections. Conducting interviews through Skype probably prevented from using visual cues for redirecting the participants to the topics that the researcher wanted (Hanna 2012; Holt 2010). The lack of visual contact undermined the role of non-verbal communication in redirecting the interview towards the topic of discussion should divergence happen. The lack of non-verbal communication also limited the ability of the researcher in
probing through visual cues. Doing the interviews through a computer introduced the challenge of maintaining focus and concentration. For example, in one interview the participant referred to a website that the researcher was eager to check immediately. Checking a website during the interview was perhaps a source of distraction. Finally, doing the interview through Skype/phone made it impossible to explore the place of the interviewee and examine cues that might add depth and richness to the interview materials.

Despite the challenges described above, several practical reasons led to the decision of doing most of the interviews through Skype/phone. Most of the interviewees who were involved in the initial introduction of the BHSP in Iraq were no longer based in the country. Some moved to other geographical locations. Furthermore, most of the internal interviewees were located in areas that were deemed too dangerous for the researcher to visit. Being a Kurd, the researcher could have been a target for terrorists in areas that people are persecuted based on their ethnic, religious or sectarian identities. Finally, the Skype/phone interviews were considerably cheaper to conduct compared to physically travelling to the locations of the interviewees (Shuy 2002).

All of the Skype interviews were done using the phone rather than the video feature of the service. The researcher only turned on the video feature if the interviewer did that first to give the participant the freedom to use this feature. Some of the participants were doing the interviews from their homes, and the researcher did not want to be too intrusive into their privacy (Hanna 2012). Only one interview was done through a phone call using Viber (an application for free international phone calls). The interviews were recorded using an MP3 Skype voice recorder. All of the Skype interviews were done through a computer (rather than a Skype application on a phone). Conducting the interviews through a computer allowed the researchers hands to be free to write notes (Stephens 2007). Doing the interview with a computer also allowed engaging with the questions from the interview schedule. Finally, doing the interviews through Skype/phone allowed the researcher to be more in control of the interview setting than would have been otherwise the case in a face-to-face interview (Stephens 2007). Therefore, although there is still some scepticism (Weinmann et al. 2012), Skype interviews represented a feasible alternative to face-to-face interviews (Hanna 2012; Deakin & Wakefield 2014; Janghorban et al. 2014).
Finally, it is necessary to underline here the temporal distance of the chronological events leading to the introduction of Iraq's BHSP from the time of the interviews. Such distance implies at least two consequences. First, interviewees might have not quite exactly remembered the details of the events and discussions related to the BHSP. After all, interviewees were asked about events that spanned 10 years of time in the past. Second, several interviewees had changed institutions and were working at a different organisation from the ones that they did at the time of the introduction of the BHSP. This change in role likely meant a change in the way they articulated their accounts of the events leading to the introduction of the BHSP.

The analysis of documents as secondary sources of data were particularly useful in triangulating the account of interviewees. The next section will provide an overview of the nature of the data collected through documents.

2.4.3 Documents

Documents were the second principal source of data for this study. While keeping the inclusion criteria wide, only documents that considerably focused on the BHSP in Iraq or other countries were included. Other documents that did not exclusively focus on the BHSP but addressed directly relevant aspects of the BHSP such as health policy in Iraq with a particular emphasis on the post-conflict period were also included. Health policy documents before the 2003 war were also consulted for the special purpose of exploring continuity from past policies.

The website of the MoH was searched for policy documents, statements, briefs and announcements related to the BHSP. Websites of relevant organisations were also searched. Those included the World Bank, WHO, USAID, UNICEF and several consultancies that were involved in the formulation of the BHSP. A Google search was also conducted to locate similar policy documents in other post-conflict countries. Further documents were also identified during the review of the already selected materials. Finally, interviewees were asked about resources that were relevant to the purpose of the research.

The search strategy yielded a total of 47 documents (Appendix 3). Out of the entire 47 documents, 20 were official government publications (six were from Iraq and the rest were
from other post-conflict countries and the United States). Eleven were published by the
United Nations and its member organisations (WHO, UNICEF, FAO). Six documents were
reports issued by consultancies such as EPOS and Abt Associates. The World Bank and IMF
released seven. Finally, three were issued by a non-governmental organisation, an academic
institution and a former minister of health. The majority of the documents were published
after the Iraq war of 2003 (only 15 were issued before that date). The documents included
formal government policy publications (from both Iraq and other post-conflict countries).
They also included consultative papers, assessment reports, and archives both from
government and from non-governmental sources.

The identification and collection of relevant documents for this research faced several
challenges. First, the search was limited to electronic sources and websites. This restriction
was the result of the inability to access government buildings and headquarters due to
security concerns (please refer to limitations below). Second, it was not possible to obtain
materials such as meeting minutes. Iraqi government officials at the MoH declined to offer
such materials citing confidentiality reservations. In some cases, those officials indicated that
meeting minutes were simply not kept. Finally, as explained in more details in the limitations
subsection, it was not possible to obtain earlier drafts of Iraq’s BHSP despite multiple
attempts. Those difficulties, however, did not undermine to a large extent the utility of the
available documents in helping achieve the aims of this study. A decision was made that a
critical mass of documents was reached because the data obtained from the collected
documents deemed adequate in contributing to answering the questions of the study.

Several reasons justified using document review and analysis as a principal source of
data for this research. The examination and analysis of documents were helpful in
triangulating the claims and observations obtained through interview materials. Analysing the
documents was also useful in identifying areas that can be further explored through
interviews. It also provided the opportunity for exploring and unpacking the assumptions
underpinning what otherwise appeared as facts (Iannantuono & Eyles 1997). Finally,
document review helped in demonstrating and examining the changes in the views of the key
informants who participated in authoring those documents (the former minister of health for
example).
Other conceptual reasons contributed to choosing documents as a principal data collection and analysis method. The health policy analysis literature uses document review extensively, and it is a standard method for data collection in health policy analysis (Gilson 2012; Hanney et al. 2003). This is also the case in relation to health policy analysis in fragile and conflict-affected settings (Shuey et al. 2003; De Vries & Klazinga 2006; Alonso & Brugha 2006; Lee et al. 2011; Cometto et al. 2010). Document analysis also constitutes a crucial method for exploring questions related to health policy transfer (Jeremy Shiffman et al. 2004; Walt et al. 2004; Freeman 1999; Freeman 2006; Leiber et al. 2010; Bandelow 2006; Tantivess & Walt 2008; Ogden et al. 2003; Lush et al. 2003a; Ngoasong 2011). The paragraphs below will present the approaches undertaken to analyse the documents and interview data collected in this study.

2.5 The Policy transfer theoretical framework
2.5.1 Introducing the policy transfer literature

Dolowitz and Marsh define policy transfer as the “process by which actors borrow policies developed in one setting to develop programs and policies within another” (Dolowitz & Marsh 1996:357). Others define it as “application of knowledge of a set of policy instruments of one policy domain in another policy domain” (Lodge 2003:161). The transfer of policies might involve ideas, ideologies, negative lessons and concepts. It might involve contents, instruments, goals and technologies (Dolowitz & Marsh 1996; Goldfinch 2006; Newburn 2002). Some divide such transfer into hard such as tools and technologies and/or soft as ideas, ideologies, lessons and/or concepts (Evans & Davies 1999). Dolowitz and Marsh also distinguish between complete/incomplete and failed/succeeded policy transfer (Dolowitz & Marsh 2000; Larmour 2002). Dolowitz and Marsh use incomplete and failed transfer interchangeably and define the former as “although transfer has occurred, crucial elements of what made the policy or institutional structure a success in the originating country may not be transferred, leading to failure” (Dolowitz & Marsh 2000:17). They also recognise ‘uninformed transfer’ as a category of transfer failure where “the borrowing country may have insufficient information about the policy/institution and how it operates in the country from which it is transferred” (Dolowitz & Marsh 2000:17). Finally, they also highlight ‘inappropriate transfer’ as another category of failed transfer arising from “insufficient attention…to the differences
between the economic, social, political and ideological contexts in the transferring and the borrowing country” (Dolowitz & Marsh 2000:17).

While those definitions and terminologies describe the nature of the transfer, other frameworks attempt to present the mechanisms through which transfer occurs such as convergence, emulation, elite networking, and harmonisation or a combination of these (Bennett 1991; Jones & Newburn 2002; Wolman 1992; Bennett 1997; Dolowitz 1997). A useful framework to examine those mechanisms is that developed by Dolowitz and Marsh (Dolowitz & Marsh 2000) Figure 2.2

**Figure 2.2: Dolowitz and Marsh’s Policy Transfer Continuum**

![Dolowitz and Marsh’s Policy Transfer Continuum](image)

Source: (Dolowitz & Marsh 2000)

According to this continuum, policies can be transferred through voluntary (lesson-drawing) to coercive modes of transfer (direct imposition). Clearly, it is rare to find pure forms of such modes and probably most instances of transfer is located somewhere on the continuum that does not correspond to a well-defined category (Dolowitz & Marsh 2000; Dolowitz & Medeiros 2009). Similarly, policy makers may ‘copy or emulate’ BHSPs and their financing methods from other settings (Lee & Strang 2006). They may engage in ‘elite networking’ with experts and professionals at the trans-national level (e. g. membership in an international organisation) who advocate a particular policy (Greenhill 2010). Alternatively, the latter is the outcomes of the harmonisation of conditions with other countries (which adopted BHSP) leading to similar policies (Bennett 1991; Jones & Newburn 2002) or policy convergence (Holzinger & Knill 2005; Lenschow et al. 2005; Jones & Newburn 2002).
External actors might even coercively impose policies (Dolowitz & Marsh 2000; Dolowitz & Marsh 1996). Finally, policy makers might selectively pick and choose various elements of the final policy from different sources in what can be termed synthesis (Ettelt et al. 2012; Dwyer & Ellison 2009; Padgett 2011; Gilardi 2012; Sharman 2010).

Whether copied, emulated, the outcome of networking, imposed or the result of harmonisation, it appears that some form of learning (whether rational, bounded or otherwise) is involved in policy transfer (Meseguer 2005). Policy transfer is part of a common theme that includes convergence, policy diffusion, and lesson drawing or learning (Bennett 1991; Dolowitz & Marsh 1996; Dolowitz & Marsh 2000; Stone 2001). Hence, the adoption of policies by one country might be the result of the latter becoming similar to other jurisdictions in a process of globalisation induced convergence (Bennett 1991; Drezner 2001; Knill 2007; Holzinger & Knill 2005). They might also result from policy diffusion or “any pattern of successive adoption of a policy innovation” (Bennett 1991:220) (Marsh & Sharman 2009; Tews et al. 2003). The inherent assumption, therefore, is that policy transfer is part of the policy process and that it is linked to the notions of learning, lesson drawing, and evidence-based policy making (Stone 2001; Ogden et al. 2003; Evans 2009; Bennett & Howlett 1992; Hall 1993; Stone 1999). The adoption of particular policies in one setting may have resulted from decision-makers actively seeking lessons in response to domestic problems (Jacobs & Barnett 2000; Mills et al. 2002; McPake 2002; C. J. Bennett 1991; Rose 1991). In the process, shared preferences and interests between internal and external actors (including ‘veto players’) that may drive the adoption of particular policies and shape the utilization of relevant evidence should be taken into consideration (Bräutigam 2000; Korkut & Buzogány 2013).

The role (both successful or otherwise) of external actors (including organisations, experts, consultants, think tanks) or what have been termed ‘transfer agents’ is repeatedly emphasised in the literature (Legrand & Vas 2014; Eccleston & Woodward 2014; Bock 2014; Stone 2000; Stone 2008; Stone 2010). Stone defines transfer agents as those actors that “facilitate the exchange between a number of polities” (Stone 2004:549). Those agents are operating within the local historical and institutional context of the transfer process (Padgett & Bulmer 2005; Radaelli 2005; Tervonen-Gonçalves & Lehto 2004a; Dolowitz & Medearis
Incongruent contexts might allow the transfer of labels through the easier diffusion of ideas without complete transfer of the policy instrument itself and making each instance of transfer unique (Radaelli 2005; Massey 2009).

2.5.2 Health Policy Transfer

In comparison to the relatively large body of literature on policy transfer in other disciplines, there are only few that explicitly apply the concept of policy transfer of health policies. Several publications focused on particular health policies, interventions or programmes. Some examined the transfer of clinical interventions such as DOTS for the management of Tuberculosis (TB). Relatedly, Walt and colleagues examine the role of international organisations in the transfer of DOT and syndromic management of sexually transmitted diseases. One publication studied the transfer of interventions concerning access to medication in Cameron (Ngoasong 2011). Two other publications explored the transfer of whose idea of health promotion and more specifically Health for all by the Year 2000 policy to Portugal and Finland (Tervonen-Gonçalves & Lehto 2004b; Tervonen-Gonçalves 2013). While the cited studies examined a particular policy or intervention, other publications explored broader health policy transfer and health reform measures among Germany, the UK, Netherland and France (Bandelow 2006; Leiber et al. 2010). Finally, others examined theoretical and methodological questions related to health policy transfer (Marmor et al. 2005; Clavier 2010).

The small literature on health policy transfer can be categorised according to its main purposes into three categories. While all of the identified publications assume that transfer occurs, they differ in the way they explore it. On one hand, a group of studies examines the impact of the transferred policy or intervention on the receiving end of the process. For example, some claim that the transfer of the Health for All by the year 2000 to Portugal and Finland did not result in significant changes in the latter countries (Tervonen-Gonçalves & Lehto 2004b). By contrast, Shiffman and colleagues claim that safe motherhood policies were effectively transferred to Honduras and attribute such success to what they call an unusual cooperation between local and international actors (J Shiffman et al. 2004). Others conclude
that transferring policy instruments and normative ideas between Germany and the UK did impact health reforms in those two countries (Bandelow 2006). Conversely, Lieber and colleagues do not find convincing evidence of the influence of the Dutch health system on health policy reforms in Germany (Leiber et al. 2010).

The second category of the health policy transfer literature mainly studies the processes involved in the transfer of health policies and related theoretical and methodological considerations. Ogden and colleagues examine how and why DOTS was transferred between international and national levels (Ogden et al. 2003). They report that international organisations branded and marketed the interventions to low and middle-income countries. They also highlight the contestations occurring during transfer process because of assuming political rather than technical positions by transferring individuals and actors. While underlining the facilitating role of ‘windows of opportunities’ in the transfer, they caution against ‘one-size-fits-all’ and top-down approaches. They identify the latter with failures in the implementation of the transferred policies. Lush and colleagues, on the other hand, view the transfer of the syndromic management of STI as a two-part process (Lush et al. 2003b). They identify a somewhat straightforward medical development of clinical guidelines and a more complicated international dissemination of those directives in the form of policies. Walt and colleagues synthesise evidence from the two previously cited studies to conceptualise health policy transfer process as occurring in what they call ‘iterative loops’ (Walt et al. 2004). They claim that local policies and interventions are initially adopted and then adapted and branded to be marketed later to wider contexts. They recognise different and occasionally contested positions adopted by various actors situated at each of the identified loops.

The third category corresponded to studies that explored not only the outcome of the transfer but also examine the policy process. We were able to locate one study (A Ph.D. thesis) that could be classified under this category. The study explored the outcomes and processes involved in the transfer of hospital autonomy and decentralisation reforms in Malawi (Tambulasi 2011). It found out that hospital autonomy was not implemented while decentralisation was implemented after considerable changes in the policy. The study attributes those changes to various factors related to the transfer process itself and contextual
factors. It concludes that even in contexts that are dependent on aid and conditionality might be involved; policies will not be transferred in their entirety and change will inevitably occur.

This overview of the limited literature on health policy transfer uncovered several biases. First, many of the publications focused on policy transfer and policy learning between developed countries. Those that examined such learning and transfer among low and middle-income countries did not explore such transfer in post-conflict, conflict-affected or fragile settings. We were able to identify only one study that explicitly used the policy transfer framework in the post-conflict setting of Afghanistan (Strong 2003a). Second, most of the studies of transfer in developing countries focused on medical or clinical interventions rather than policies. Applying the policy transfer framework to the post-conflict setting of Iraq will contribute to filling those gaps in the health policy transfer literature.

2.5.3 Critiquing the policy transfer framework

The policy transfer literature helped with developing specific objectives for this study, but it is the subject of critique by several scholars (Dussauge-Laguna 2012; Benson & Jordan 2012; James & Lodge 2003). It is limited in assisting the development of a better framework that accounts for the fluidity and complexity of the transfer process. The literature exhibits positivism and adopts several assumptions about the policy transfer process (Dolowitz & Marsh 1996; Freeman 2002). Although it has evolved from a state-centred approach to embracing more actors, it nevertheless, emphasises an agent-based framework (Benson & Jordan 2011). It embodies a ‘mechanistic’ understanding of innovations and policies as objects transferable from one context to another (Freeman 2002). Three assumptions underpin this approach; innovations (as the BHSP) exist independently from and before the transfer process, they diffuse from a single source to an ultimate user, and the transfer process is managed centrally without the interference of emerging demands (Schon 1973). Counterarguments to these assumptions would articulate the ‘organic’ approach to policy transfer. Policies according to this, evolve during the transfer and neither diffuse from a single source nor are managed centrally (Freeman 2002). They are not transferred in a one-way process but rather through multidirectional interactions (Reich 2002). Moreover, finally, the ‘n-way’ transfer combined with informal interactions (in addition to formal ones) undermine a centrally managed hierarchy (Lee & Goodman 2002). Hence, a multilevel
approach to analysis is appropriately suited to address questions of policy transfer (Evans & Davies 1999; Evans 2009). A definition of policy transfer that conveys those features would be the “patterns according to which policies spread and the geographic and structural characteristics of countries which might explain them” (Freeman & Tester in Stone 2001:5). A policy that is transferred through translation is transformed during the transfer process (Pedersen 2007). The tension between the mechanistic and organic or the positivist and constructivist approaches to policy transfer can be reconciled through understanding transfer as translation (Freeman 2002; Armstrong et al. 2006).

However, what is translation? There is little consensus on what translation or more specifically policy translation is. Some highlight the controversy while recognizing the universal importance of the concept (Woolf 2008). In ‘translational medicine’, for instance, it can simply imply the transfer of evidence from research to practice (Wehling 2008). Others define it as “a communicative process in which actors inhabiting different social worlds enter into relations with each other and begin to recast or reconstruct themselves, their interests and their worlds” (Freeman 2009:436). This definition underscores both the origin of translation in linguistics and translation sciences (Hodgson & Irving 2007). It also emphasises the dynamism and complexity of policy as something that is persistently distorted and transformed (Latour 2005). It is not only the social actors but also non-social objects (documents) that collectively form a complex web of network interacting with each other (Hodgson & Irving 2007; Freeman 2009; Stone 2012; Pal & Ireland 2009; Freeman 2006; Freeman & Maybin 2011).

Translation attempts to explain these interactions and interconnections through making four assumptions (Freeman 2009); First communication is not unilateral, dialogical or one way, but it is multilateral or n-way (Star and Griesemer quoted in Freeman, 2009). Second, objects in addition to texts can function as instruments for translation. Third, meaning is constructed (and reconstructed) during the communication process rather than existing beforehand. Finally, the product of the communicative process reshapes the identities and interests of the actors not only with the product but also among themselves. This process implies the erosion of the principles of source or origin on one hand and target on the other in the communicative process. Translation, therefore, can provide valuable insight into policy
transfer at trans-national level (John Clarke quoted in Hodgson, 2007:178) which is relevant to the introduction of the BHSP and its financing methods in Iraq.

Another critique of the policy transfer literature comes from geographers who argue that transfer can be more appropriately understood as assemblage, mutations or mobility (Ward 2006; Prince 2010; Peck & Theodore 2001; McCann & Ward 2012a; McCann 2008; McCann & Ward 2013; McCann & Ward 2012b; Peck 2011). However, it seems that this literature is focusing on the mutability of policies during the implementation phases rather than on other stages the policy cycle such as agenda setting (that this research is focusing on).

### 2.5.4 Using the policy transfer framework in this study

Several reasons contributed to the decision to use policy transfer (and its critique) as the conceptual framework for this study. First, Iraq’s BHSP represents a distinct piece of policy that is potentially transferable from one setting to another. Second, there are equivalent policies in other similar post-conflict settings that could have served as a template for Iraq’s BHSP. Third, many international actors with knowledge and experience in those similar policies (particularly Afghanistan’s BPHS) were present and active in Iraq during the introduction and formulation of Iraq’s BHSP. Hence, the policy transfer literature helped to begin examining the processes through which Iraq’s BHSP was introduced and formulated. However, the policy transfer framework was not applied uncritically for the purpose of this study.

This study attempted to incorporate the critiques directed at the policy transfer framework in the application of the latter. The study did not view Iraq’s BHSP as a rigid and unchangeable piece of policy that can ‘diffuse’ from one setting to another. Rather it viewed it as a flexible policy that is amenable to alterations that potentially reflect the preferences and interest of transferring agents and actors. The study also did not restrict its search for the potential origins of the policy to one source, but rather it investigated multiple local, regional and international sources. Furthermore, this research did not concentrate on a particular mechanism of transfer, but rather explored the various combination of such mechanism that is suggested by the policy transfer literature.
2.6 Data analysis

This section reports the analytical tools employed to examine the data collected in this research. It will first present the analysis of interview data. Then it proceeds to report the analytical examination of document data.

2.6.1 Analysing interview data

A Computer Assisted Qualitative Data Analysis Software (CAQDAS) was used to assist in the analysis of the interview data. More specifically, NVivo was used to organise and analyse the collected data. NVivo was helpful in conducting the analysis process more efficiently (Bringer et al. 2001). The programme was also useful in allowing the researcher more time to focus on analysis rather than spending time on tasks such as printing, photocopying and labelling of materials. NVivo was helpful in terms of providing transparency to the analytical process that would have been difficult if manual tools should have been used (Morse & Richards 2002). Finally, the programme helped in the organisation, record keeping, and linking and comparing nodes, memos and documents through an interactive analytic process (Appendix 4) (Weitzman 2000).

Despite the advantages described above, the use of NVivo was not without challenges and shortcomings. One of the main problems was the difficulty in attempting to convert a non-linear analytical exercise such as the one done in NVivo into a liner document to describe the process (Bringer et al. 2001). Furthermore, the use of software such as NVivo might push the researcher to adopt the same or similar theoretical approaches as those used to develop the software (Grounded Theory in particular) (Lonkila 1995). Being aware of the theoretical background of CAQDAS helped in avoiding such tendency (Glaser & Strauss 1967). Also, the ability of the software to offer quick counts of terms introduced the temptation to quantify concepts instead of attempting to interpret the rich data (Richards 1999). Hence, CAQDAS can result in replacing human interpretation by a rigid, automatic analysis of the text (Kelle 1995). The programme, however, could not replace a detailed examination of the data by the thorough, multiple, and in-depth reading of the material itself (Bringer et al. 2001; Kelle & Laurie 1995).
Following numerous readings and in-depth examination of the interview data, several themes emerged. Some of the themes emerged from the data itself, but some were informed by the literature and the conceptual framework used in the research (policy transfer). Themes that were identified initially were later discarded, modified or merged into other themes. Others that originally seemed interesting were subsequently become less prominent given the focus of the study. Table 2.2 presents the chronological progression of the themes that emerged from the analysis.

Table 2.2: The evolution of the emerging themes of analysis

<table>
<thead>
<tr>
<th>Nodes</th>
<th>Child nodes</th>
<th>Sub-themes</th>
<th>Major themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHSP</td>
<td>policy transfer/ policy translation</td>
<td>Borrowing ready models from other countries</td>
<td>Similarities and differences with other post-conflict countries</td>
</tr>
<tr>
<td></td>
<td>The experience of other countries</td>
<td>Harmonization/convergence with other countries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Justifications</td>
<td>Justification for the BHSP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>History</td>
<td>The need for change (do something)</td>
<td>The local origins of the BHSP</td>
</tr>
<tr>
<td></td>
<td>Local origins of the BHSP/ evidence</td>
<td>The supremacy of technocrats/ Emergence of Powerful internal actors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the pre-existing health system</td>
<td>Branding and labelling already existing structures as new ones</td>
<td></td>
</tr>
<tr>
<td></td>
<td>External actors</td>
<td>Coercion by external actors</td>
<td>The external origins of the BHSP</td>
</tr>
<tr>
<td></td>
<td>international standards and best practice</td>
<td>High values attached to external actors (policies) vs. internal actors (policies)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the main actors</td>
<td>Multiplicity of actors/Key actors/ multidirectional interaction</td>
<td></td>
</tr>
<tr>
<td>User fees</td>
<td>With/ history</td>
<td>User fees are necessary because other countries have it/ People are abusing the system</td>
<td>The views of external and internal actors on the financial features of the BHSP</td>
</tr>
<tr>
<td></td>
<td>Mixed/neutral/ against</td>
<td>It was the idea of internal actors/ external actors did not agree or were neutral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>decision making on user fees/ harmonization</td>
<td>Influential internal actors changed their positions on user fees</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.2 shows that the thematic analysis of the interview data evolved throughout the analytical process. As Appendix 4 also shows, initially the data was organised under the
two main descriptive themes of the BHSP and user fees (first column of Table 2.2). This categorisation was done to facilitate the analysis of a large amount of data. It was also done because the financing of the BHSP through user fees represented a big part of the puzzle that this research attempts to explore. The analysis of the data then proceeded by coding the interviews under child nodes (the second columns of Table 2.2 and Appendix 4). Column three represents a later stage in the evolution of the analysis in which subthemes emerged from the coded material under each child node. The last column is the configuration that the researcher saw as an adequate organisation of the result chapters representing the convergence of related sub-themes into major themes. The following section reports on the analytical examination of the documents.

2.6.2 Analysing documents

The review and analysis of the selected documents were useful in fulfilling three main purposes. First, Iraq’s BHSP, in particular, was instrumental in guiding the development of questions for interviews. Second, the analysis helped in triangulating and verifying the claims made by interviewees. Third, the analysis of BHSP document in various post-conflict countries shed some lights on the potential origins of Iraq’s BHSP. The paragraphs below provide more details about how the document analysis was conducted and how it helped in achieving those three purposes.

First, Iraq’s BHSP is a relatively large document consisting of 104 pages. There is a section in the document that describes the process of developing the BHSP (Ministry of Health 2009:15). However, it leaves many questions that are of interest to this research unanswered. For example, multiple readings through the document raised questions about the potential sources of borrowing from other countries. Iraq’s BHSP does not make explicit references to such sources. Furthermore, the document is unclear about the relative roles and influence of internal and external actors in the development of the BHSP. Also, the document does not offer clear justifications for the particular financing methods (user fees for example) that it adopts. Those areas (and many others) constituted the basis for formulating questions for later interviews.

Second, this research employed document analysis and interviewing as its main data
collection methods. Those two approaches did not, however, function in isolation. Rather, they were used to support and complete each other. Attempts were made to corroborate findings from one source of data with other sources (Keen & Packwood 1995). Iraq’s BHSP was not treated as a rigid policy statement. It was, rather, approached as an agent that can offer different and contrasting meanings to various actors (Prior 2004; Freeman & Maybin 2011). Therefore, the interviews helped in shedding light into how different players interpreted puzzling aspects of Iraq’s BHSP. On the other hand, the documents offered insight into some of the positions adopted by various key informants who were interviewed in this research. The interviews were especially useful in exploring the process through which Iraq’s BHSP was authored. The insight offered by the interview materials partly mitigated the difficulty or even the impossibility of uncovering the evolution of policy through an official document alone. Examining various drafts of the same policy statement would have been useful in unpacking the evolutionary process. Unfortunately, despite numerous attempts, it was not possible to obtain such drafts from the author.

Third, another aim of analysing the document was to explore the origins of Iraq’s BHSP and the extent to which it was replicated measures from other sources. It was very challenging (even impossible) to elicit the origins of Iraq’s BHSP only from the document itself. Iraq’s BHSP document did not contain explicit references to equivalent policies in other post-conflict countries. To investigate for evidence of borrowing or duplication, the plagiarism detection software Turnitin was recognised as a useful tool (iParadigms LLC. 2012). This software has also been innovatively used by other colleagues at the University of Edinburgh to examine similar instances of borrowing in other research contexts (Weishaar et al. 2014).

Twelve documents were uploaded into Turnitin. The uploaded documents were official publications that described the BHSP in nine selected countries. The countries included Iraq, Afghanistan, Liberia, Sierra Leone, Cambodia, South Sudan, Uganda, Timor-Leste and Somalia. Three documents were updated modifications of earlier versions of the BHSP in two countries (Afghanistan and Liberia). Most of the documents were available in a PDF format that is compatible with Turnitin. Only Uganda’s BPHS was not accessible in neither a PDF nor a word format. It, therefore, had to be typed in manually into a word
document.

The similarity index (the overall percentage of identified matches) of each document was noted. Similar documents to the ones that were uploaded were identified. Each document was then compared with the most similar ones. Initially, the focus was not on a particular document per se, rather, the exercise was done to examine the extent to which the documents duplicated elements from each other. Later on, the exercise focused on Iraq’s BHSP. Appendix 5 presents the first page of the originality report for Iraq’s BHSP from Turnitin, the content of which is discussed in further details in chapter five. Due to the large size of the report, it was not possible to present it here.

The exercise was helpful in identifying sentences that were duplicated in Iraq’s BHSP from other documents. It was also useful in identifying substantive policy measures that were similar between Iraq’s BHSP and other equivalent documents. Guided by the Turnitin exercise, a thematic content analysis of Iraq’s BHSP and equivalent policies in other countries was undertaken (Krippendorff 2013). The analysis started with reading the Iraq’s BHSP and the other documents multiple times. Distinctive themes were identified that were common to most documents. The chosen themes touched upon the aims and goals of the policy, the involved actors, the interventions included (or excluded) and the financing principles adopted. Then the themes were compared for similarities and differences between Iraq and the other countries. The aim was to identify and explore themes that were potentially transferred from elsewhere. Since the focus of this research is on exploring the formulation of Iraq’s BHSP, we did not examine the extent to which other documents duplicated elements of Iraq’s BHSP.

2.6.3 Reflexivity

In this subsection, I will share information about myself and reflect on both this research’s journey and how my various personal characteristics affected it. Before doing that, it is useful to clarify how I came to understand reflexivity and why it is important. Reflexivity is defined as turning “a critical gaze towards the researcher or examining how the researcher and intersubjective elements impact on and transform research” (Finlay 2008: 3, 4). It is necessary to reflect on the research journey because as Bonner argues “it would be
fundamentally incomplete…not to make reflexivity an essential component of social analysis” (Bonner 2001:273). Upon reflection, it seems that both an insider and outsider statuses were in operation and shaped the Ph.D. journey.

In retrospect and considering my insider status, it seems natural why I chose to undertake a Ph.D. project on health policy in Iraq. I am native of the country and has been involved in clinical and public health practice since the early 2000s. Being a medical doctor also helped with particular aspects of the research project. For instance, it was perhaps easier to establish and sustain connections with colleagues in the field. Those connections assisted in recruiting participants and obtaining documents for this research.

Beside clinical practice, I also assumed leadership positions both within the MoH (In Kurdistan Region of Iraq) and in international organisations. In the latter role, I was the manager for a research and service provision programme that was implemented by Heartland Alliance International in partnership with Johns Hopkins Bloomberg School of Public Health and funding from USAID. It tested the implementation of various mental health interventions for torture survivors in Iraq some of which were included in the BHSP (Weiss et al. 2015; Bolton et al. 2014). It also examined the adaption of those interventions to the post-conflict context of Iraq (Kaysen et al. 2013). Those research activities provided me with the experience and the courage to undertake further research projects.

Being a medical doctor and a civil society activist in the Kurdistan region of Iraq also motivated me to do research in the field of health policy. This motivation started while conducting a master degree in health policy. Engaging with health policy debates in Iraq helped in shaping my thoughts about the health system in the country. Therefore, the intention was to do something about it through a Ph.D. project. The initial feelings of excitement, to some extent, were dampened by the realisation that such a project will probably contribute only incrementally rather than radically to change the realities of health in Iraq. Resulting feelings of boredom or dissipated interest were later replaced by the excitement of the results and findings of the project. This extended engagement with health policy in the country offered the opportunity for access to key documentations and informants for interviewing.
However, such insider status presented certain challenges for the project as well. Doctors and other policy makers view public health as perhaps a subordinate discipline compared to clinical medicine in Iraq. Despite my realisation of the importance of those disciplines, I had to grapple with conflicting emotions resulting from a change in career to public health or health policy from clinical medicine. Furthermore, it was not easy to relocate myself from the positivist paradigm that clinical medicine entails. It was even harder to learn, adopt and apply the relativist worldview for a qualitative methodological approach.

Beside the effects of my status as a doctor on the nature of the research I undertook and how I approached it, it also probably has some influence on how my interviewees interacted with my and responded to my questions. Most of my local interviewees were specialist doctors who were prominent figures both within their clinical field and at the MoH. Being a non-specialist medical doctor who is now doing something that is perhaps looked as less prestigious (public health) might introduced an asymmetry in terms of power dynamics between myself and my local interviewees. Such dynamics meant that I was less able to probe and challenge the information that my local interviewees were providing. Furthermore, they also likely had implications on the nature of the information that the interviewees were providing. Talking to a perceived equally powerful person would have probably provided a different set of information. However, efforts were made to triangulate the findings I got from interviews with similar data or information obtained from documents for example.

Similarly, my status as an insider might have affected the positionality of interviewees who were not Iraqis. My status as an insider might tempted individuals who were not Iraqis to convey a favourable picture of insiders. As is demonstrated in the results chapters, most of the non-Iraqi interviewees portrayed Iraqi policymakers as capable and knowledgeable. However, unlike the Iraqi interviewees, most of the non-Iraqi individuals were not medical doctors but rather public health specialists. That might affected their positionality both towards myself and towards the way, they answered the questions. Again, every effort were made to ensure that the results obtained from such interviews were triangulated with information from other interviews and documents.

On the other hand, there are certain outsider characteristics of my status that probably
shaped the research journey. Being a Kurd and a Sunni, I was perhaps at an increased risk of targeting due to ethnic and sectarian tensions while the research was underway. The difficult security situation in Iraq in general and Baghdad limited the ability to spend extended periods in the city. Those factors were partially mitigated through conducting most of the interviews through Skype and/or phone. Attempts were also made to do interviews with informants at meetings, conferences and other events that were conducted in more secure parts of the country such as Kurdistan region.

Finally, this research has been a rewarding journey. It offered me the opportunity to grow academically, personally and intellectually. I was immensely fortunate to benefit from the mentorship and advice of my supervisors. Formal and informal discussions with colleagues also offered valuable insight into all research aspects. Reflecting back on the starting point of this study, I can clearly see the substantial evolution that occurred over these few years. When I started, I was more of a civil society and public health activist. I was mainly driven by burning questions of how to improve the health of disadvantaged people in my country. Now, I feel proud to have maintained that eagerness but also gained the tools that allow me to approach those questions more objectively.

2.6.4 Ethical Considerations

This research adhered to the ethical standards for conducting a Ph.D. study. Those standards included obtaining ethical approval from relevant bodies, obtaining informed consent from participants and respecting the time and preferences of informants.

The Scientific Committee of the Ministry of Health in Iraq approved this study (Appendix 6). The committee is responsible for considering the ethical aspects of conducting health research in Iraq.

A checklist for level 1 ethical review by the University of Edinburgh was also completed (Appendix 7). The Research and Research Ethics Committee of the School of Social and Political Science provides this checklist. Conducting research in the unstable setting of Iraq is probably associated with the significant potential of physical and psychological harm to the researcher and participants. Given the potential risks, a decision was made early in the research to conduct interviews through Skype or in places that security
threats are non-existent (such as the Kurdistan region of Iraq). Given these considerations, it was deemed appropriate to conduct a level 1 ethical review rather than a level 2 or 3. A decision was also made to refrain from approaching and contacting persons whose welfare might be directly affected such as civil society activists, journalists or members of the public.

A written consent form was provided to each participant before conducting interviews (Appendix 8). The participants were asked to read the consent form and were given the opportunity to offer any reservations. All participants were assured that their identities will not be disclosed, and their answers will remain anonymous. Informants were also informed that their responses will only be used for academic purposes. Finally, the time of the participants was respected by asking about the duration that each individual was available at the start of the interview. Roughly halfway through the interview, every participant was asked whether they were willing to continue the interview for the remaining expected period.

2.7 Conclusion
This chapter provided an overview of the methodological approaches, strategies, and techniques adopted in this research. The chapter identified relativism as the paradigm of knowledge for this investigation. This paradigm is selected because of the explicit assumption that knowledge is partial, perspectival and situated in social circumstance and contexts.

The chapter then proceeded to an exploration of a range of methodological toolboxes and what and why this research use a certain methodology or borrow ideas and tools from others. The flexibility toward the methodological approaches in general and the identification of a case study approach, in particular, is appropriate given the knowledge paradigm and epistemological positions adopted by the study. The case study approach allows the provision of a thick description of the social phenomenon under investigation. It can offer the opportunity to describe and explore the multiple views, meanings and realities constructed and con-constructed by the various actors.
3 Literature Review

The purpose of this chapter is to review the literature on health policy making in post-conflict, conflict-affected and fragile settings. Such review deemed necessary for several reasons. First, this study explores the processes of introducing the BHSP in the post-conflict setting of Iraq. Therefore, it is essential that such study be informed by what is known previously about health policymaking in conflict-affected, post-conflict or fragile settings. Second, reviewing the literature allowed for identifying the most important issues about the topic under study. It also allowed for recognising what is missed, understudied or neglected. Third, being familiar with such literature allows for not only testing prior evidence but also enriching and expanding such evidence through exploring unexamined contexts. Hence, the findings of this study were positioned within the broader field of health policymaking in conflict-affected settings.

Before engaging in the findings of this chapter, it is necessary to provide some reflections on the terminologies used. By post-conflict settings, we mean states or regions where active hostilities have ended, and a recognised government is formed in the aftermath of the conflict (Canavan et al. 2008; Witter 2012; Patel et al. 2015). Fragile states, on the other hand, are understood as “those where the government cannot or will not deliver core functions to the majority of its people, including the poor” (DFID 2005:7).

It is necessary to provide here some reflections on the terminologies used. The use of terms such as 'post-conflict' was intended to aid the identification of literatures that address those settings. Their use was not meant to undermine the broad range of situations and contexts that they examine. The beginning of a 'post-conflict' period is often vague and ill-defined (Cometto, 2010). Relatedly, the use of the term ‘post-conflict’ should not imply that hostilities and conflict will never recur. Also, in these settings political transition is not always smoothly linear (Witter, 2012). As the case of Iraq clearly demonstrates, the 2003 Iraq war-related conflict did not end with the removal of Saddam Hussein from power. Rather, there were periods of calm, interspersed with episodes of violence and conflict.

Nevertheless, we chose to use the term post-conflict in the case of Iraq for a number
or reasons. First, the term allowed us to identify clear temporal boundaries that are necessary for a case study. Shortly after the start of conflict, the US led coalition defeated the Saddam Hussein regime and active hostilities ended. We considered the period that followed the end of active hostilities a post-conflict period during which Iraq’s BHSP was introduced. Second, the use of term post-conflict does not necessary mean the complete cessation of violence. Rather, as it was in the case of Iraq, some form of violence is not uncommon in the immediate post-conflict period. However, the term post-conflict can be flexible enough to incorporate elements of episodic violence. Third, and more importantly for the purpose of this study, it is the creation of a relatively functioning government that together with the end of active hostilities that herald the beginning of a post-conflict period. Such government, nonetheless, might at times be unable or unwilling to provide basic services (i.e fragile). In our case, the Iraqi government was a post-conflict entity that was at times fragile. We believe, therefore, that the Iraqi experience has relevance to both post-conflict and fragile settings. In short, the term post-conflict can be used to refer to a broad range of situations and its use does not necessarily imply the complete cessation of conflict.

Despite issues with definition and terminology, the notion of a post-conflict setting is particularly salient with regards to health systems reforms. Adopting the above definition of post-conflict, has implications Conflict and its aftermath can be viewed as an opportunity for reform. For example, Bertone and colleagues, examine such potential in relation to human resources for health policies in Sierra Leone (Bertone, et al, 2014). Similarly, Witter and colleagues look at the same policy in multiple conflict-affected setting to explore the opportunities offered by conflict for reform (Witter et al, 2017). These studies seem to suggest that post-conflict can provide the context where new and old actors negotiate to find solutions for existing and emerging problems. In Kindgon’s view, this were problem, policy and politics stream meet (Kingdon, 2010). We believe the conflict in Iraq provided a window of opportunity for reforms in the health sector.

Adopting the above definition for post-conflict has implications for the countries that we include in our study. The end of active hostilities as well as the formation of a government, implies some degree of normality. Although the post-conflict period may be unstable and fragile, but the active of end of hostilities and the formation of a government can offer the
opportunity for policymaking similar to non-conflict situations. Therefore, it is essential to consider the literature on policymaking in non-conflict contexts while analysing health policymaking in conflict-affected settings. Therefore, while we are interested in health policymaking in conflict-affected settings, this chapter dedicated a section to explore debates in relation to the BHSP in non-conflict affected settings. Furthermore, we also included Uganda in our analysis because the BHSP in that country was introduced in 1997. Uganda, in 1997, could be described as a post-conflict setting, and as such it was included in the ReBuild consortium (ReBuild. 2017). ReBuild is research programme that aims at exploring approaches to health systems development in such post-conflict countries as Sierra Leone, Uganda, Cambodia and Zimbabwe. It attempts to address gaps in health systems research related to neglecting post-conflict settings through exploring decision made in those contexts. It is not clear, however, the extent to which the post-conflict setting of the country contributed to the introduction of the BHSP.

3.1 An overview of the literature
A search of the literature on health policy making in post-conflict, conflict-affected and fragile settings resulted in retrieving a total of 200 articles, documents, reports and papers (For a more detailed description of the literature review methods, please refer to chapter two on page 40). The retrieved publications were divided into two broad groups. The first included 56 peer-reviewed journal articles and reports that described specific policies or interventions in post-conflict settings. The second group contained 144 descriptive reports or journal articles that addressed wider health policy and system issues in post-conflict contexts. This classification was deemed necessary for two principal reasons; first, the retrieved literature was relatively large. It is hard to extract and synthesise the findings of such a diverse and vast literature without dividing the identified publications into well-defined, but related, categories. Second, it seemed inappropriate to synthesise findings across a wide range of studies of varying approaches, methodologies, quality, and settings.

The following paragraphs offer a description of the main features of the included studies. An overview of the results of the extracted and synthesised findings of the identified literature will be provided in the subsequent sections.
A detailed description of the first group of the identified literature is provided in Appendix 9. The table in the appendix presents the details of 56 articles in peer-reviewed journals and reports that described a particular health policy or intervention in a post-conflict setting. The table offers information about the author, setting, aim, methodology and major findings of each study.

Some of the general features that are relevant to this study are presented here before proceeding to a more in-depth analysis of their conclusions. Those features are related to the geographical focus, the examined policies, and the adopted methodologies. One of the prominent characters of the identified literature is its tendency to focus on a particular country. For example, out of 53 articles that examined a specific policy, 21 studied Afghanistan while 12 focused on more than one country. Health policies in South Sudan, Cambodia, East Timor and Kosovo were examined by three articles each. It was not possible to identify any peer-reviewed article that primarily addressed the introduction of policies or interventions in the post-conflict setting of Iraq.

In addition to the tendency to focus on a particular country, the literature also favours a specific policy or group of interventions. Table 3.1 presents the numbers of the articles that examined a particular policy or intervention.
Table 3.1: Number of articles that examined a specific policy

<table>
<thead>
<tr>
<th>Intervention/policy</th>
<th>Number of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contracting</td>
<td>7</td>
</tr>
<tr>
<td>2. Basic Package of Health Services</td>
<td>6</td>
</tr>
<tr>
<td>3. Strategies to improve the safety of pregnancy and childbirth</td>
<td>5</td>
</tr>
<tr>
<td>4. Tuberculosis</td>
<td>5</td>
</tr>
<tr>
<td>5. Policies on human resources for health</td>
<td>3</td>
</tr>
<tr>
<td>6. Health system strengthening</td>
<td>3</td>
</tr>
<tr>
<td>7. Aid coordination/ SWAp</td>
<td>3</td>
</tr>
<tr>
<td>8. Clinic reconstruction</td>
<td>2</td>
</tr>
<tr>
<td>9. Sexual and reproductive health delivered through the BPHS</td>
<td>2</td>
</tr>
<tr>
<td>10. Rural expansion of community-based health care programme</td>
<td>1</td>
</tr>
<tr>
<td>11. People-centred governance approach</td>
<td>1</td>
</tr>
<tr>
<td>12. National Drug Control Strategy</td>
<td>1</td>
</tr>
<tr>
<td>13. Village health Team (VHT)</td>
<td>1</td>
</tr>
<tr>
<td>14. Mental health policy reforms</td>
<td>1</td>
</tr>
<tr>
<td>15. Infrastructure reconstruction and development</td>
<td>1</td>
</tr>
<tr>
<td>16. Health equity fund intervention</td>
<td>1</td>
</tr>
<tr>
<td>17. Monitoring and Evaluation</td>
<td>1</td>
</tr>
<tr>
<td>18. Roll back Malaria</td>
<td>1</td>
</tr>
<tr>
<td>19. Global Fund</td>
<td>1</td>
</tr>
<tr>
<td>20. Public-private partnership</td>
<td>1</td>
</tr>
<tr>
<td>21. Decentralisation/ community participation</td>
<td>1</td>
</tr>
<tr>
<td>22. Paying for performance</td>
<td>1</td>
</tr>
<tr>
<td>23. Removal of user fees</td>
<td>1</td>
</tr>
<tr>
<td>24. E-health innovations</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3.1 reveals that the retrieved studies examined a broad range of policies and interventions. Some focused on a single intervention (TB, malaria, infrastructure reconstruction, monitoring, and evaluation). Others examined a group of interventions (BPHS, pregnancy, sexual and reproduction). Some addressed one particular policy (contracting, human resources for health, aid coordination, drug control, mental health policy, user fees, E-health, paying for performance, decentralisation). Others examined policies that cut across a broad range of interventions and issues (health system strengthening, people-centred governance, health equity, public-private partnership). Similar to the narrow focus on a particular country observed above, the retrieved studies focused on several targeted interventions and policies. It appears that more studies examined policies and interventions...
such as contracting, BPHS, maternal health and tuberculosis than others (Please see below for a more detailed description of the studies focusing on the BHSP). It is also evident that a relatively large number of articles examined the BHSP. However, as a more detailed analysis of those articles presented below shows, they tended to have a narrow focus.

Finally, the identified studies adopted four main methodological approaches; qualitative, quantitative, mixed, and a literature review. Out of the 56 studies that focused on a particular policy 32 was qualitative, 14 quantitative, 7 mixed and 3 was a literature review.

The next paragraphs will examine the main features of the second group of the retrieved literature. Table 3.2 presents the types of the retrieved descriptive studies and the number of documents identified per each type.

<table>
<thead>
<tr>
<th>Type</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Journal articles</td>
<td>54</td>
</tr>
<tr>
<td>2. Reports</td>
<td>28</td>
</tr>
<tr>
<td>3. Other documents</td>
<td>42</td>
</tr>
<tr>
<td>4. Working papers</td>
<td>4</td>
</tr>
<tr>
<td>5. Thesis</td>
<td>5</td>
</tr>
<tr>
<td>6. Case studies</td>
<td>2</td>
</tr>
<tr>
<td>7. Books</td>
<td>1</td>
</tr>
<tr>
<td>8. Book sections</td>
<td>1</td>
</tr>
<tr>
<td>9. Discussion notes</td>
<td>2</td>
</tr>
<tr>
<td>10. Occasional papers</td>
<td>1</td>
</tr>
<tr>
<td>11. Policy briefs</td>
<td>1</td>
</tr>
<tr>
<td>12. Research papers</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3.2 shows that the majority of the identified documents were journal articles. This category included articles that were conducted in post-conflict settings but did not address a particular policy or intervention. It is evident from Table 3.2 that a wide range of both peer-reviewed articles and publications from the grey literature were included in the second category. The findings from this category helped in supporting, triangulating or sometimes refuting the conclusions of the first category and vice-versa. Such triangulation was also possible because of the wide range of the organisations and agencies that either published or supported the publications of the second type of literature (Table 3.3).
Table 3.3: Number of the descriptive studies based on the publishing body

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Journals</td>
<td>91</td>
</tr>
<tr>
<td>2. WHO</td>
<td>11</td>
</tr>
<tr>
<td>3. World Bank</td>
<td>11</td>
</tr>
<tr>
<td>4. USAID</td>
<td>8</td>
</tr>
<tr>
<td>5. LSHTM</td>
<td>7</td>
</tr>
<tr>
<td>6. KIT</td>
<td>6</td>
</tr>
<tr>
<td>7. DFID</td>
<td>5</td>
</tr>
<tr>
<td>8. UN</td>
<td>5</td>
</tr>
<tr>
<td>9. Overseas Development Institute (ODI)</td>
<td>3</td>
</tr>
<tr>
<td>10. OECD</td>
<td>3</td>
</tr>
<tr>
<td>11. Save the Children</td>
<td>2</td>
</tr>
<tr>
<td>12. Asian Development Bank (ADB)</td>
<td>1</td>
</tr>
<tr>
<td>13. Oxford Policy Management (OPM)</td>
<td>1</td>
</tr>
<tr>
<td>14. RAND Corporation</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3.3 shows, perhaps unsurprisingly, that the retrieved documents were published by organisations and agencies that are most active in post-conflict settings. What is also striking about the table is that most of the organisations, academic institutions, and organizations represented are principally Western. Examining the authors of those reports also revealed that the majority were westerners who occasionally co-authored the publication with individuals from post-conflict countries. The dominance of Western writers, organisations, and academia introduces a host of advantages and problems. It might be argued that the external status of the authors could offer a measure of objectivity. However, such status might also introduce problems related to the use and preferences of western ideas, policies, and worldviews. More publications by authors, organisations, and academic institutions from the post-conflict settings themselves are, therefore, needed.

This section has reviewed some general features of the identified literature. It revealed that the literature focuses on a particular geographical location, favours a restricted set of policies and adopts a host of methodologies. The next section will present an in-depth analysis of the findings of the literature about health policymaking in conflict-affected, post-conflict and fragile settings.
3.2 Synthesizing the results of the literature review

The analysis of the aims and findings of the literature noted the emergence of four prominent themes. The themes are categorised under the following headings: external influences, policy choices, context and interactions between internal and external actors. Those four categories are also relevant to the aim of this research and the questions that it attempts to address. The following sections present a synthesis of the findings of the literature based on the four categories mentioned above. The section on policy choices was further divided into four subcategories reflecting the stages of a policy cycle (Howlett et al. 2009; Jann & Wegrich 2006).

3.2.1 External influence (external actors, external models)

The literature examines the influence of a range of external actors in health policy and health systems of post-conflict settings. Those actors include specific organisations and agencies such as the World Bank and other financial institutions (Boye 2004; The World Bank 1998), WHO (Ville et al. 2001), Global Health Initiatives (Patel et al. 2015; Bornemisza et al. 2010), International NGOs (Pfeiffer 2003; Patrick 2001), OECD (Nay 2014), security forces (Bourdeaux et al. 2015; Chrétien et al. 2010; Mcinnnes & Rushton 2012), non-state providers (Veen & Commins 2011), and other donors and unnamed external players (Rechel & Khodjamurodov 2010; Macrae et al. 1996; Macrae 2001; Cassels 1996; Cliff 1993; DiCaprio 2013; Graves et al. 2015).

This section examines the findings of the literature with a particular focus on the influence of external actors and models on local health systems and policies in conflict-affected settings. Such literature can be divided into two broad categories based on whether it concentrates on policy outcomes or processes.

3.2.1.1 On policy outcomes

The literature tends to present the influence of external actors as predominantly positive, principally negative or a combination of those two depictions. The first group suggests an essentially positive impact through a few studies and reports (Kevany, Sahak, et al. 2014; Kevany, Jaf, et al. 2014; Chrétien et al. 2010). For instance, one article suggests that certain external actors were able to adapt their programs and interventions to local contexts (Kevany,
Sahak, et al. 2014). Another publication underlines the positive ‘collateral’ impacts of global health projects such as improving diplomatic relations (Kevany, Jaf, et al. 2014). An article, on the other hand, reports on the claimed constructive role of security forces in building health institutions (Chrétien et al. 2010).

The second category of studies included those that highlighted mainly claimed negative influences by external actors. Nay (2014) suggests that actors such as the World Bank have promoted the concept of ‘fragile states’ and attached to it a package of controversial policies in a technical format inhibiting dissent in the process (Nay 2014). Macrae and others underline particular problematic aspects of project-based donor aid in post-conflict countries (Macrae 2001; Macrae et al. 1996; Cassels 1996). They argue that projects by international actors which focus mainly on physical reconstruction, are unrealistic, lack consideration for accountability and sustainability, and are influenced by the political priorities of donor countries (Macrae 2001). Cassels (1996), on the other hand, reports issues such as overloading national administrations and distorting budgeting systems and priorities (Cassels 1996). Others highlight disruptive effects of international NGOs on the local health systems in particular post-conflict settings (Pfeiffer 2003; Cliff 1993). They report effects such as brain drain, the distortive nature of financial incentives, social inequalities and emotional resentment introduced by the activities of international organisations in the local health system. Finally, Patrick reports limited efforts in part of external actors to involve local communities to enhance participation (Patrick 2001).

The third category of studies presented both positive and adverse effects in their findings. Some reported positive effects such as the provision of needed services, offering technical assistance, providing policy recommendations and financial support (Patel et al. 2015; Bourdeaux et al. 2015; Bornemisza et al. 2010; Veen & Commins 2011; DiCaprio 2013; Graves et al. 2015; Rechel & Khodjamurodov 2010; McInnes & Rushton 2012). The same studies also highlighted certain issues. Those included distorting of local priorities, distracting health workers from more essential services, providing services of questionable importance, focusing on infrastructure, and limiting the ability of local institutions to own the policy process (Patel et al. 2015; Rechel & Khodjamurodov 2010; The World Bank 1998). Others presented evidence suggesting that while aid in fragile and conflict-affected settings
was necessary, it was either less effective or not prioritised in comparison to more stable contexts (Bornemisza et al. 2010; Graves et al. 2015). Finally, Ville and Sondorp show that external actors can play a significant role in policy-making and as a neutral broker in the early post-conflict setting (Ville et al. 2001). However, they also highlight issues related to assuming the role of the MoH, not playing a pro-active coordination function, and having insufficient capacities to continue and maintain successes.

The analysis above shows that the literature depicts the influence of external actors in a more or less normative fashion. While identifying the outcomes of such influence is necessary, it is also important to explore the extent and the mechanisms of such influence. Therefore, this research attempts to go beyond examining the influences of external actors and categorising them into such contentious labels as positive or negative. It is more concerned with exploring the extent to which external actors were influential and the mechanisms through which they exerted such influence.

3.2.1.2 On processes

The majority of publications under this subcategory explored process issues related to aid in post-conflict, conflict-affected and fragile settings. Several publications reviewed aid operations in previous post-conflict experience to draw lessons and recommendations. One report by OECD drew lessons from previous evaluations and offered a series of recommendations for aid response in Afghanistan in the early 2000s (OECD 2002). It communicated the need for a coherent policy framework, long-term international engagement, clarity of structures, restricting the role of the external military to security protection, use local institutional capacity and strengthening accountability and learning mechanisms of the aid. The recommendations of the OECD report are reiterated by other editorials and reports issued by other organisations (WHO 2007; Sullivan et al. 2011; WHO 2008b). While those publications focused on aid instruments in various contexts, others focused their analysis and recommendations on a single actor such as the World Bank (Menocal et al. 2008). Others concentrated on the conceptual phasing of aid activities arguing that post-conflict rehabilitation lie at the nexus of the relief-development divide (Macrae et al. 1995). Macrae and colleagues highlight the limitation of existing approaches to international assistance in unstable situations. They argue that achieving development in those situations
will require a reappraisal of the objectives and modalities of assistance.

Other publications adopted a critical stance towards aid operations in post-conflict situations. Leader and colleagues, for example, examine practices of aid instruments in fragile states and offer alternatives (Leader & Colenso 2005). They define instruments as “the mechanisms and procedures through which donors channel resources to fragile states” (Leader & Colenso 2005:10). They identify budget support, global funds, and social funds as examples of such instruments. They argue that those instruments do not meet the policy challenges of working effectively in fragile states. They recommend against adhering to a single approach. They also advise approaching issues at a national and programmatic level rather than regarding projects. Furthermore, Leader and colleagues argue that supporting political reform although difficult is possible. In addition, they recommend experimenting with various ideas and tools. Finally, they advocate that general principles of aid effectiveness should also be applied to fragile states. The latter point is highlighted and reiterated by others who recommend applying the Paris Declaration on Aid Effectiveness to fragile and conflict-affected stations (OPM/IDL 2008; Rubenstein 2011). Some argue that individual donors (such as the US) should adhere to the principles of the Paris Declaration (Rubenstein 2009). The principles that are particularly highlighted by the cited publications include an emphasis on the importance of supporting state legitimacy through the provision of health services. They also include discouraging the provision of health services through the military. They recommend measures such as the provision of health services through NGOs contracted by the states through contracting.

Other contentious issues that are debated in the literature include the trade-offs between responding to short-term humanitarian needs versus targeting long-term institutional and capacity building goals. Waldman, for example, suggests that humanitarian emergencies are like individual medical emergencies. Therefore, in his opinion, the most important things should be addressed first. He claims that the long-term solutions to conflict are political and that the international community, therefore, should focus on short terms health measures. He recommends the provision of a comprehensive package of health services in the humanitarian context. Others, on the other hand, appear to disagree with what they call the short-termism of immediate relief operations (Waters et al. 2007a). They recommend that, as much as
possible, short-term relief and assistance programmes should be compatible with longer-term health system rehabilitation. They view post-conflict reconstruction of the health sector as three interrelated continuum of responding to immediate health needs, establishing a package of essential health services and rehabilitating the health system itself. Some apply those recommendations to the work of particular agencies (Carlson et al. 2005). They believe that capacity building should be started early in the relief process and that funding should be long-term to avoid short-termism. They also advice overarching policy framework that guides the relief, rehabilitation and development process.

3.2.2 Policy/ intervention choices (reform measures)

As shown in Table 3.1, the literature on health policymaking in conflict-affected settings examines a broad range of policies. Several publications that focus specifically on the BHSP. Given the topic of this research, it is necessary to assess in-depth those publications that examine the BHSP. Table 3.4 describes the general features of articles on the BHSP.
<table>
<thead>
<tr>
<th>Author</th>
<th>Setting</th>
<th>Aims</th>
<th>Method</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Ameli &amp; Newbrand er 2008)</td>
<td>Afghanistan</td>
<td>Examine the effects of contracting on health service utilization and quality on the costs of the BPHS</td>
<td>Quantitative</td>
<td>Access can be extended through contracting mechanisms in post-conflict settings in the presence of security problems.</td>
</tr>
<tr>
<td>(Blaakman et al. 2013)</td>
<td>Afghanistan</td>
<td>Examine economic trade-offs in the provision of the BPHS through two alternative approaches of contracting</td>
<td>Quantitative</td>
<td>An approximate 60% increase in costs yielded a 16.8% increase in technical efficiency in the delivery of the BPHS</td>
</tr>
<tr>
<td>(Haidari et al. 2014)</td>
<td>Afghanistan</td>
<td>Examine the readiness of stakeholders in Afghanistan for sustaining delivery of BPHS without external assistance</td>
<td>Qualitative</td>
<td>Sustainability is questionable as stakeholders are sub-optimally organised, uneven ownership, divisive positioning, influential actors are lukewarm and most supportive are less influential.</td>
</tr>
<tr>
<td>(Hansen et al. 2008)</td>
<td>Afghanistan</td>
<td>measure and manage the performance of the BPHS through a balanced Scorecard</td>
<td>Quantitative</td>
<td>Progress has not been made in the priority areas (2005, 2006) identified in earlier balanced scorecard exercises (2004)</td>
</tr>
<tr>
<td>(Howard et al. 2014)</td>
<td>Afghanistan</td>
<td>Examine Stakeholders perspectives on intervention for Sexual and reproductive health delivered through the BPHS</td>
<td>Qualitative</td>
<td>Improvements in service coverage and workforce (gender balance, numbers, training and standardisation). Weaknesses in access, usage, staff retention, workload, and accountability.</td>
</tr>
<tr>
<td>(Najafizada et al. 2014)</td>
<td>Afghanistan</td>
<td>Describe facilitators and challenges to the BPHS, community health workers, explore gender dynamics</td>
<td>Qualitative</td>
<td>Community health workers play a significant role in post-conflict countries contributing to health system strengthening</td>
</tr>
<tr>
<td>(Newbrand er et al. 2014)</td>
<td>Afghanistan</td>
<td>Examine why the BPHS was needed, how it was developed, it content and the changes resulting from the rebuilding</td>
<td>Mixed</td>
<td>Translating policy into practice, focusing on priorities, precise definition of delivered services and helping MoH to expert stewardship</td>
</tr>
<tr>
<td>(Petit et al. 2013)</td>
<td>Liberia</td>
<td>Explore perceptions of providers and policy makers on the implementation of the BPHS</td>
<td>Qualitative</td>
<td>Limited understanding of the BPHS, suboptimal delivery, needs for dialogue between health providers and policy makers.</td>
</tr>
<tr>
<td>(Rechel &amp; Khodjamurodov 2010)</td>
<td>Tajikistan</td>
<td>Examine the introduction of the basic benefits package and co-payment</td>
<td>Qualitative</td>
<td>External agencies strengthened and weakened national health governance, international actors have limited technical and institutional capacity of MoH</td>
</tr>
<tr>
<td>(Roberts et al. 2008)</td>
<td>Afghanistan, Southern Sudan, and DR Congo</td>
<td>BPHS contracting approach and challenges for sexual and reproductive services</td>
<td>Qualitative</td>
<td>BPHS can scale up SRH, but there are many challenges.</td>
</tr>
<tr>
<td>(Hrabac et al. 2000)</td>
<td>Bosnia and Herzegovina</td>
<td>overview of the methodology for designing a basic package of health entitlements and solidarity</td>
<td>Descriptive</td>
<td>The package was developed based on agreed-upon criteria</td>
</tr>
</tbody>
</table>
A close examination of the studies presented in Table 3.4 reveals some notable general features. First, most of the identified studies were conducted in Afghanistan (only one study in Liberia and Tajikistan and one in Afghanistan and two other countries together). This geographical tendency probably reflects in part the larger bulk of overall studies conducted in Afghanistan. Second, most of the identified literature tends to focus on how the BHSP is provided or examines a particular aspect or feature of the BHSP. For example, several studies explored the provision of the BHSP through contracting with NGOs (Ameli & Newbrander 2008; Blaakman et al. 2013). Others examined a component of the BHSP such as sexual and reproductive health (Roberts et al. 2008) or how well the BHSP is provided (Hansen et al. 2008). Some explored the views of various stakeholders with regards to the provision of the BHSP (Haidari et al. 2014; Howard et al. 2014; Petit et al. 2013). Only a few studies approached how the BHSP was introduced (Newbrander et al. 2014; Rechel & Khodjamurodov 2010). A more detailed examination of those cited studies is provided below as part of a broader review of the literature on health policymaking in conflict-affected settings. To facilitate the synthesis of the results of the literature, categories that correspond to the policy cycle are utilised as thematic sub-headings.

### 3.2.2.1 Policy Formulation

Few publications explicitly explore the formulation of health policies in post-conflict, conflict-affected and fragile settings. One particular exception is an article by Newbrander and colleagues that this article describes the development of the BPHS in Afghanistan (Newbrander et al. 2014). Given its relevance to this study, the article deserves a detailed examination. As shown in Table 3.4 Newbrander and colleagues use a mixed methodology to examine “why the BPHS was needed, how it was developed, it content and the changes resulting from the rebuilding” (Newbrander et al. 2014: S6). They report that Afghanistan’s BPHS was adapted from previous models in other countries and the World Bank’s Bobadilla study (Bobadilla et al. 1994). They also allude to tensions and disagreements among the actors that were involved in the development of the policy. For instance, they claim that the initial draft that was developed by WHO lacked input from local actors and did not incorporate an implementation strategy. They are not, however, very explicit about the roles
of local actors, such as the MoPH, in comparison to those of external actors. In this regard, they state that the MoPH leaders lacked public health knowledge. Then, somewhat paradoxically, they acknowledge that the MoPH developed a sophisticated measure such as a public health decision tool. The article also reports on the tensions between internal and external actors about the adoption of contracting for the delivery of the BHSP. It states that the MoPH distrusted the provision of health services through the NGOs. It also suggests that NGOs were worried that they might lose their independence if they would provide services through the government. The article suggests that the MoPH agreed to the model of contracting after successful examples from abroad were presented to the ministry. Newbrander and colleagues also claim that other countries such as Liberia, South Sudan, and Somalia used the Afghan BPHS as a model in their post-conflict reconstruction of the health system.

While Newbrander and colleagues explored the development of Afghanistan’s BPHS in its entirety, others examined a particular component or aspect of the policy. For instance, some studied the costing of Afghanistan’s BPHS (Newbrander et al. 2007; Blaakman et al. 2013). They recommended similar exercise to other post-conflict or fragile contexts. Others described the BPHS in other contexts such as Bosnia and Herzegovina without providing adequate insight into the processes of its development (Hrabac et al. 2000). Waldman briefly reports on the emergence of the BPHS as part of a broader study of the case of the Democratic Republic of Congo (Waldman 2006). He describes it as a political process while highlighting the potential benefits of the BHSP by coordinating donor’s efforts and extending services to rural areas. A master thesis attempted to track the origins of particular health policies (such as performance-based contracting) in Afghanistan to other post-conflict contexts such as Cambodia using policy transfer frameworks (Tulier 2005).

While those cited publications limited their analysis to one setting and a particular policy, others reviewed the literature on health policy formulation in conflict-affected and fragile contexts in general (Bornemisza & Sondrop 2002). Bornemisza and colleagues conclude that health policy development is disrupted in conflict-affected settings. They also report that it is rare for a joint health policy and strategy framework to develop to guide the various agencies in their activities. They argue that policy formulation can be supported
through mechanisms such as Sector-Wide Approach (SWAp) partnership agreements and consolidated appeals processes.

In short, Newbrander and colleagues’ work (Newbrander et al. 2014) is perhaps the closest to what this study is attempting to achieve. Nevertheless, they, and the other cited studies leave some gaps that this research try to fill. First, they appear to focus more on the how the BHSP is provided (through contracting) rather than the latter itself. Second, they seem to suggest that Afghanistan’s BPHS was duplicated, perhaps entirely, from external models. They do not examine the extent to which the local health system might have shaped the policy. Third, and related to the previous point, they appear to imply that the local health system was devastated, and perhaps the BHSP started the latter from scratch. Fourth, they assert that Afghanistan’s BPHS served as a model for other countries, but they do not offer any evidence to support that claim. Finally, they offer some useful insight into the interactions between internal and external actors. However, they are less explicit in their depiction of such interactions and potential interpretations.

### 3.2.2.2 Policy Implementation

Several publications explored the implementation of a particular policy or intervention or the implementation of a broad health reform measure in a conflict-affected setting. Percival and Sondorp, for example, describe health reforms in the post-conflict setting of Kosovo (Percival & Sondorp 2010a). They draw their conclusions from the findings of a Ph.D. thesis, in which Percival examines the implementation of health sector reforms in Kosovo (Percival 2008). Both publications report that the health reforms failed to achieve their objectives. They attribute such failures to three findings: health reforms were driven by external actors, they were implemented hastily, and the capacity of local ministries of health was low and was influenced by political factors. They also attribute such failures to ignoring the strengthening the capacity of government institutions and a disregard for building the foundation for reform before initiating ambitious health sector modernisation projects.

While also focusing on Kosovo, others examined a particular intervention such as developing a system of epidemic prevention and preparedness (Brennan et al. 2001). Brennan and colleagues report on what they describe as the successful conduction of a baseline
survey, development of a surveillance system, rehabilitation of laboratories and establishing capacity for epidemic response. They partly attribute such success to what they call a unique collaboration model between Kosovo, the World Health Organization, and an international, nongovernmental organization. They also highlight some lessons drawn from the implementation of the rehabilitation process and advocate their application to similar post-conflict settings.

Similarly, others examined the implementation of a particular intervention or policy in other post-conflict, conflict-affected or fragile settings. Howard and colleagues, for example, qualitatively explore the views of various stakeholders on the effects of the BPHS on the provision of sexual and reproductive health services in Afghanistan (Howard et al. 2014). They convey an overall positive picture of the role of the BPSH in expanding services. They report that international actors would not have funded the BPHS if it did not include a sexual and reproductive health component. The article discusses some of the limitations introduced by contextual factors on the provision of the BPHS. For example, it describes barriers such as geography (distance, difficult terrains, bad weather) and culture (gender roles and religion). It, however, provides less description on the process through which the BPHS was introduced. Others used quantitative methodologies to conclude that his implementation of the BPHS in Afghanistan resulted in improvement in access and quality of primary and emergency health services (Acerra et al. 2009).

Likewise, Petit and colleagues explore the perceptions of various stakeholders on the implementation of the BPHS in Liberia using Lipsky’s street-level bureaucrat framework (Petit et al. 2013). They mainly demonstrate disconnect between policy makers and service providers regarding their understanding of the policy and the motives for its implementation. They recommend better communications between those two stakeholders. The article, however, does not comment on the process of introducing the BPHS. It further does not address the role of international actors in the process.
3.2.2.3 Policy Evaluations

A BHSP was introduced in many post-conflict settings. In these contexts, the introduction of the BHSP was seen as a practical method to improve access to health services rapidly (Palmer et al., 2006, Roberts et al., 2008, Kruk et al., 2010). For example, evidence from Afghanistan suggests that the BHSP initiative was successful in expanding access to services (Richards, 2007, Loevinsohn and Sayed, 2008, Waldman et al., 2009). Others, such as Belay and colleagues, provide statistical evidence of increasing access to health care through the BPHS (Belay 2010). They also reported on the strengths of the BPHS by describing the potential for the BPHS to enable all stakeholders to focus on a common strategy. They also highlighted the BPHS as a shorthand for policies to deliver interventions while strengthening the stewardship role of the MoPH. Furthermore, the report underlines the equity benefits of the BPHS by providing services to rural populations and those in need. The report also identifies some challenges concerning the difficulties of improving coverage and utilisation, enhancing the M&E of the BPHS, revising the content and increasing managerial autonomy. Likewise, publications exploring the BPHS in other contexts such as Liberia identified similar findings. Lee and colleagues highlighted the ability of the BPHS to minimise inconsistencies in provided services through a competitive bidding process and underlined the utility of the BPHS in enhancing health system strengthening (Lee et al. 2011).

Despite its ability to expand access to services, the BHSP in post-conflict settings initiative was criticised for several reasons. Some argue that the BHSP approach ignored important considerations and objectives such as equity or sustainability (Macrae et al., 1996, Waters et al., 2007). For instance, the user fees element of the BHSP in Afghanistan continued to threaten equitable access and proved an important impoverishing factor (Trani et al., 2010, Arur et al., 2010). This restriction of access added to the existing inequities that persisted from pre-conflict systems (Vaux and Visman, 2005, Pavignani, 2005). Others, for example, Macrae & Bradbury, criticised actors such as UNICEF that promoted the BPHS in particular settings like Somaliland (Macrae & Bradbury 1998). They claim that UNICEF encouraged authorities to abandon universal free health, citing impracticality arguments. The authors report that UNICEF persuaded the authorities to develop a “minimum” package of health services. Macrae & Bradbury view the latter as an example of “declining standards in
international responses to humanitarian crisis” (Macrae & Bradbury 1998:47) and an attempt to shift from free services to rationalise resources to a minimum package of essential services. Others claim that the BPHS, in the case of Afghanistan, can offer the opportunity for various interest groups to include interventions that are of limited benefit and considerable cost (Newbrander 2007a). However, they suggest that a tool such as the Public Health–Based Decision Framework can mitigate such risk.

Several other publications examined contracting, a particular tool that is often associated with the BHSP. Contracting out with NGOs to provide the BHSP in Afghanistan, is seen by some as the only practical method of providing access in settings where public health facilities did not exist or were unable to provide essential services (Strong et al., 2005, Ameli and Newbrander, 2008, Arur et al., 2010). Some argued that contracting through a competitive bidding process promoted consistency in service provision through the BPHS in Liberia (Lee et al. 2011). Others, however, disagreed by indicating that contracting the BHSP with NGOs has introduced fragmentation through the decentralized provision of services (Palmer et al., 2006, Sabri et al., 2007). Likewise, Sabri and colleagues conclude that contracting introduced distortions with the Afghan health system (Sabri et al. 2007). They highlight issues related to lack of long-term vision and sustainability in part of the operations conducted by NGOs. They also claim that contracting encourages a trend towards privatisation given the weak public provision in comparison to the better-funded NGOs. The authors also report issues with coordinating NGOs and harmonising their activities with the public sector. They identify the absence of standardised processes of provision and strategies to build the capacity of local NGOs to replace international NGO should the latter withdraw. Others examined particular aspects of contracting such as performance-based financing (Strong et al. 2005; Morgan 2005) Strong and colleagues highlight the limited evidence base for the Performance-based partnership agreements. The effect of those policies, according to the authors, are also not adequately studied such as scaling up, sustainability and effects on health staff.

Rather than focusing on a particular policy or intervention, such as the BHSP, other publications examined broader health policy issues such as health system strengthening in post-conflict settings. Cassels, for example, examines the shift from project-focused aid towards broader sectoral assistance and accompanying changes in aid instruments such as
budgetary support (Cassels 1996). Cassels highlights a mix of development and assistance tools that, appreciating inevitable difficulties, should be complementary and appropriate to the local context. Lee and colleagues, on the other hand, evaluate efforts to strengthen Liberia’s health system in the post-conflict period (Lee et al. 2011). They highlight a host of lessons from such evaluation including the inappropriateness of a ‘one size fits all’ approach. Lee and colleagues, on the other hand, advocate the use of tools such as health sector pool fund, community health workers and standardised information and data management systems.

Likewise, Newbrander evaluates the efforts to rebuild health systems in fragile settings (Newbrander 2007b). Unlike Lee and colleagues, this publication advocates the provision of a BHSP (potentially as a one size fits all) as a priority task for assisting ministries of health in fragile settings recognising the former as a medium-term response that should be provided by NGOs. Others arrive at similar conclusions in their evaluation of post-conflict reconstruction efforts in the context of Timor-Leste (Rosser 2007). They conclude that the restoration of basic health services helped in improving basic service delivery to the poor reduced negative spill over effects from disease and poverty reduction. They also recommend similar activities in other post-conflict settings. However, Tulloch and colleagues arrive at contradicting conclusions evaluating the same efforts at reconstructing the health system in Timor-Leste (Tulloch et al. 2003). They conclude that substantial financial investments might not result in positive outcomes if the absorptive capacity of receiving ends are not adequate. They also highlight issues with staff recruitment and procurement of drugs and other goods. Finally, they underline issues with coordinating various stakeholders through addressing the challenges of incompatible demands. Others focused on the operations of a particular agency such as the World Bank criticising the latter as ad-hoc (Kreimer et al. 1998). The World Bank evaluated its activities in post-conflict Uganda concluding that the Bank’s efforts were mainly limited to economic recovery and neglected to some extent the social sector (health and education) (World Bank 1998).

Several other publications evaluated what is called ‘relief-to-development continuum’ of aid operations in post-conflict, conflict-affected and fragile settings. There are two essentially opposite views on this issue. Macrae and colleagues are sceptical about what they call ‘developmental relief’ where development assistance are promoted as effective tools for
managing conflict (Macrae et al. 1997). Evaluating the Sudanese case, they caution against rapid transition from relief to development unless some enabling conditions for such transition are in place. Macrae and colleague identify minimal security, end of hostilities and local government legitimacy as fundamental conditions for the end of relief and start of development operations. Vergeer and colleagues, however, are on the other end of the argument on the issue of the relief-to-development continuum (Vergeer et al. 2009). They evaluate aid mechanisms in four post-conflict settings of Liberia, South Sudan, Timor-Leste and Sierra Leone. Vergeer and colleagues conclude that there is often artificial divided between relief and development aid that needs creativity in addressing both humanitarian and development needs. They call for mixing and matching those tools to best fit the needs of the context in question. WHO reiterate those arguments by recommending that two imperatives should be undertaken simultaneously in transition situations; the humanitarian imperative and the development imperative (WHO 2007)? Along the same lines, others recommend various tools to ensure that relief agencies incorporate sustainability and long-term policy outcomes into their operations (Schowengerdt et al. 1998).

3.2.3 Health context (domestic actors and local health systems)

Although many of the reviewed publications examined local contexts in their background sections, only a few specifically explored those contexts as their primary aim. Those rare publications examined the post-conflict roles of local institutions, domestic actors or the political economy in the health policymaking in post-conflict, conflict-affected and fragile settings.

In their analysis of the evolution of health policy in the post-conflict context of Liberia, Sondorp and Coolen (2012) offer many useful observations. They identify what they call two ‘traps’ that health planners in post-conflict health reconstruction often fell into. The first is the tendency to attempt building the health system from scratch. The latter is usually encouraged by the apparent complete collapse of the existing system as a result of conflict. Sondorp and Coolen call this tendency a trap and argue that it is problematic for two main reasons. They state that previous health systems are rarely entirely destroyed. They also claim that the remnant of existing health system tend to influence health reforms and their
outcomes. The second trap is the tendency to regenerate the ‘glories’ of the past by trying to replicate the past system or parts of it. They claim that such efforts are deemed to fail since circumstances usually fail and it is difficult or impossible to completely replicate the successes of the past in the present.

Therefore, Sondorp and Coolen recommend undertaking post-conflict reforms while taking the previous structures into consideration. They also divide the post-conflict period of Liberia into the immediate (2003-2005) and the period following 2006. They argue that the humanitarian agencies were key actors during the immediate post-conflict period. Then, the government became more dominant following the establishment of a new government in 2006. They argue that the first stage was characterised by fragmentation and weak planning, but the second period (government led) resulted in better policy processes and, potentially, outcomes. They identify weak capacity as one of the obstacles for ensuring country ownership of health reforms in any post-conflict situation.

With regards to the role of national players in the introduction of the BPHS in Afghanistan, Newbrander and colleagues claim that local institutions such as the MoPH identified interventions to be packaged in the BPHS (Newbrander et al. 2007). They also highlight what they report as the changed role of the MoPH from a provider of services to a steward of policy-making. In contrast to this claimed prominent role of local institutions, others paint a less favourable picture. With regards to the BPHS in Afghanistan, some claim international actors introduced it rather than the MoPH (Haidari et al. 2014). Beesley and colleagues also offer an account of the failures of strategies for health workforce management in the post-conflict setting of South Sudan (Beesley et al. 2011). The authors attribute this failure to the lack of capacities in part of the Ministry of Health to absorb and use information provided by international actors.

Besides local institutions (such as the MoH), other publications examined the role of other domestic stakeholders. Haidari and colleagues use a stakeholder analysis to examine the sustainability prospects of the BPHS in Afghanistan (Haidari et al. 2014). They demonstrate that the stakeholders with the most interest and intention for the BPHS to continue (such as the population) were the less powerful. The article questions the prospect of the sustainability
of the BPHS without a well thought through plan by the MoPH. Others claim that domestic stakeholders were excluded by external ones in the post-construction efforts in the context of Iraq (Jawad et al. 2011).

Others examined the wider political and economic context and their interactions with the health system. Jones and colleagues examine such interactions in the context of South Sudan focusing on politics (Jones et al. 2015). They use the WHO framework to describe the view of stakeholders on the various components of the health system. Others attribute the success of this particular project (World Bank’s health projects in Timor-Leste in this case) to favourable political economy factors (Rosser & Bremner 2013). Those factors include a political economy that was conducive to aid effectiveness and relatively little elite resistance to the World Bank’s health policy agenda. Finally, Ranson and colleagues examine the issue of health equity and its implications in fragile and conflict-affected settings (Ranson et al. 2007). They attempt to identify the drivers and strategies to reduce health inequity and the role of different actors in developing those strategies.

3.2.4 Interactions between internal and external actors

Few publications explicitly explore the interactions between internal and external actors in health policy-making in conflict-affected, post-conflict or fragile settings. Lanjouw and colleagues, for instance, examine the interactions between local and external actors through describing the coordination process among various players in the post-conflict setting of Cambodia (Lanjouw et al. 1999). They report on the problems involved in coordinating aid in the context of limited legitimacy of the government. The coordination, according to the article, was limited to sharing of information. It failed to extend to further elements such as frameworks (priorities) or structures (management and administration coordination). This failure happened, according to the article, because many actors (especially bilateral donors) were reluctant to work with the government due to legitimacy issues. Similarly, Pavignani and Durao claim that the MoH in Mozambique was not able to lead the coordination process (Pavignani & Durao 1999). According to them, the coordination efforts was limited to external actors and local actors were excluded from sensitive discussions such as user fees. Kolaczinski also appears to suggest that local projects were dependent largely on external
actors (Kolaczinski 2005). The article claims that a Roll-Back Malaria project in Afghanistan completely failed with the departure of the external actors that supported them.

Similarly, others highlighted the influence of external actors, but they also underlined the role of internal actors in policy-making in conflict-affected settings. Lerberge and colleagues, for example, report that internal actors, such as the Ministry of Health in the post-conflict setting of Lebanon, lacked the capacity to introduce and manage reforms (Lerberge et al. 1997). However, they also claim that, with the support of external actors, the MoH was able eventually to seize opportunities and muddle through the reform process. Mercer and colleagues, on the other hand, present an optimistic picture of the health system development of the post-conflict setting of Timor-Leste (Mercer et al. 2014). They attribute the claimed success of Timor Leste’s experience to the ability and willingness of the MoH to own and lead the collaboration with international organisations. The leadership and ownership by the MoH are also recognised as an important factor in enhancing the success of international programmes and policies.

To sum up, as is evident above, there are only few publications that explore the interactions between internal and external actors in the health policy-making in conflict-affected settings. Those studies examine mainly the mechanisms of those interactions (such as coordination) or the relative roles of internal and external actors. We were not able to identify studies that investigate the preferences of actors concerning particular health policy issue in conflict-affected settings.

3.3 Literature on BHSP in non-conflict settings
The previous paragraphs reviewed the literature on health policymaking in post-conflict, conflict-affected or fragile settings. Although it explored health policymaking in general, it focused specifically on the BHSP in conflict-affected setting in particular (please refer to section 3.2.2). However, there is not an insignificant literature that studies BHSPs in non-conflict settings. Examining such literature is useful in shedding light on aspects of introducing the BHSP in Iraq that might not be necessarily related to conflict. This sections attempts to identify how the usage of BHSP in non-conflict settings assists in understanding why they have been also promoted in conflict-affected contexts.
Before presenting the findings of this review, it is important to highlight certain issues. The literature on BHSP does not explicitly consider their application to conflict-affected, post-conflict or fragile country settings. Such literature refers to the application of the BHSP in ‘low- and middle-income’ or ‘developing’ countries without distinguishing such application between non-conflict and conflict-affected settings. For example the major publications that advocated the introduction of BHSPs did not explicitly mention their application to conflict-affected settings (WDR 1993, World Health Report 2010 and The 2001 Report of the Commission on Macroeconomics and Health). Therefore, the literature review that is presented here must be treated with caution as it presents conclusions related to a literature that addresses both conflict and non-conflict settings.

Several authors viewed the BHSP as a cure for many of the problems plaguing health systems in developing countries (Bobadilla et al. 1994; Ham 1997; Söderlund 1998). They suggested that BHSP can accomplish priority setting, provider accountability and user empowerment tasks and can be used as a tool for financial and managerial reforms (Frenk 2006). More recently, Waddington (2013) attempted to address in more formal terms what BHSPs are for and what they are designed to change. Given the importance of the paper in describing the experience with introducing BHSPs in mainly non-conflict settings, we provide a more detailed examination of the paper below.

As far as the local contexts are concerned, Waddington suggests that BHSPs are more relevant to insurance-based compared to tax-based systems. She suggests that in an insurance-based system, consumers (as well as purchasers and providers) are interested in the nature of the package and its contents. This suggestion implies that local contexts should be taken into consideration when making decision on where to introduce BHSPs. It also implies that existing structures be used in the implementation of the new policy of the BHSP. In contrast, as the literature on BHSP in conflict-affected situations suggests, the BHSP has been used as a reform tool to change existing structures or introduce new ones in post-conflict settings. In non-conflict settings, when reforms are deemed necessary, BHSP have been used more as political and aspiration tools to guide future reforms rather than just technical instruments. In others, they are intended for a more immediate application. In the latter contexts, they are understandably linked to short-term affordability considerations.
Concerning accountability, transparency and political representation, it appears that in non-conflict settings, BHSP has been seen as tools to promote accountability and transparency. For example, Waddington argues that at least theoretically, consumers are able to hold providers and governments accountable because they are aware of the contents of the BHSP (Waddington, 2013). The same author claims that the BHSPs are seen as tools to define contract terms with different and often competing providers which in turn would promote accountability. Finally, in non-conflict settings, the importance of value-based and political judgment in the introduction of BHSP and determining their contents are highlighted.

The BHSP is also believed to improve the effectiveness of service delivery through clarity with regards service provision at various levels. Relatedly, the inclusion of effective interventions in a package is believed to improve the overall effectiveness of the service delivery. The latter goals are directly related to the utility of BHSPs as a priority setting exercise. In terms of the mechanisms through which the content of the BHSP are determined; in non-conflict settings, cost-effectiveness analysis is usually recommended to achieve those aims.

Despite the benefits claimed above, the BHSP model has been the subject of criticism (Zwi & Yach 2002). Three major issues are highlighted by the literature on introducing the BHSP in non-conflict settings; issues with cost-effectiveness analysis; accountability and political representation; and lack of consideration of local contexts.

The BHSP and the cost-effectiveness element attracted criticisms. Some highlighted issues concerning the content of the policy while others underscored problems about its implementation. For example, Paalman et al. (1998) showed scepticism about the cost-effectiveness methodology adopted by the WDR 1993 (Paalman et al. 1998; Musgrove 2000). They suggested that the method was inconsiderate to local contexts, ignored the effects of other sectors on health, lacked rigour, overestimated benefits, and underestimated costs. Zwi and Mills (1995), on the other hand, viewed the BHSP mainly as a method of reducing public expenditure through the introduction of cost-effective measures and private financing through user fees (Zwi & Mills 1995). With regards to the latter point, they cautioned that
governments may abuse the BHSP as a justification for predetermined decisions to circumscribe the role of the state and reduce public expenditure. Some noted that the BHSP sacrificed such important objectives as financial risk protection, equity and fairness in exchange for ensuring efficiency (Söderlund 1998; Daniels et al. 2000). Relatedly, Palmer and colleagues suggested that the implementation of the BHSP ignored important goals such as strengthening the health systems or ensuring sustainability (Palmer et al. 2006). The focus on mortality and disability in the BHSP was attacked by others for its inability to include other interventions that were able to achieve less tangible but still important results (Mooney & Wiseman 2000). Several authors were concerned more with the inability of developing countries to implement such expensive reforms (Bobadilla & Cowley 1995). They attributed this inability in part to the absence of high-quality data and evidence that can be used to produce cost-effectiveness and burden of disease analysis (Paalman et al. 1998; Gottret et al. 2008). In consequence, some warned about defaulting to ideological and political prescriptions in the absence of a solid evidence base (Rechel & McKee 2009).

Other Critics focused on issues related to accountability, values and representation. Some indicated that the BHSP is a package of vertical interventions funded and delivered by international actors without consideration of local realities and health systems (Rechel & Khodjamurodov 2010). Others alluded to the harmful effects of the exclusive reliance on experts such as economists and epidemiologists and the exclusion of the wider population in designing the package (Zwi & Mills 1995). Furthermore, Abel-Smith (1994) highlighted the political difficulties that may arise as a result of the exclusion of health services on the basis of cost-effectiveness (Abel-Smith 1994). Similarly, others suggested that the reallocation of resources from tertiary services to basic care can be resisted by vested interests and may prove extremely difficult where accountability and community participation is limited (Paalman et al. 1998).

Relatedly, several issues related to adequate considerations of the local context were highlighted. For example, some underscored the lack of an evidence base for health reform initiatives which led to the dominance of the ideological views of external actors (Rechel and Khodjamurodov, 2010, Rechel et al., 2011). An example of this was the introduction of formal co-payments as a method of private financing of the BHSP in eastern European
countries (Borowitz and Atun, 2006, Rechel et al., 2011). Inadequate consideration of contextual factors in the introduction of the BHSP in countries such as Ukraine and Kazakhstan also resulted in further fragmentation and inefficiencies (Borowitz and Atun, 2006, Kutzin et al., 2010a). These failures were exacerbated when the BHSP was used as a single tool rather than being embedded in a comprehensive health financing reform (Gottret et al., 2008, Kutzin et al., 2010a, Rechel et al., 2011). The introduction of the BHSP in Kyrgyzstan was considered more successful since it was approached as a sequential step in a wider health financing reform initiative (Kutzin et al., 2010a).

In summary, the review above highlights several important points. The BHSP has been presented by organisations and actors such as the World Bank as a best-practice tool in developing countries including conflict-affected settings. However, a brief review of the literature demonstrates that the BHSP is heavily contested on technical, operational and political grounds. Such controversy and debate around the introduction of the BHSP in developing countries makes scientific investigation into its introduction in the conflict-affected setting of Iraq necessary.

3.4 Literature on the health policy process
This research can be characterised as more an empirical study. Advancing theoretical understanding is not one of its major contributions. However, the study was informed by a number of theories and models that provided the conceptual foundation for this research. This section provides definitions of policy and policy making process. It then outlines a number of theories that we believe are relevant to this research.

There are several definitions of policy that this study adopts in its approach to the analysis of Iraq’s BHSP. Heclo defines policy as “a course of action or inaction rather than specific decisions or actions” (Heclo, 1972:85). Similarly, Easton emphasises action but highlights what he calls “web of decisions and actions” (Easton; 1953:130). Jenkins takes this definition further to describe policy as a “set of interrelated decisions” (Jenkins; 1978:15). As a case of a policy, this study views Iraq’s BHSP as a course of actions and decisions. Those actions were taken over a relatively prolonged period of time. The idea emerged in the immediate aftermath of the 2003 Iraq war and was introduced formally in 2009. Such a
relative period of time allows for investigating the decisions and actions made that were involved in its development. This study is interested in investigating the process involved in making Iraq’s BHSP over that period of time.

But what do we mean by the policymaking process? Analysing the policy process can be of descriptive (analysis of) or prescriptive nature (analysis for) (Hill, 2005; James & Jorgensen, 2009; Lasswell, 1971; Weimer, 2008). Analysis for policy is interested in improving the quality of a particular policy or policies. Analysis of policy attempts to describe and explain policy content, process and/or outputs. Analysis of policy content explores the origin of policies and how they emerge and how they were implemented. Analysing the policy process, on the other hand, investigates decision making and how those decisions shape policies in action. Studies of policy outputs involve examining the output of policies and how they vary over time for example.

This study is more a study of than a study for policy. It investigates the origins of Iraq’s BHSP and traces the decisions involved in its making. Such distinction is useful in providing a focus for the study. We believe that the ultimate goal of a policy analysis should be improving the quality of policy. However, this study takes the view that understanding the policy process is essential for recommending better or alternative policies. Without understanding and attempting to explain the policy-making process, any recommendations for alternatives would be misguided (Hill, 2005).

Defining policy, the policy process and whether a policy analysis is for or of policy is not enough in undertaking the analysis itself. Conceptual and theoretical frameworks are necessary to guide the process of exploring and explaining the policy under investigation. Therefore, a brief description of key theories of the policy process that are relevant to this research are provided below.

Various models exist that attempt to describe and explain the policy-making process. Some of those models which are particularly relevant to this study include the policy cycle framework, Kingdon’s policy windows, incrementalism, muddling through, and the rationalist model (Walt, Gilson; 1994; Kingdon, 2010; Dwyer & Ellison 2009; Walt &
Gilson; 1994). Those models were not directly used as an explicit theoretical framework for this research (please refer to section 2.5 for more on the conceptual framework adopted for this study). However, they have informed various aspects of the thesis.

The policy cycle framework proposes that policy evolves through discrete phases or stages (Howlett et al, 2009). This framework divides the policy process into agenda-setting, formulation, implementation and evaluation. This model is a heuristic tool that provides a simplified characterisation of the policy process as a series of discrete phases. This study used the stages heuristic in two main ways. First, for clarity purposes the study examined mainly the agenda-setting aspect of the BHSP policy in Iraq. Second, as a tool to organise the literature on health policy in conflict-affected settings (please refer to the literature review chapter). Despite those uses, this study is conscious of the limitations of the policy cycle framework not least, its inability to account for and explain the complexity involved in the policymaking process.

Rather than just describing the policy process, other theories attempt to explain the outcomes that emerge from it. Kingdon's multiple streams theory focuses primarily on the agenda setting stage of the policy process (Kingdon, 2010). It proposes that the policy process is characterised by a random flow of problems, policies and politics streams. Windows of opportunity emerge when those streams merge at particular temporal junctures. The multiple streams theory is useful in explaining the emergence of the BHSP in Iraq's health policy agenda. The Iraq war of 2003 can be viewed as a window of opportunity where the problem, policy and politics stream came together. Although references are made to Kingdon's model in this thesis, the research did not use it as a central theoretical framework. However, the multiple streams theory is clearly useful in explaining why particular actions and policies emerge during post-conflict periods. For example, this study is interested in exploring whether the post-conflict period after the 2003 war provided a window of opportunity. Such window might allowed policy actors to advance ideas (such as the BHSP or user fees) into the agenda that would have otherwise been difficult or impossible. More specifically, new actors who advocated new ideas may have become more influential during and as a result of the post-conflict context.
The multiple streams model arguably focuses on a particular historical juncture where a window of opportunity develops. Other models seem to be more interested in decisions and actions that are made over longer periods of time. Incrementalism (muddling through), that is classically associated with Lindblom, is principally concerned with what happens in organisations (Walt, Gilson; 1994). This approach assumes that the policies are made through a process of bargaining among various groups of interest. The latter could be seen as an example of what some described as “nicking stuff from all over the place” (Dwyer & Ellison 2009). The incrementalist approach is potentially useful in informing the interpretation of the findings of this research. For example, this research is interested in exploring the views of various actors with regards to the BHSP in Iraq. It is also interested in exploring the tensions and bargaining involved among those actors during the process of developing the BHSP.

Among the models described above, the rationalist model is the least useful for the purposes of this study. In contrast to the above models that attempt to offer explanations and descriptions, the rational approach prescribe how policy should be undertaken (Walt & Gilson; 1994). It deals with identifying the values that should underpin specific goals for a particular policy. It is mainly concerned with selecting the best policy approach given available information about cost and consequences of various alternatives.

In short, the definitions, terminology and theories that are briefly examined in this section provided the conceptual foundation and terms of reference for this study. We propose that Iraq’s BHSP is an example of a particular policy since it can be seen as a course of actions or decisions made over a period of time. This study explores the policymaking process involved in its development. The policy cycle heuristic enables the analysis to focus on a particular stage (agenda-setting and formulation) while other models (multiple streams and incrementalism) inform the analysis. The issue with these theories as far as this study is concerned is that they struggle to explain dramatic policy changes such as the BHSP in Iraq. Kingdon’s model is potentially an exception because it attempts to explain how and why policy change happens. This section provides a brief account of relevant policy-making models and identifies those parts of the study that they inform.
3.5 Conclusion

One of the main features of the literature reviewed for the purpose of this study is the almost total absence of studies that examine the introduction of policies in the Iraq’s post-conflict health system context. Such a dearth of studies had both disadvantages and advantages for this research. The limited availability of scholarship on the post-conflict setting of Iraq undermined the ability of this study to use and test prior knowledge the topic. However, the new knowledge generated by this study in the context of Iraq is shaped by prior evidence from other contexts. Second, the literature focuses mainly on the impact of policy action in post-conflict settings, largely neglecting the processes through which those policies are introduced. Even when examining the policy processes, the literature did not adequately explore the potential internal and external origins and sources of policies. Third, while the literature focuses on the roles of external actors, it pays limited attention to the role of domestic actors and politics.
4 Iraq’s socio-economic context and health system

This chapter will explore the geographic, demographic, political economy context of Iraq. It will also review the health system of the country. It provides a comprehensive overview of those features in the country. Such a deep description is necessary to set the scene for the examination of the policy process of introducing the BHSP. The basic premise of the chapter is that any piece of policy is not introduced in a vacuum. Hence, an awareness of the context of the country is of critical importance in the analysis of the policy process.

The chapter begins by providing a description of the basic geographic and demographic features of Iraq. It will then proceed by offering an in-depth examination of the political economy of the country. The chapter will do that through a historical overview of major political and economic events and policies throughout the 20th and beginning of this century. Following that, the chapter will then focus on the health system. First, it will provide some basic public health and health system indicators for Iraq. It will then offer a thematic description of major institutions that dominate Iraq’s health system and health policy.

4.1 Geography, Demography, and Political-Economy

Iraq is located in the Middle East with a total area of 438,317 Square Metre (Central Intelligence Agency 2015). Iran borders it from the east, Kuwait from the South, Saudi Arabia from the South West, Jordan, and Syria from the West and Turkey from the North (Figure 4.1)

Figure 4.1: Map of Iraq

Source: US Department of states
As of 2015, the country had a population of 37,056,169 (about 2 million more than Canada), making it the 37th most populous country in the world (Central Intelligence Agency 2015). Iraq has a population growth rate of 2.93% with a birth rate of 31.45 births/1,000 population and death rate of 3.77 deaths/1,000 population. The majority of the population is young with a median age of 19.7 years. The age group of 0-14 constitutes 40.25% while 65 or more only 3.33% of the population. Nearly 70% of this expanding and young population lives in urban areas. The people of Iraq are mostly Arabs (75-80%). Kurds compromise 15-20% of the populations while the remaining 5% are Turkoman, Assyrian, and others. About 99% of the population are Muslims (Shia 60%-65%, Sunni 32%-37%); Christians represent 0.8% (Central Intelligence Agency 2015).

Governance is undertaken through the legislative, executive and judicial branches of the government. The legislature is a unicameral Council of Representatives consisting of 328 members. By law, 25% of the seats of the Council of Representatives should be females and 8 are dedicated for minorities such as Christians and Turkomans. The executive branch, on the other hand, consists of the President and three vice-presidents. The President appoints the Prime Minister and voted for by the Parliament. The Judicial branch consists of the Federal Supreme Court (9 judges) and Court of Cassation. The members are appointed by the Higher Juridical Council. Other courts include the Court of Appeal, First Instance, Personal Status, Labour, Criminal, Juvenile, and Religious courts. The legal system is a combination of a mixed system of civil and Islamic law (Central Intelligence Agency 2015). Administratively, the country consists of eighteen provinces and one federal region (Kurdistan Regional Government) (Central Intelligence Agency 2015).

Economically, Iraq is an upper middle-income country with a GDP of $223.5 million (as of 2015) (World Bank 2015). Its annual GDP growth, however, has dropped dramatically in recent years from nearly 14% in 2012 to -2.1% in 2014. This decline resulted from a combination of low oil prices and the current conflict in the Middle East (World Bank 2015). Iraq is ranked the 130th in the world on the Human Development Index (World Bank 2015; UNDP 2015). The country has an abundance of natural resources particularly oil, natural gas, phosphate, and sulphur. The oil sector dominates the economy and provides more than 90% of government revenues, 80% of foreign exchange earnings and 74% of the GDP (Central
Intelligence Agency 2015; Looney 2006). Only 18.1% of its land is agricultural.

4.2 Background of Iraq's political economy

Table 4.1: Chronology of events 1914-2003

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1914</td>
<td>British Occupation of Iraq</td>
</tr>
<tr>
<td>1918</td>
<td>San Remo meeting assigns mandate for Iraq to the United Kingdom</td>
</tr>
<tr>
<td>1921</td>
<td>Enthronement of King Faisal in Baghdad</td>
</tr>
<tr>
<td>1927</td>
<td>First major oil finds</td>
</tr>
<tr>
<td>1932</td>
<td>League of Nations ends mandate and grants independence to Iraq</td>
</tr>
<tr>
<td>1936</td>
<td>Military coup d'état</td>
</tr>
<tr>
<td>1941</td>
<td>Another coup d'état, British troops march on Baghdad</td>
</tr>
<tr>
<td>1958</td>
<td>Military coup d'état, monarchy was overthrown and Republic established</td>
</tr>
<tr>
<td>1963</td>
<td>Military coup d'état by Baathist and Arab nationalists</td>
</tr>
<tr>
<td>1964</td>
<td>Nationalisation of all banks, insurance companies, and large industrial firms</td>
</tr>
<tr>
<td>1968</td>
<td>Military coup d'état</td>
</tr>
<tr>
<td>1969</td>
<td>Saddam Hussein becomes vice-president</td>
</tr>
<tr>
<td>1972</td>
<td>Iraq and USSR sign 15 years agreement</td>
</tr>
<tr>
<td>1979</td>
<td>Saddam Hussein becomes president</td>
</tr>
<tr>
<td>1980</td>
<td>Iraqi army invades Iran</td>
</tr>
<tr>
<td>1988</td>
<td>Iraq–Iran war ends</td>
</tr>
<tr>
<td>1990</td>
<td>Iraq invades Kuwait; UN imposes sanctions on Iraq</td>
</tr>
<tr>
<td>1991</td>
<td>Liberation of Kuwait by allied forces, uprising in the south and Kurdistan</td>
</tr>
<tr>
<td>1996</td>
<td>Oil-for-food programme allowing limited Iraqi oil sales for purchase of civilian supplies</td>
</tr>
<tr>
<td>2003</td>
<td>US and allies invade Iraq</td>
</tr>
</tbody>
</table>

Sources: (Hiro 1989; Tripp 2000; Makiya 1998)

To better understand the context during which Iraq introduced the BHSP, it is necessary to provide a historical overview of the political economy of the country prior and during and the introduction of the BHSP. The section will provide a brief description of main aspects of policy making during each period. For the sake of clarity, the following description of the political economy of the country is divided into two main periods. The first starts with the founding of the state of Iraq in the 1920s till the Iraq War of 2003. The second describes developments during and following the war.

4.2.1 1920s-2003

Significant oil production began only in 1927 and until then the revenues were derived mainly from customs and excise duties, and agricultural and income tax (Burrows & Cobbin 2011). Up until 1964, Iraq used to have a strong commercial private sector dominated initially by the Jewish minority and then by the Shiites following the former’s departure in the early 1950s to Israel (Chaudhry 1991). In 1964, the Baathists, who were closely linked
with the Sunni minority, nationalised all of the Shiite-dominated commercial sectors including lands, banks, industry, insurance and services (Chaudhry 1994). Chaudhry suggests that sectarian motives more than the socialist ideological rhetoric of the Baath party drove nationalisation (Chaudhry 1991). She also claims that by 1970, these nationalisation policies resulted in the almost complete elimination of the commercial and landed Shiite elite.

Substantial revenues from oil explorations started to accrue to Iraq in the late 1940s and early 1950s. Between 1961-1970 oil revenues doubled although the income from oil was still relatively modest by comparison with later years (Farouk-Sluglett & Sluglett 2001). The nationalisation of the oil sector in 1972 and the subsequent spike in global oil prices resulted in doubling of national income in one year from 1973 to 1974 and then tripling in the next two years in 1976 (Alnasrawi 1992). In the late 1970s, oil became the most important contributor to GNP and the main source of foreign exchange (Alnasrawi 1986). These economic developments occurred in parallel to a pact with communists in 1973, an agreement with the Soviet Union and a temporary solution of the Kurdish revolt in 1975 (Farouk-Sluglett & Sluglett 2001). By 1980, Iraq became one of the strongest economies in the Middle East (Henderson 2005; Alnasrawi 1992).

The vision of the Baath party in Iraq, which ruled from 1963 to 2003, was to build an industrialised and urbanised society led by a centralised state guided by pan-Arab socialist ideology (Ismael 1980). Helped by large oil revenues, Iraq was able to achieve comprehensive social services. Those services included comprehensive health services, universal education, a heavily subsidised food distribution system and social support to those families falling below the poverty line (Drèze & Gazdar 1992). In tandem with those generous social policies, Iraq started in the 1970s to dedicate the largest bulk of the increasing oil revenues to building its army and security apparatus (Ismael 2003). Also, during the 1970s and the subsequent decade a massive shift of labour from the civilian to the military economy occurred accompanied by an increase in military spending and imports (Alnasrawi 2001). Despite the socialist rhetoric of the Baath party, the social and economic policies adopted since 1963 led to the creation of state capitalism rather than socialism (Farouk-Sluglett & Sluglett 2001; Amuzegar 1974). The massive increase in oil revenues in the 1970s helped the establishment and rapid development of a private sector
largely dependent on government support (Farouk-Sluglett & Sluglett 2001). Wages were five times higher in the private than the public sector and the government had to compete with it. The state issued several legislations to retain skilled forces within the public sector (Farouk-Sluglett & Sluglett 2001). Then, all of this unravelled with the start of the 1980s.

The Iraq-Iran war (1980-1988) heralded major economic, social and political changes in the country. With the 1979 Iranian revolution, even more oil revenues were dedicated to military spending rather than social services or building infrastructure (Alnasrawi 1986). During the Iraq-Iran war, military expenditure increased from 10% to 30% of GNP while health spending, for example, reduced to only 0.8% (Hoskins 1997). Destruction of oil facilities due to the war resulted in massive decreases in oil revenues (Alnasrawi 1992). Some suggest that the loss of oil exploration capacity for Iraq was the most severe economic consequence of the war (Alnasrawi 1986). Iraq also suffered from low oil prices in the 1980s resulting from improved US relations with Saudi Arabia, recession in the world economy and a tendency toward energy conservation (O’Connor 1991).

Furthermore, the war proved longer and more expensive than the Iraqi leadership initially anticipated. The human cost of the Iraq-Iran war was millions dead and injured from both sides (Hiro 1989). The financial and economic costs to Iraq from the war are estimated at around $452.6 billion (Mofid 1990). The latter corresponds to a loss of 112% of GNP per year throughout the eight years of conflict (Alnasrawi 1992). In response to the shortages that enlisting in the army caused during the 1980s, Iraq imported scores of workers from Arab countries (Drèze & Gazdar, 1992). Remittances from those foreign workers introduced further difficulties for the economy. In addition to the significant losses in both human and infrastructure, the war led to a debt of around $80 billion, the largest bulk of which were owed to the Gulf States of Saudi Arabia and Kuwait (Farouk-Sluglett & Sluglett 1990). In only one decade, Iraq converted from a creditor to a debtor country (Alnasrawi 1992). The large debt did not, however, translate to significant policy influence by external agencies at least during the 1980s (Chaudhry 1991). According to Chaudhry, international financial institutions exerted minimal influence on Iraq’s economy during that period. This limited leverage was mainly because Iraq was dealing with debtor countries (such as Saudi Arabia and Kuwait) individually rather than in the form of consortia.
By the second half of the 1980s, Iraq started a series of austerity, privatisation and liberalisation policies. Austerity measures included reductions in spending, freezing of infrastructure projects and imports, and devaluation of the currency (Chaudhry 1994). Iraq called this initiative ‘the administrative revolution’ (Farouk-Sluglett & Sluglett 1990) some commentators argue that these initiatives were the most extensive privatisation programmes in the developing world at the time (Chaudhry 1991). The largest change occurred in the agricultural sector, where previous trends of land reforms such as ceilings on land ownership and distribution of privately-owned lands to peasants were reversed (Springborg 2015; Chaudhry 1994). Iraq also privatised many state-owned enterprises except for the oil and military industries. Other changes at the bureaucratic level included dissolving 200 directorships and their entire staffs (Chaudhry 1994). Nevertheless, the state remained the main engine of the economy and the intermediary between the oil and private sectors (Drèze & Gazdar 1992).

In parallel to privatisation, Iraq also liberalised trade and private enterprise. The government removed ceilings on private investment, cross-sectoral enterprise, taxes on profits and introduction of tax holidays of ten to fifteen years (Chaudhry 1994) Iraq also introduced similar policies in the services, trade and construction sectors. Some claim that a radical shift from equity to efficiency occurred in the 1980s (Chaudhry 1994). In tandem with these changes, the government dissolved labour unions, abolished the minimum wage and allowed free labour export from the regional countries of Jordan, Egypt and Yemen (Chaudhry 1994). Iraq also liberalised prices and removed price controls on almost all goods. Liberalisation replaced the state monopoly with private monopolies which, combined with the relaxation of the state’s price fixing capacities, resulting in high prices (Alnasrawi 1992). Iraq introduced some ringing measures of political liberalisation with the privatisation and liberalisation of the late 1980s (Farouk-Sluglett & Sluglett 1990). However, this move did not rise to the level of genuine democratisation or the establishment of the rule of law (Chaudhry 1991). In fact, it appears that the repressive nature of the Baath regime enabled the Iraqi government to proceed with the liberalisation and privatisation policies at a sheer speed with minimal opposition from disaffected groups (Chaudhry 1991). Finally, it appears that the oil boom of the 1970s decreased the extractive (taxation), regulatory and information gathering
capacities of the state while it increased the distributive and productive abilities. Therefore, although privatisation occurred, this did not automatically translate into a market-based economy (Chaudhry, 1991, 1994).

In addition to the financial difficulties resulting from the war with Iran and accompanying decreases in oil revenues, a number of other economic and political factors facilitated privatisation and liberalisation. It appears that the main rationale was to make savings to enable military expenditure that would ensure military parity with Israel and strategic advantage over Iran (Chaudhry 1991). It also seems that Iraq wanted to appease the United States and join the Western Block through privatisation and liberalisation (Cordesman 1984). Large oil revenues helped a shift from dependence on Soviet Technology and policies towards the West (Springborg 2015). Saddam Hussein also worked on creating a group of private businesspeople to support his leadership. This shift entailed a weakening of the Baath’s party’s authority over the public sector. However, economic contingencies resulting from the low oil revenues and the increasing external debts were the main reasons behind the adoption of these policies by the Iraqi government (Alnasrawi 1992).

The privatisation and liberalisation policies of the late 1980s resulted in high levels of inflation, unemployment, scarcity of essential goods, inequalities and the emergence of a black market (Chaudhry 1991). Such policies led to high inflation at about 45% in 1990 accompanied by a devastating blow to the middle class (Farouk-Sluglett & Sluglett 1990). They also resulted in economic crises and shrinking of Iraq’s sources of foreign exchange. By 1989, the Iraqi government started a range of measures to counter the consequences of its earlier privatisation and liberalisation policies. Such measures included price freezes, limitations on profit margins, and increases in the salaries of civil servants (Alnasrawi 1992). However, these measures proved to be only temporary political fixes. Ultimately, Iraqi regime felt that it needed to look south for solutions in the form of invading Kuwait. Iraq’s government attributed the invasion of Kuwait to the latter’s refusal to cancel its debt, stop oil exportation from disputed fields and allow the country’s trade access to the Persian Gulf (Alnasrawi, 2001; Chaudhry, 1991). As a result, Iraq resorted to military power to achieve economic ends.
Iraq occupied Kuwait on August 2\textsuperscript{nd}, 1990 heralding thirteen years of wars and sanctions that culminated in the 2003 invasion. To liberate Kuwait, the US and its allies launched a military offensive in January 1991. The air campaign was expanded beyond the originally planned military targets to include civilian facilities (Gellman 1991). The initial target of 84 increased in the course of the war to 723 which included hospitals and other health facilities (United States Congress 1992). As a result of the air bombing, power production capacities of the countries were reduced to 1920 levels (Hiro 1992). The following quote from a report by the special United Nations mission to Iraq at the time captures the scale of the devastation inflicted by the 43 days of the conflict:

\textit{“The recent conflict has wrought near-apocalyptic results upon what had been, until January 1991, a rather highly urbanised and mechanised society. Now, most of modern life support have been destroyed or rendered tenuous. Iraq has, for some time to come, been relegated to a pre-industrial age, but with all the disabilities of post-industrial dependency on an intensive use of energy and technology”} (UN, 1991:5)

Many reports by other organisations and individuals reiterated those observations by the UN and highlighted hunger, illness and human suffering in those years of the early 1990s (Dammers 1991; The Lancet 1991; Field & Russell 1991; Harvard Study Team 1991; Hoskins 1991; Blakeley 2001). For instance, infant mortality rose three times between January and August 1991 (Harvard Study Team 1991). The Lancet reported, at the time, high incidence of starvation and malnutrition especially among children (The Lancet 1991). Communicable diseases such as Typhoid, Cholera and other types of gastroenteritis reached epidemic proportions (Dammers 1991). The incidence of diarrhoea, for instance, increased as much as four times compared to the previous year (Khan 1991). Other evidence suggests that following the war the majority of the Iraqi population was below the poverty line (Drèze & Gazdar 1992). One commentator reported that Iraq returned to a 19\textsuperscript{th}-century state as a result of the war and subsequent sanctions (Alnasrawi 2001).

Following the invasion of Kuwait, in addition to a comprehensive UN embargo, all Iraq’s assets were frozen (Alnasrawi 1992; Drèze & Gazdar 1992). The sanctions that were imposed in August 1990, virtually cut the country from the world economy (Alnasrawi 2001; Cortright & Lopez 2000). According to some, the sanctions were the longest and most comprehensive in the world’s history (Lopez & Cortright 2004). Those measures resulted in
ending 90% of Iraq’s imports and 97% of its exports. They were mostly successful in preventing the Saddam Hussain regime from building and developing its previous weapons of mass destruction programmes (Lopez & Cortright 2004). Some attributed the failure to discover any weapons of mass destruction at the start of the 2003 war, to the effectiveness of the sanctions (Lopez & Cortright 2004). Some suggested that the sanctions against Iraq were a form of mass destruction ironically employed to eliminate more conventional weapons of mass destruction (Mueller & Mueller 1999). Although the embargo officially excluded supplies for medical purposes and foodstuff of humanitarian nature, an actual restriction on the import of those supplies existed (UN 1990).

Since Iraq was highly dependent on food imports, the sanctions of the 1990s resulted in famine throughout the country in a short period (Drèze & Gazdar 1992). They resulted in massive decreases in the availability of food since Iraq imported 70-80% of calorie needs of the population (Alnasrawi 2001). However, mass migration due to hunger or dying of starvation did not happen thanks mainly to the food rationing public programme. Nevertheless, it appears that hunger and famine were used as a political weapon to force Iraq to agree to the terms of the sanctions (Freedman & Karsh 1995). Also, starting in August 1990, real earnings have sharply decreased as a result of low employment rates and wages and dramatic increases in prices (Drèze & Gazdar 1992). Food prices, in particular, increased by 200%-1800% between August and November 1990 (Provost 1992). The government of Iraq introduced a food rationing system in August 1990 following the embargo and sharp increases in food prices. The rationing system entailed the provision of pre-determined amounts of essential food items at fixed prices through private agents to households (Drèze & Gazdar 1992). These food rations, however, reduced the per day calorie intake of the average Iraqi person to half of its pre-crisis levels (Drèze & Gazdar 1992). Other estimates suggest that they represented 37% only of the average calorie intake of 1987-89 period (FAO 1993).

A series of UN resolutions proposed that Iraq sells limited amounts of oil to fund the import of foods and medicines. Iraq on its part refused those proposals which further aggravated the humanitarian situation in the 1990s (Alnasrawi 2001). The repeated refusals of the Iraqi government to accept those proposals by the UN led to further economic deterioration. The value of the Iraqi dinar, for example, plummeted to an unprecedented value
of 300 for each dollar (Alnasrawi 2001). In 1996, Iraq finally agreed on a proposal to sell $2 billion worth of oil to purchase foods and medicines of what later became known as the Oil for Food Programme (OFFP). The UN progressively elevated the ceiling on the revenues from oil exports, until it was removed in 1999 altogether. It then replaced the sanctions by a set of ‘smart’ measures in 2002 (Lopez & Cortright 2004). The latter entailed retaining the severe restrictions on building the military capacities of the Iraqi government while allowing for civilian trade and economic activities. It, however, retained all of the other conditions attached to the program (paying Iraq’s debt, compensation to Kuwait, paying UN operations). All of the proceeds from the OFFP (estimated at $64.2 billion) went to a UN escrow account rather than the Iraqi central bank (Lopez & Cortright 2004). The OFFP allowed Iraq to import $109 per person per year worth of food and medicines compared to the pre-embargo $508 per person per year (Alnasrawi 2001). It became the largest assistance program in the world at the time (Garfield, 2001). However, According to many, the OFFP failed to fix the worsening economic and social conditions of the Iraqi population. The UN Secretary General at the time indicated that “resolution 986 was never intended to meet all the humanitarian needs of the Iraqi people” (El-Bayoumi, 2000:26). The programme ended with the US-led invasion of Iraq in 2003.

4.2.2 The Iraq War of 2003

In the build-up to the Iraq war, many influential individuals, think-tanks and organisations advocated a rapid transformation of Iraq’s economy through neoliberal policies (Cohen & Riscoll 2003; Marcel & Mitchell 2003; Barton & Crocker 2003). The intentions of the Bush administration to export the neoliberal model to Iraq became apparent in the first few days and weeks of the invasion through the disclosure of classified documents (King 2003). The Coalition Provisional Authority (CPA) appointed individuals to oversee economic policies in Iraq based on their commitment to neoliberalism, association with the Bush administration and experience with major US corporations (Chandrasekaran, 2007; Docena, 2007). It appears that the Bush administration intended to use Iraq as a case to test the introduction of neoliberal policies in the entire Middle East (Laursen 2003; Crocker 2004). It also seems that the Bush administration’s hope was to show how a newly introduced economic model (neoliberalism) can transform a previously destroyed system
Immediately after the 2003 invasion the US and the UK led CPA implemented a package of policies that was reminiscent of similar policies in Central and Eastern Europe in the 1990s (Looney 2004b; Crocker 2004). One commentator suggested that almost overnight Iraq became the most open economy in the entire Arab region (Mulugeta 2003). The Economist also noted that "If carried through, the measures will represent the kind of wish-list that foreign investors and donor agencies dream of for developing markets." (The Economist 2003).

The US-led CPA attempted to transform rapidly Iraq’s ostensibly state-based economy to one based on private enterprise (Whyte 2007). It issued 100 legally binding orders that ended state ownership of enterprises, eradicated import tariffs, liberalised trade, reformed taxes and ended state subsidies (Whyte 2007; Abboud 2009). The CPA privatised 150-200 State Owned Enterprises (SOEs), and it explicitly prohibited financial assistance to the remaining ones from reconstruction funds (Looney 2004b). Fighting and eliminating corruption was one of the main arguments advanced in support of this rapid privatisation (Whyte 2007). The CPA suggested that state interventions distorted the market and restricted Iraq’s competitiveness in the global economy (Bremer 2006).

The CPA also advanced other arguments such as the notion that the economy was moribund, inefficient and corrupt (Abboud 2009). As part of the reduction of the state size policy that the CPA adopted, the latter purged the public sector of about 700,000 employees (Abboud 2009; Harding & Libal 2010). The CPA did so by issuing orders such as debathification (the release of former Baath party members of their public duties) and the resolving of the Iraqi Army (Looney 2004b). The policy package also included capping income and corporate taxes at 15%, reducing tariffs to a universal 5% with none imposed on drugs, food, books and other humanitarian imports (Looney 2004b). The CPA also issued orders that allowed full foreign ownership of a wide range of enterprises including pharmaceuticals, electricity, telecommunications, banks, mines and factories (Whyte 2007). It made Iraq’s membership in WTO one of its most important goals (CPA 2004). It also granted full repatriation rights for foreign businesses (Looney 2004b). Other measures included
modelling Iraq’s banking system on western models where the Central Bank of Iraq acquired powers and authorities consistent with those operating in the international financial system (Looney 2004a). Arguably, those changes transformed Iraq rapidly from an isolated state to a free-trade zone (Looney 2003).

It appears that those policies resulted in severe consequences for the Iraqi people and economy (Basu 2003; Rodrik 1996). By the end of the CPA tenure in 2004, about two million people were unemployed (Abboud 2009). The import of labour from some of the countries that participated in the occupation (The Philippines in particular) further aggravated the problem of unemployment (Tyner 2006). CPA’s policies also resulted in a massive decrease in the prices of commodities arising mainly from the liberalisation of trade which in turn led to the inability of local businesses to compete (Abboud 2009). Some local businesspeople reported that those policies ‘killed’ Iraqi businesses which became unable to compete with cheap foreign commodities (Whyte 2007). The impacts of war and sanctions in the previous decades on local businesses added to the disadvantages of the latter in the face of international competition (Abboud 2009). On the other hand, between 2003 and 2004, US companies received 80% of prime contracts with the UK, Australian, Italian, Israeli and Iraqi companies splitting the rest (Herring & Rangwala 2005; Crocker 2004). It appears that in combination, those policies led to the perpetuation of Iraq’s dependence on oil as the main source of revenues and further undermined the extractive functions of the state (Abboud 2009).

Several commentators described those policies negatively using familiar and new terminologies. One suggested that the economic policies of the CPA accounted for a war crime according to international law (Whyte 2007). Another described them as ‘neoliberalism by other means’ contrasting it with similar attempts through trade or agreement (Lafer 2004). Yet, another writer claimed that the policies of CPA can be described as ‘creative destruction’ of the entire social fabric of the country (Abboud 2009). One of the most familiar descriptions is what Joseph Stiglitz described as ‘shock therapy’ (Stiglitz 2004). However, the shock therapy narrative ignored to a large degree the privatisation and liberalisation trends that Iraq initiated in the late 1980s and 1990s and discussed in earlier paragraphs (Mahdi 2007).
Whatever the description, an author suggested that the neoliberal policies in Iraq were one of the most important factors behind the insurgency against the US occupation (Schwartz 2007). The unrests of the late 2003 and early 2004 led the CPA to limit or in some cases completely stop its neoliberal policies (Looney 2004b). Also, the realisation that CPA’s mass privatisation and liberalisation were breaching international law might have pushed the former to postpone some of its plans (Klein, 2003, 2004). Despite these little limitations on the pace of neoliberal policies, the effects of Iraq’s debts and the involvement of agencies such as the World Bank and IMF ensured that they continue throughout the 2000s.

Following the war, Iraq’s debts were estimated at US$130 billion (Weiss 2011). Between US$60-65 billion of that was owed to Non-Paris Club countries (mostly Persian Gulf countries), about US$39 billion was owed to the Paris Club, and US$4.1 billion to the US (Weiss 2005). The remainder of the debt was owed to commercial organizations and multilateral creditors (Weiss 2011). On November 21, 2004, the Paris Club creditors plus Korea, agreed to an 80% reduction (in stages) of their debt claims on Iraq (IMF 2006). The US also cancelled its US$4.1 billion debt in the same year as did the World Bank and IMF (Weiss 2011). Agreement of the Paris Club creditors to cancel most of Iraq’s debt was possible only when the latter agreed to a string of IMF conditionality attached to the debt relieve measures (Weiss 2011; Buckley 2006). A 30% reduction was made at the time of the signing of an Emergency Post-Conflict Assistance (EPCA), another 30% to follow approval of a Stand-by Agreement (SBA) and the final 20% upon a favourable review of the SBA by 2008 (IMF 2006). One commentator suggested that forcing Iraq to agree on the conditionality of IMF debt relief ensured that the neoliberal policies of CPA continued following the end of the latter’s mandate in 2004 (Abboud 2009).

The involvement of the World Bank, following the 2003 war, arguably facilitated the continuation of the neoliberal policies following the transition of power to an elected Iraqi government. A long (but interrupted) history of engagement exists between Iraq and the World Bank. Iraq is a founding member of both the World Bank and the International Financial Corporation (IFC) (World Bank 2009b). The World Bank provided loans for an overall 43 projects in multiple sectors to Iraq (World Bank 2012).
Between 1950 and 1973, the country received a total of 6 loans (2 dropped before finishing) from the International Bank for Reconstruction and Development (IBRD)(World Bank 2009b). Those loans were targeted for agriculture, education, flood control, telecommunications and transport. The last of those loans was closed in 1979 to start a period of absent engagement until 2003. In the summer of 2003, following the end of the Iraq war, the World Bank started its engagement again in the country.

The first activity by the World Bank following the 2003 war was conducting a joint need assessment exercise with the UN (UN & World Bank 2003). The joint assessment included a health section that reiterated the need for restoration of essential services and more roles for the private sector in the health system. The assessment became the basis for an international donor conference in Madrid in October 2003. The conference pledged more than $1.83 billion for rebuilding Iraq (IRFFI 2013). Officials from the IMF prepared the macroeconomic assessment of the Iraqi situation and recommended a transition from the centrally controlled, planned economy to a market-based approach. In addition to replacing the in-kind food ration social safety net program with a cash transfer, the IMF recommended other more structural changes. It advised a prominent role for the private sector in the economy to stimulate growth and create employment opportunities (Al-Ali 2004; Ahmad et al. 2005).

The GoI and the United Nations signed an International Compact with Iraq (ICI) in 2007 (UNAMI 2007). The provisions and the objectives of the ICI, which identified benchmarks for the GoI to achieve over the following five years, were prepared in consultation with the World Bank, IMF, and other multilateral organizations. The ICI identified the provision of public social services (including health) as part of a strategy to protect the poor and vulnerable groups. A benchmark to achieve that objective was to improve access to primary health care services and to focus on prevention and healthy lifestyle. The ICI recommended the establishment of a BHSP that is accessible to all Iraqis regardless of their ability to pay. It also recommended increasing public spending on health to a minimum of 4% from the 2.5% of GDP at the time to pay for access to the BHSP. It further envisioned health insurance schemes as a mechanism for increasing public participation. The MoH viewed insurance
as a mechanism to fund secondary and tertiary health care in the country.

The previous section provided an overview of the geographic, demographic, political and economic context and history of Iraq. The description included both a cross-sectional overview and a longitudinal historical exploration of the main indicators and policy features in the country. Such extensive description is necessary to provide a comprehensive background to the introduction of the BHSP. Despite the massive shift that followed the 2003 Iraq war, policies adopted subsequently (including the BHSP) did not happen in a vacuum. One of the major trends that the previous section uncovered is a shift from socialism in the 1960s and 1970s to liberalisation and privatisation in the 1980s and 1990s to neoliberalism in the 2000s. This evolution entailed a significant transformation in the functions of the state as an owner and provider of social services such as health care. As the result chapters of this research will show, persistence from the past and the continuation of previous trends represents a crucial determinant of at least parts of policies adopted at later stages. Even more importantly, the characteristics, features and historical background of the health system are critical in understanding such health policies as the BHSP. The following sections will attempt to unpack the contextual character of the health system in Iraq to prepare the scene for exploring the case of the BHSP.

4.3 The Health System
This section provides a thematic description of the main historical features of health policy and health system in Iraq. Then the section will offer a cross-sectional description of particular characteristics and features of the Iraqi health system using the most recent figures and data available.

4.3.1 A historical overview
This sub-section explores the legacies of the health system in the past that might have some influence on the development of the BHSP. It does that by providing a description of the actors and institutions that were established and were influential over about a century (1914-2009). Such a long time of historical exploration is necessary to capture the emerging patterns of institutional stability and change.
4.3.1.1 Creating a doctor-politician interest group

The roots of the modern health system in Iraq go back to the start of the last century with the British occupation of the country in 1914. The British occupation and Mandate in Iraq advanced the education and training of doctors in the country. Sir Harry Sinderson (a doctor attached to the British Army) established The Royal College of Physicians of Iraq in 1927 (Sinderson 1973). Sinderson was a graduate of The University of Edinburgh and copied almost entirely its curriculum to the newly established Iraq’s Royal College of Physicians that was also in English. Sinderson went on to establish the first Royal Hospital in Iraq based again more or less on the British hospital system (Sinderson 1973). The British army and later mandate viewed the Iraqi medical profession not only as doctors but also as potential rulers. A.T Wilson, the Civil Commissioner in Iraq, expressed this intention in part of the British administration in 1918 by stating that “It would be an enormous advantage to the country if doctors could be persuaded to undertake political duties; the combination of hakeem [doctor] and hakim [ruler] was just what Mesopotamia needed” (Sinderson, 1973:34).

Hence, newly graduated doctors assumed political and administrative roles as ministers of health, managers of hospitals and in other leadership positions. The inspiration probably came from Sir Harry Sinderson, who arguably is the father of the modern Iraqi health system (Al Wittry 1944). He went on to become the private doctor of the Iraqi Royal Family and had an influence on the politics of the Iraqi Monarchy (Sinderson 1973; Issacs 1976). A graduate and later deputy dean of the college became the first Minister of Health in 1952 (Dougherty & Ghareeb 2013). Others became political leaders and prominent politicians. To institutionalise this exercise of influence by the newly established medical professionals, five years of mandatory work was required for publicly funded graduates of the Royal College (Issacs 1976). Many of the work concentrated at city centres because most of the health organisations were in the major cities (Al Wittry 1944). This situation allowed doctors to exert their influence by being based at administrative departments of those towns. In short, Britain gave birth to a medical profession in its image that concentrated in city centres and was politically influential (Usher 1956).

Britain founded an Iraqi medical profession that continued to increase in number, influence and prestige following the end of the British Mandate in 1932. Doctors and
academics who graduated from the Iraq’s Royal College of Physicians went on to establish similar medical colleges in every major city (UoM 2015; U.O.M 2015; UoB 2015; HMU 2015). The curriculums and methods of teaching of the subsequent colleges duplicated the British system of medical education (Issacs 1976; Husni et al. 2006; Kronfol 2012; Al Hilfi et al. 2013). Doctors also maintained their academic ties with the UK and Europe where many obtained further training and degrees (Aziz 2003; Al Hilfi et al. 2013; Webster 2011). The legacy of viewing doctors not only as clinicians but also as political leaders continued (Fleck 2003b). The increasing number of physicians continued to assume positions as ministers of health, director general of health in districts, managers of hospitals and administrators of health centres (Farouk-Sluglett & Sluglett 2001; Ismael 2003). Doctors’ membership and prominence in the Baath party, rather than merit, became the criteria for their selection to positions of leadership in the health system (Godichet & Ghanem 2004). For example, the longest serving minister of health in the history of Iraq (1968-1977) was a leading member of the Baath party (Dougherty & Ghareeb, 2013; WHO, 2014). He was dismissed later when refused to obey orders from Saddam Hussein related to a political situation in 1977 (Al-Shabandar 2014). Saddam Hussein himself allegedly killed another minister of health in 1982 due to a political dispute (MacFarlane 2006). This authoritarian grip on power, war and high oil revenues facilitated the establishment of a centralised ministry of health in the country (Al Hilfi et al. 2013).

However, the medical profession suffered setbacks in the 1980s and 1990s. The war with Iran introduced security considerations that limited the travel and exchange of information between doctors with the outside world (Al Saraf & Garfield 2008; Al Hilfi et al. 2013). In the 1990s, conflicts with the West and subsequent sanctions resulted in a sharp decrease in the salaries of health professionals (Al Saraf & Garfield, 2008; Garfield, Bendixen, Zaidi, & Lennock, 1997; Garfield, 1999). These pushed the demoralised medical profession to leave Iraq, seek private practice or support the meagre public salaries through what have later been called ‘self-financing’ policies (Frankish 2003).

The doctor-politician phenomena created by the British and later strengthened by the Baath rule continued in the 2000s under the American occupation and then the new Iraqi political configuration. As described above, during the Baath rule, doctors who were
prominent members of the party became ministers, directors, and managers in the health system. By 2004, a disproportionate number of physicians were working in administrative rather than clinical capacities (Alwan 2004). Those who were working in a clinical capacity were seeking specialisation in clinical medicine rather than public health or family medicine for example (Alwan 2004). After 2003, the parties who took the MoH’s leadership selected their affiliated doctors to management positions (Mason 2007). Notwithstanding their political, sectarian and ethnic differences, all the frequently changing ministers following 2003 were doctors. The first interim minister, Dr Khudair Abbas, who is a surgeon, spent twenty years in his UK exile before being appointed by a Shiite political party to lead the MoH (The Lancet 2003). The second minister, Dr. Ala Alwan, was an internal medicine doctor with a background in public health and experience in a high ranking position in WHO (Alwan 2004). The third, Dr Ali Al-Shemari, was again an internal medicine doctor affiliated with a radical Shiite political movement (The Guardian 2007). The BHSP was introduced during the terms of the fourth minister of health, Dr Salih Al-Hasnawi, who is a psychiatrist, affiliated with a less radical Shiite party (Ministry of Health 2009).

One of the few early decisions made by the newly established MoH was to increase the salaries of physicians and other health workers (Rawaf 2005). The increases in the salaries of doctors combined with a fragile security situation rendered the former an easy target for kidnapping, killing and ransom (Mason 2007; Jamail 2005). An estimated range of 628-2000 doctors was murdered in the 2000s (Webster 2011). These security threats combined with the relaxation of bans on travel resulted in a ‘brain drain’ of Iraqi doctors. In the 1990s, Iraq had 34,000 physicians, by 2008 that number decreased to 16,000 the majority of whom had left the country (Marx 2012; Webster 2011). A major loss of human capital occurred mainly between 2004 and 2007 with the majority of specialist doctors leaving the country (Burnham et al. 2009). This development led the MoH to issue extreme measures such as refusing to issue diplomas to newly graduated doctors to prevent them from leaving the country and legislating laws to protect doctors (Brulliard 2007). The majority of the leaving doctors chose the UK, North America or Australia (Al Hilfi et al. 2013). Iraq became the 9th largest source of physicians for the UK and the second largest source of doctors in the Middle East only after Lebanon (Mullan 2005). The departure of doctors did affect not only
clinical services but also introduced administrative and managerial problems given their role as administrators and managers in the health system (Webster 2011).

The previous paragraphs told the story of the path taken by the medical profession in Iraq. In this description, the medical profession can be viewed, as an institution that developed along a particular path that is appears to be resistant to external and exogenous factors. Once the doctor-politician phenomenon was established by the British, it more or less was able to continue its development along that path. It was strengthened by an authoritarian rule and high oil revenues and then weakened by security threats and changing political circumstances. However, it did not seem to have lost its influence completely. The prominence and influence of the medical profession in health policy in Iraq might be helpful in shedding light on some of the puzzling aspects of the BHSP.

4.3.1.2 Primary, secondary, and tertiary health services
This section examines the historical development of health organisations in Iraq. It demonstrates that health organisations in the country developed along a tertiary health care based trajectory. It further reveals that a selective approach dominated primary health care services. This trajectory appears to have implications for the formulation of the BHSP.

With the start of the British occupation of Iraq, a large 500 beds military hospital, numerous British and Indian doctors, pharmacists and nurses accompanied the British army (Sinderson 1973). These replaced the limited and interrupted number of hospitals and dispensaries in the country under the Ottoman rule (Al Wittry 1944). Most of the hospitals established at the time were previous dispensaries converted to accommodate inpatients (The Colonial Office 1930). By 1943, there were 43 hospitals attached to the Ministry of Social Affairs while 34 affiliated with other ministries. A total of 28 hospitals did not attach to any government body at the time. During the 1940s, there was a focus on vertical interventions directed to particular epidemics and diseases such as plague, malaria, cholera and tuberculosis (Al Wittry 1949). A Directorate of Preventive Medicine was also established in 1941 but with limited capacity and influence (Al Wittry 1944). At the Directorate, there were branches dealing with specific diseases and conditions (malaria, tuberculosis, eye diseases). The mandate of the Directorate also extended to measures such as housing and hygiene. By
1958, the numbers of hospital beds, dispensaries (health centres), doctors, nurses, dentists, pharmacists and hospital staff all increased (Naief 1967). This increase in the number of medical personnel and organisations occurred in parallel with the development of the health administration.

Organised health services in Iraq first appeared as a “Health Secretariat” attached to the medical departments of the British Army. Doctors headed The Secretariat while public health workers were seconded from the British Army (Issacs 1976). The Secretariat was renamed Directorate General of Health when a temporary Iraqi cabinet was established in 1920 under the Ministry of Health and Education. The Ministry of Health was separated from the Ministry of Education in 1921 to be later joined with the Ministry of Interior as the Directorate General of Health. By the early 1940s, there was a quasi-centralised health system. In each Liwa (governorate), there was a Chief Health Officer, who managed all of the health personnel and institutions in the governorate. Under his control were the Health Officers in each Qadha (district) and larger Nahya (sub-district) (Al Wittry 1944). Separate ministries established their boards of health and these were not affiliated to the health administration of the Ministry of Interior (Al Wittry 1944). It seems that these health institutions were not supervised by British advisors who assumed a stronger influence on other ministries and departments such as defence, finance and interior. Although the health department was under the Ministry of Interior, it does not seem that the British advisor attached to that ministry exercised direct oversight over the health services (Sluglett, 2007:197).

The Kingdom of Iraq (1921-1958) and then the Republic of Iraq (1958 to present) maintained and expanded hospitals, health centres and other organisations built during the British occupation, mandate and subsequent monarchy. The increasing oil revenues helped this trajectory. Iraq nationalised its oil in 1972 (Farouk-Sluglett & Sluglett 2001). The subsequent spike in oil prices of the mid-1970s provided the resources for an exponential expansion of hospitals in particular (Al Saraf & Garfield 2008; Farouk-Sluglett & Sluglett 2001). Iraq built large Western-style hospitals with advanced technologies in every major city (called Saddam Hospitals) (Frankish 2003; Al Hilfi et al. 2013). Oil revenues also allowed building scores of health centres and hiring increasing numbers of doctors and other health
professionals. In parallel, mainly in the 1970s, private hospitals and pharmacies were either nationalised or confiscated (Mokdad et al. 2014). Also, hospitals and medical facilities affiliated with the Ministries of Defence, Oil and Presidential Office were built (Alwan, 2004; Farag et al., 2004). As a result, utilisation of health services increased to levels seen in the UK and Australia (Habib & Vaughan 1986). By 1990, primary care services reached 97% of urban and 78% of rural populations (Frankish 2003). Health indicators also improved dramatically to become one of the best in the region (Alwan 2004). However, the war with Iran and fluctuation of oil prices in the 1980s forced the state to maintain rather than expand this extensive infrastructure (Stork 1989; Al Hilfi et al. 2013). In parallel, by 1982 a shift in the Baath ideology occurred from socialism and Arab nationalism to attaching importance to wealth creation and private enterprise (Tripp 2000). These developments seem to have limited the potential realisation of the Public Health Law that was enacted a year earlier in 1981.

The Public Health Law of 1981 might have heralded a shift towards comprehensive primary health care (Government of Iraq 1981). It appears that it had incorporated most of the recommendations of the Alma-Ata Declaration through advocacy from WHO (WHO 1981). The law introduced what it called essential health services for primary healthcare centres (PHCs) to provide in both rural and urban areas. Those services included maternal and childcare, school, vision, auditory and dental health, nutrition, health education, mental health and health investigations and tests. It required the provision of those services at all PHCs free of charge. The law also affirmed the role of the state as the guardian of the health of the population. However, it introduced a decentralised approach through creating health council at the governorate levels to provide recommendations and information to the central health council at the MoH. Nevertheless, the law did not decentralise financing functions to local levels.

Furthermore, it appears to have applied for the first time an inter-sectoral approach to health where water, sanitation, health at the workplace, and testing of food import came under the authority of the MoH. The law also abolished all of previous health legislations that were mostly fragmented and directed at specific health problems or particular health interventions (malaria, tuberculosis, drugs). Also, it emphasised the role of the community in
programmes such as training lay women to provide maternal and child health services (Stork 1989). Despite the introduction of this ground-breaking law, some authors claim that primary health care centres at the time remained neglected and low in status compared to hospitals (Al Hilfi et al. 2013). Subsequent sanctions and wars in the 1990s devastated the extensive infrastructure and aborted any attempts at basing the health system on primary health care (Garfield et al. 1997; Garfield 1999; Taylor 2012).

However, there appears to be structural and institutional factors behind the limited potential for the development and prominence of primary health care in Iraq. The medical profession was, and still is, more attracted to hospital-based practice, which is perhaps not unique to Iraq. A general practice or family medicine practice has never developed (Nazar P Shabila et al. 2012). Doctors were (and are) required to work for one year in a rural area or a primary health centre after two years of clinical internship in hospitals. Doctors appear to see this as a mandatory burden before attempting to enter a specialist training in clinical practice (Shabila et al. 2013). Most of the doctors practising in PHCCs either spent time preparing for clinical speciality entry exams or work in private practice. Many worked for only a few hours. Only a few continued to work in primary health centres. The better financial incentives for specialists in both the private and public hospital sectors can explain in part the attractiveness of clinical specialisation. Since most ministers of health were specialist doctors, it was only natural that health policy eschew towards hospitals rather than primary health care (Alwan 2004).

The Iraq war of 2003 resulted in significant deteriorations of the health of the Iraqi people and its health system. Several studies reported dramatic increases in mortality rates compared to the period prior to the war. Les Roberts and colleagues reported in 2004 that the risk of death was 2.5 fold higher after the invasion compared to before. They made a conservative estimate of 100,000 additional deaths as a result of the war resulting mainly from violence as the main cause of excess mortality. They also highlighted that the primary cause of death was violence and that most of the persons killed were women and children. (Roberts et al. 2004). The previous study was updated in 2006 and found that more than 650,000 excess deaths in the 40 months post-invasion. According to the survey, mortality rates increased from 5.5 pre-invasion to 13.3 per 1000 post invasion. Gunfire remained the
most common cause of death (Burnhman et al. 2006). Those studies came under considerable criticisms and scrutiny both from their scientific credibility perspective and their alleged political motivations (Tapp et al. 2008; Apfelroth 2007; Horton 2004). More recent studies reported about half a million deaths as a result of the war. Most of deaths were related to direct violence but about one third were attributable to failures of the health system and related functions such as sanitation or transportation (Hagopian et al. 2013).

Following the 2003 war, the already crumbling health infrastructure was further devastated as a direct result of the combat and subsequent looting. During and immediately following the war 12% of hospitals were looted, and 7% more were damaged due to combat (Garfield 2003; Rawaf 2005). Some argue that the looting was systematically centred on the health system. Frederick “Skip” Burke (the first MoH American adviser) reported, “It cantered on health care. The looters were able to destroy morale very quickly by looting the health-care system. It was highly organized, focused on hospitals, the public healthcare system, pharmacies, and pharmaceutical warehouses, and it was unrelenting.” (Mason, 2007:8).

As a result, during the early years of the war, primary health care services (immunisation, laboratory services, and preventive services) became disrupted (Furber & Johnstone 2004). Some argue that the US invasion in 2003 triggered a complete collapse of the health system at the time (Fleck, 2003b; Kapp, 2003a). For example only 27% of the equipment necessary to provide vaccination programmes were destroyed during or following the war (Ni’ma et al. 2003).

Nevertheless, the visibility of the apparent collapse of the system, outbreaks of cholera and mismanagement of the early post-conflict situation triggered debates about the future directions of the system. Some argued that the task was to rebuild the Iraqi health system from scratch (Fleck 2003a). A senior WHO official during the early years of the war indicated that “The first priority was to jump start the Iraqi health system so that it can provide basic functions again like disease surveillance, provision of medicines, and basic hospitals services”.(Fleck, 2003a:848).

The 2003 war also seems to have offered the opportunity for some to change the
direction of the system towards a more primary health care based system. A number of conferences and symposiums offered the opportunity for Iraqi policy-makers and academics to interact with their international counterparts. During a series of events about the health system in Iraq, the concept of a package of services was emphasized (Institute of Medicine, 2004; D. A. Tarantino & Jawad, 2007; D. Tarantino, Morton, & Kosaraju, 2008). These events occurred between 2004 and 2008 mainly in the United States and Iraq. The US Department of Defence, Department of States, Institute of Medicine and others sponsored and organised those events (Institute of Medicine, 2004; D. Tarantino et al., 2008). The World Bank, in particular, emphasised the need to develop and apply a package of basic services that is accessible and affordable to the entire population (D. Tarantino et al., 2008). A prominent WHO official at the time suggested that the health system was “heavily medicalised and ought to be based on more of a primary health service that reflects the dual burden of non-communicable and communicable disease” (Fleck, 2003b:889).

The minister of health at the time echoed those concerns by indicating, “The system is also basically hospital-oriented with inadequate emphasis on sustainable health development. There is no effective health information system. Services only partially match population health needs, and there is lack of emphasis on cost-effective public health interventions. The levels and distribution of available human resources for health is inadequate…excessive focus on clinical medicine has led to limited involvement of the government and the health system in tackling the underlying risks to health experienced by much of the population.” (Alwan, 2004:49).

Some developments probably have helped this initial apparent desire to shift to primary health care. The trend for more specialisation among the medical profession continued following 2003. This increased specialisation appears to have filled the gaps in numbers of specialist doctors created by the brain drain, killings, and kidnappings. Available hospitals and consultancy centres could not accommodate the additional numbers of specialist physicians (Shabila et al. 2013). Therefore, more and more specialists were assigned to PHCs (Nazar P Shabila et al. 2012). Furthermore, actors such as WHO and USAID became prominent in the health policy process (Burkle & Noji 2004). The infighting between the US Departments of Defence and State seems to have allowed other actors (such
During this period, the BHSP was introduced as part of the “Strengthening Primary Healthcare System in Iraq-Phase I and Phase II (SPHCS-I &II)” (UNDG & WHO 2010). This $37 million program was implemented between 2004 and 2010. The United Nations Development Group’s Iraq Trust Fund (UNDG-ITF) provided the funding and WHO offered technical support. The SPHCS emphasised the importance of providing a minimum collection of essential services that ensure maximum health gains for the money spent (UNDG & WHO 2010). The SPHCS describes the BHSP as a crucial reform, and it divided its development and implementation into SPHCS-I and SPHCS-II respectively (UNDG & WHO 2010; UNDG Iraq Trust Fund 2010; UNDG Iraq Trust Fund 2012). The SPHCS-I contributed to the process of the development of the BHSP through reviewing population health status to diagnose major health issues and select health services that are appropriate for those problems (UNDG & WHO 2010). In addition to the SPHCS, the BHSP was also highlighted in the Iraq Public Sector Modernisation Programme (I-PSM). The I-PSM was a $55 million, four-year, joint UN and Government of Iraq programme. The European Union funded the project while the UNDG-ITF and United Nations Development Assistance Framework implemented it (UNDAF) (Iraq Trust Fund 2012). Phase I of the I-PSM (April 2010-December 2012), focused on the situational and functional analysis of three pilot sectors including health (Politis 2012). During this phase, Oxford Policy Management developed a roadmap for reforms in the area of health (Oxford Policy Management 2011). EPOS health management group, on the other hand, undertook the costing of the BHSP. Continuing the development and implementation of the BHSP is one of the prescriptions of the I-PSM phase II that started in January 2013 and to be concluded at the end of 2014 (Iraq Trust Fund 2012).

However, the period immediately following the war up until the formal introduction of the BHSP showed an apparent reproduction of the previous legacies of focus on infrastructure and building large hospitals. This reproduction occurred in parallel to a desire for the MoH to focus on decentralised primary health care services and a private hospital sector (Cetorelli & Shabila 2014). Immediately after the war, a significant portion of MoH’s budget was allocated to rebuilding the looted and destroyed infrastructure (Cetorelli &
The MoH at the time indicated, “Progress depends on repairing the basic infrastructure such as buildings and electricity. At present, doctors can do little more than admit patients to emergency rooms, where they receive basic medical treatment at best” (Aziz, 2003:1289). James Haveman, the American advisor to the MoH, echoed the focus on infrastructure by stating:

“When I toured our equipment warehouse the other day, the staff were telling me that upwards to 50–70% of the equipment in the hospitals, which had been purchased over the past 10 years; either wasn’t working or was inadequate. When I go to most of the hospitals, most of the regulators for intensive care units are all from about 1980. You do not find defibrillators in hospitals. I mean, none of that type of equipment was purchased. Throughout this, though, the physician community—there’s about 23 000 physicians and 39 000 nurses—provided basic services.” (Department of State 2003)

The American-led CPA attempted to continue the focus on tertiary, hospital-based care in the country (Garfield 2003; Furber & Johnstone 2004). Following the war, a $500-700 million was requested to build a paediatric hospital (The Lancet 2003). This application was turned down by the US Congress which suggested an additional USD $100 million to add to the sought fund to refurbish and modernise hospitals and primary health centres throughout Iraq (The Lancet 2003). The construction of the hospital, supported by the first lady of the United States, was stalled by corruption and ineffective implementation (Mason 2007). Some attributed these kinds of projects to their highly visible nature (Furber & Johnstone 2004). Others argue that the construction of hospitals in this period reinforced and replicated previous regimes’ attempts to introduce and strengthen legitimacy (Al Hilfi et al. 2013).

During the 2000s, primary health centres have also been expanded, updated and equipped (Cetorelli & Shabila 2014). For example in 2012, there were 1000 more PHCCs compared to 2003. The expansion, however, was offset by the population growth, increased needs and high expectations (Cetorelli & Shabila 2014). Attempts have also been made to establish a family medicine or general practice speciality (Al Hilfi et al. 2013). However, this has remained small and unable to change the existing provision of health services at the PHCs. Hence, the previous models of service delivery at PHCs continued (Nazar P Shabila et al. 2012). The designation of PHCs as gatekeepers to hospitals meant that they were overcrowded. This problem was complicated by limited experiences of the junior doctors working for short hours at the PHCs (Shabila et al. 2013). Such centres also continued to be
unevenly distributed with the most concentration in the city centres (Shabila et al. 2013; Nazar P Shabila et al. 2012; Cetorelli & Shabila 2014). They also continued to receive limited attention and support from the MoH compared to hospitals (Shabila et al. 2013). Hence, the perceived low quality of services provided at the PHCs endured (N P Shabila et al. 2012).

The previous paragraphs showed that there was a particular path for the development of the health care organisation in Iraq. This route was established by the British in the early 20th century and was based on a biomedical approach to health and health care. The independent Kingdom and later the Republic of Iraq consolidated it. It appears to be characterised by the dominance of tertiary health care and a selective approach to primary health care. The Alma Ata declaration, public health law of 1981 and the war of the 1980s with Iran, did little to shift the attention from hospital-based to primary health care. The system started to crumble under the sanctions and wars in the 1990s and then was devastated by looting and destruction of the Iraq war of 2003. The war seems to have provided a window of opportunity for seeking a different path from the past. However, the evidence from the early years following the 2003 war appears to suggest that the previous path is stubbornly resistant.

4.3.1.3 Subordinating health financing to other considerations
This section explores the influence of political, economic and military considerations in Iraq on health in general and health financing in particular. The section demonstrates that health financing throughout the history of health policy in Iraq has been subordinated to such considerations. It offers a historical account that might shed some light on the adoption of user fees as a source of financing the BHSP.

Arguably the main reason for establishing health institutions by Britain in Iraq was to protect the British troops from the diseases and epidemics of the day (Romer 1959). Provision of health services was also part of a campaign to win the ‘hearts and minds’ of Iraqis. This campaign was consistent with similar policies in other colonies. Some in the British military of the time argued: “If there is something that ennobles [colonial expansion] and justifies it, it is the action of the doctor, understood as a mission and an apostleship”
Furthermore, economic reasons also featured in the arguments of those who supported a rapid expansion of health services in Iraq by the British army and then the mandate (Bell 1920). The latter regarded medical and health services as tools to increase the population, promote their health and hence enhance economic production. Large numbers of health personnel, therefore, were needed to advance the country from feudalism to an industrialised nation. Furthermore, the British mandate was seen as a guardian on the local population to further the latter’s interests and raise their standard of civilisation rather than just exploit them economically (Hales 1940). The promotion of health services by the mandate administration was used to support that claim. Britain also used its ‘achievements’ in the health sector to support particular political aims. In its report to the League of Nations asking for Iraq’s admission to the league as an independent country, Britain claimed that “the health service is well organised and efficient, with about 80 percent Iraqi personnel” (Evans, 1932:1039). In short, viewing health as a mean for military, political and economic ends left it at the mercy of exogenous contingencies.

The vulnerability of health to financial considerations at the time is particularly interesting. By early 1930s, Britain decided to push for admitting Iraq to the League of Nations and end the mandate (The Colonial Office 1930). Independence and admission to the League required building a strong Iraqi army to replace the leaving British forces. It also meant that Iraq had to shoulder part of the debts of the dissolved Ottoman Empire (Burrows & Cobbin 2011). These developments required financial resources that the limited revenues from newly discovered oil in 1927 were not able to cover. Hence, despite the surplus in the Iraqi budget of the time, cuts in other aspects of expenditure including health were one of the few options for Iraqi officials and their British advisors. The Secretary of State for the Colonies, therefore, dispatched E Hilton Young (an MP and a later British Minister of Health) and Ronald V. Vernon (a civil servant) to cut expenses in the Iraqi budget (Burrows & Cobbin 2011). The Young-Vennon report of 1925 excluded health from such cuts and recommended that revenues for health should be increased rather than expenditures cut. It also recommended that “localities where hospitals and dispensaries are provided should be required to pay the rent…of the premises occupied…the practice of allowing free treatment
in ‘paying wards’...should be discontinued” (Colonial Office, 1925:30). It also suggested that “the attempt to throw the whole cost of hospitals and dispensaries upon local funds has been made and had to be abandoned” (Colonial Office, 1925:30). It quickly stated, however, that funds for health should be drawn from what it called a large property and income held for charitable and religious purposes (Colonial Office, 1925:30). Thanks to this exclusion and the increasing share of health from the oil revenues the health budget during 1920-1931 increased by 105% (Burrows & Cobbin 2011). Although this was a positive development, it manifests the vulnerability of health services to political and economic considerations. As we see later, this continued throughout the 20th century.

With the start of the 1930s, oil production had increased with consequences for health and other social services. Significant oil production began only in 1927 and Iraq did not receive substantial oil revenues until the 1950s (Burrows & Cobbin 2011). Until then the revenues were derived mainly from customs and excise duties, agricultural taxes and income tax. Substantial revenues from oil explorations started to accrue to Iraq in the late 1940s and early 1950s. Some of these revenues were used to build hospitals and dispensaries (Habermann 1955). This trend accompanied the emergence of a socialist rhetoric in the Baath party that viewed health as a right to be guaranteed by the state. The Baath constitution (which formed the base for Iraq’s constitution of the 1970s) indicated “health care is identified as an institutionally based activity under direct state subsidy” (Ismael 1980:238). During the Baath party’s rule of Iraq, free health services (besides education and other social services) was viewed as a tool for economic progress (Khadduri 1978). Therefore, the apparent aim of health policy was to raise the standards of health services and to provide them free of charge to the poor in particular and rural areas (Khadduri 1978). The large revenues accruing from oil production and export assisted the implementation of such policies.

Despite the socialist rhetoric and the high oil revenues, health continued to be subordinated to political, military and economic factors during and after the accession of the Baath to power in 1968. This subjugation can be viewed as a continuation of the same policies by the British occupation and mandate of Iraq in the early 20th century. In 1977, Iraq’s expenditure on health services represented 6% of its military spending. During the
1980s (with the Iraq-Iran war), the spending on health declined even further to less than 1% of the GNP (the military spending was 30%) (Ismael 2003). Between 1960 and 1990 the public expenditure on health declined from 1% to 0.8% of the GNP (Ismael 2003). However, this should be taken into consideration in the context of the increase in GNP from $15 billion in 1960 to $31 billion in 1987. Moreover, this relative stability of health expenditure is minimal in the face of the significant increase in military spending during the same period. Although it appears that health came second to other priorities, high oil revenues seemed to have enabled the country to continue providing health services free at the point of use. That changed in the late 1990s.

It was also during this period that Iraq introduced user fees for the first time. The recognition of user fees as a method of financing the BHSP can be traced to the introduction of the ‘self- or auto-financing’ scheme in 1997. Trends in the experimentation with user fees in Iraq correspond to particular political and economic developments. Iraq introduced nominal user fees (25 fills) for therapeutic services at hospitals for the first time in 1972 (WHO 2006). A decade later, it was increased to 100 fills, and a similar fee was levied on medicines. These nominal and minimal charges reflected the high public expenditure on health care services during the 1970s and 1980s. For instance, by the late 1980s, Iraq was spending US$400-500 million on imports of medical instruments and medicines alone (Garfield 1999). By 1990, the country was dedicating 3.72% of its growing GDP to health (WHO 2006). During the 1990s, however, public expenditure on health care was reduced by 90% (Fleck 2003b; Alwan 2004; Garfield et al. 1997; WHO 2006). Health expenditure constituted 0.9% of GDP only in 1995 and was further reduced to 0.81% in 1997 (WHO, 2006). By 2002, 82% of the US$50 operating expenditure on the health care system came from out-of-pocket spending (Alwan 2004; Taylor 2012). In 1997, the Iraq piloted a ‘self-financing’ policy in seven specialized hospitals (WHO, 2006:31; Yassin, 2009). It levied user charges on primary health care services and hospital services and co-payments for medicines. The policy was applied to all public hospitals in 1999 and then to all Primary Health Centres (PHCs) in 2001.

By 2002, out of $50 million operating expenditures, more than $41 was derived from the self-financing scheme (Alwan 2004). At least three types of fees were levied from
patients: visit charges, drug co-payments and inpatient fees for operations (Farag et al. 2004). Although some variations existed, the general rule was that half of all the revenues generated were used to pay incentives to doctors and other staffs. The other half was used to cover operating costs and purchasing medicines (Farag et al. 2004). The revenues from medicines that were sold at the market price were used to purchase subsidised medicines from KIMADIA, which is the government-owned pharmaceutical company (Farag et al. 2004). Most of the funds generated from the ‘self-financing’ scheme were retained at the facility level. Each facility had a separate bank account to put the revenue it generated (Farag et al. 2004). The remaining revenues were transferred to higher levels of the MoH (Farag et al. 2004).

During 1997-2003, the UN Oil for Food Program provided US$25 per person in health expenditure. However, the public health expenditure was only US$2 per person, 85% of which was coming from user fees (Garfield 2003).

Following the Iraq war in 2003, the United States-led CPA abolished user fees briefly to re-introduce them again following subsequent shortages in medicines and staff payments (Farag et al. 2004; Garfield 2003). Some praised the ‘self-financing scheme’ and opposed its abolition by reporting “the design and implementation of systems such as ‘auto-financing’ to adapt to the situation and continue to function have resulted in creating skills and strengths that are worth building on. The most significant strength is that health facilities were autonomous to a great extent.” (Farag et al., 2004:24). According to others, user fees were “Widely accepted as necessary to provide most of the budget for salaries and equipment in the ambulatory care centres” (Garfield, 2003:1234).

The elimination of user fees greatly reduced doctors’ income and introduced challenges in maintaining equipment and supplies (Garfield 2003). These difficulties occurred despite the fact that MoH budget increased from USD $22 Billion in 2002 (before the war) to USD$ 210 Billion in 2003. Furthermore, most of the increase was dedicated to salaries and the purchase of medicines (Aziz 2003; Alwan 2004). Also, large proportions of the government’s budget had to be devoted to security (Cetorelli & Shabila 2014). As a result of those challenges, the US administration reintroduced user fees again a few months after its abolition (Garfield 2003). The minister of health in 2004 indicated that “while the strength of the auto-financing system is that facilities managed themselves as autonomous entities
providing staff incentives, the system resulted in a large burden on the patients since most of the revenue came from out-of-pocket funds.” (Alwan, 2004:66).

The Minister of Health at the time also suggested some options for raising revenues for the health sector. Besides social health insurance, introducing sin, payroll and income taxes for the health system, he suggested “co-payments or charges for the use of health services: These can help to discourage the inappropriate use of health services and also provide an additional source of revenue but an effective exemption policy will need to be developed so that for example the poor and chronically sick can continue to receive the health care they need.” (Alwan, 2004:67)

Similar arguments were put forward about the financing of primary health care centres. Some argued for user fees as a method of reducing ‘unnecessary’ access to services and improving their quality (Nazar P Shabila et al. 2012). Participants of a study of primary health care centres argued that “The low consultation fees (250 Iraqi Dinars ($0.2)) charged by PHCCs encouraged irrational and repeated visits to PHCCs. They suggested that increasing the fees to 1000 or 2000 Iraqi Dinars per consultation might help in reducing many unnecessary visits and lower the irrational use of services” (Shabila et al., 2012:3)

It appears that the introduction of user fees in 1997, and their later consolidation by the American-led CPA has institutionalised, made it the norm in Iraq’s health system. Arguably, the severe financial constraints introduced by sanctions and wars in the 1990s might represent a turning point that led to a new trajectory in health financing. Such institutionalisation might partly explain their appearance in the BHSP.

In short, this section has demonstrated that there are particular actors and institutions features in the Iraqi health system that managed to continue their existence and influence throughout the years. Examining and understanding those agents and institutions (as this section attempted to do) are necessary to begin to unpack some of the puzzling aspects of the BHSP. Next, we shall provide information about more recent data about the health system in Iraq.
4.3.2 Basic health indicators

Table 4.2 presents some of the most recent available basic health indicators in the country in comparison to similar statistics for the MENA region and the World.

**Table 4.2: Basic Health Indicators for Iraq**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Iraq</th>
<th>MENA</th>
<th>World</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-5 mortality rate (UNICEF-MICS-4) (UNICEF)</td>
<td>37.9</td>
<td>28.9</td>
<td>42.5</td>
</tr>
<tr>
<td>Infant mortality rate (under 1) (UNICEF-MICS-4) (UNICEF)</td>
<td>32.9</td>
<td>23.0</td>
<td>31.7</td>
</tr>
<tr>
<td>Births attended by skilled health personnel (%) (IHFS) (UNICEF)</td>
<td>88.5</td>
<td>79.0</td>
<td>68.0</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births) (WHO, UNICEF)</td>
<td>84.0</td>
<td>110.0</td>
<td>210.0</td>
</tr>
<tr>
<td>Life expectancy (WHO, UNICEF)</td>
<td>68.0</td>
<td>71.0</td>
<td>71.0</td>
</tr>
<tr>
<td>Contraceptive prevalence % (IHFS, UNICEF)</td>
<td>51.2</td>
<td>58.0</td>
<td>55.0</td>
</tr>
</tbody>
</table>


Table 4.2 reveals that Iraq is showing better statistics compared to the MENA region and/or the World in some indicators while it is worse in others. Iraq achieved better results regarding the percentage births attended by skilled workers and maternal mortality ratio than both the MENA region and the World. On the other hand, Infant mortality rate, life expectancy, and contraceptive prevalence were worse than both the MENA region and the World. Although under-5 mortality rate was higher than the MENA region it was lower compared to the World’s average. In short, it is evident from Table 4.2 that Iraq is showing a mixed picture regarding its health indicators. However, the table hides significant historical changes in the presented statistics. Figure 4.2 attempts to do so by presenting the trajectory for infant mortality rates (IMR) and the World over about five decades.

**Figure 4.2: IMR in Iraq, MENA region, and the World over time**

Sources: UNICEF, CME info
Figure 4.2 illustrates that Iraq was achieving lower IMR’s than the MENA and the World averages until the mid-2000s. In the latter period, Iraq’s IMR became worse than those for the MENA region. Figure 4.2 also shows that Iraq’s IMR decrease began to slow down the early 1990s. This trend is attributable to the untoward political, economic and social developments of the same period (for more background on this time please see below). Despite this setback, Iraq is not showing an upwards trend in IMR that might have been expected in a country affected by conflict.

In short, those numbers and figures indicate that it is perhaps unhelpful to categorise Iraq in the same group of conflict-affected countries such as Afghanistan. Following the conflict with Taliban, Afghanistan was having the worst health indicators ever recorded (Islamic Republic of Afghanistan 2005). Consequently, those numbers also show that it is perhaps inappropriate to advocate policies based only on such conflict-affected status without taking into consideration current and long term country data and information.

The following section provides a deeper overview of the health system in Iraq, focusing particularly on the health financing functions of the system.
4.3.3 The structure of the Ministry of Health

Figure 4.3: The structure of the Ministry of Health

Figure 4.3 shows the structure of the MoH as of the year 2006. Although some changes have happened in the presented structure following the Iraq war of 2003, however, the main contents have mostly remained unchanged. Arguably, one of the most striking features that Figure 4.3 shows is the level of complexity and different layers of bureaucracy in the MoH. For instance, the Minister of Health has three deputy ministers. Each deputy is responsible for a set of functions with a considerable overlap among those functions. Moreover, it appears that the MoH had a well-developed structure. The complexity of the administrative structure within the MoH has implications for health policymaking. In the case of Iraq’s BHSP two deputy ministers of health, one for technical affairs and the other for donor affairs, oversaw its development (Ministry of Health 2009).

At the health services provision level, the health system in Iraq is grossly divided into public and private providers (WH, 2006). The MoH is responsible for the public health system with...
some oversight over private providers. The public health system encompasses hospitals, Primary Healthcare Centres (PHCs), labs and other public institutions. Private providers operate through hospitals and clinics.

Administratively, the country is divided into 118 health districts with each covering 200,000–300,000 people (MoH, 2009). The health districts are managed by 18 Directorates of Health (one for each of the 16 governorates and two for the capital Baghdad). There are 5-10 PHCs in each health district and as of 2009; there were 1989 PHCs in Iraq. PHCs are not evenly distributed and there exists a considerable geographical disparity in their allocation. The inequality is particularly prominent in relation to the rural-urban distribution of PHCs. About 30% of people in rural areas need to travel at least 30 km to reach a PHC. The same figure is 5.4% for inhabitants of urban areas.

Prior to the introduction of the BHSP in Iraq the primary healthcare systems was organised into PHC main centres and PHC sub-centres (Ministry of Health, 2009). Main centres are those that are staffed by at least one doctor. PHC main centres in turn comprised three categories A, B and C. Those categories are distinguished based on the availability of a training room (in category B) and a labour and emergency services room (in category C). Sub-centres, on the other hand, have no doctor. They are also known as Category D. They provide basic maternal and child health services including immunisations.

Prior to the introduction of the BHSP, there were no community health houses in Iraq. Therefore, the PHCs, whether main or sub-centres or whatever category, represent the first contact of patients with the health system.

PHCs provide preventive, health promotion and basic curative services together with simple diagnostic tests. The PHCs do not provide specialist outpatient services. The latter are provided at hospital levels. There is no formal family medicine practice at the primary health care level. Doctors are required to spend one year of their post-graduate career in PHCs without a formal training or qualification in primary care.

Patients are referred from PHCs to hospitals when they need further investigation and/or treatment. However, a formal referral policy and procedure does not exist neither for
referral among the PHC nor between PHCs and hospitals. Patients usually prefer and seek to be referred directly to hospital rather than be seen at PHC level. District, general and teaching hospitals provide secondary and tertiary care for patients in their catchment area. As of 2009, there were 208 hospitals in Iraq compromising more than 36 000 beds. In addition to publicly funded hospitals, there are about 100 private hospitals.

The BHSP introduced a new structure that is only slightly different from the existing one. It proposes that the BHSP be provided at four levels; community health houses, PHC-sub-centres, PHC main centres and district hospitals. It appears that Community Health Houses are intended as the first point of contact with patients. However, the BHSP document describe their role as “advisory and supportive...in strengthening the link between the community and the PHCs” (MoH, 2009: 21). The services provided are limited to health education, support during vaccination campaigns, offering contraceptives, providing micronutrients, DOTS provision and providing care during normal deliveries. The BHSP maintained the original structure of the PHC main and sub-centres. However, it specified the type and number of services to be provided at each of those categories.

In addition, the BHSP document states that district hospital should provide all the services included in the BHSP. This can be seen as a point of departure from the original structure. Although some primary health care services were provided at hospital level previously in Iraq, the BHSP seems to require district hospital to provide all the services included in the package in addition to secondary and tertiary care services.

Finally, the BHSP document does not provide clear policy and procedures for patient referral between the levels of care that it introduces.
4.3.4 Health Financing

Some of the main health financing indicators in Iraq for selected Fiscal Year periods is presented in Table 4.3

Table 4.3: Health financing indicators for Iraq

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita total expenditure on health (PPP int. $)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total health expenditure as a % of GDP</td>
<td>3.72%</td>
<td>0.9%</td>
<td>4.4%</td>
<td>3.9%</td>
<td>4.8%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Government Expenditure as a % of total health expenditure</td>
<td>16.1%</td>
<td>73.4%</td>
<td>72.2%</td>
<td>60.5%</td>
<td>63.5%</td>
<td></td>
</tr>
<tr>
<td>General government expenditure on health as a percentage of total government expenditure</td>
<td>1.9%</td>
<td>3.3%</td>
<td>3.1%</td>
<td>6%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Private expenditure on health as % of total expenditure on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>39.5%</td>
<td>36.5%</td>
</tr>
<tr>
<td>External resources for health as a percentage of total expenditure on health</td>
<td>6.4%</td>
<td>4.9%</td>
<td>3.1%</td>
<td>0.4%</td>
<td>0.2%</td>
<td></td>
</tr>
</tbody>
</table>


These figures in Table 4.3 mask significant variations in the relative significance of the role of the government or external donors in financing health services. The table, nevertheless, provides a rough picture of the nature of the health financing system in Iraq. It depicts an overall increase in total health expenditure, which reflects dedicating a larger share of GDP and government spending to health. The former provides a better explanation for the rise in total health expenditure since the share of health in the total government expenditure remain very low compared to both regional and international figures (WHO 2015).

A description and analysis of the collection, pooling and purchasing functions of the health financing system in Iraq is provided below.
4.3.4.1 Resource Mobilization

Resources for the health care system in Iraq are collected through a combination of multiple sources (Table 4.4)

*Table 4.4: Sources of health funds*

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
<th>Per capita US$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Finance</td>
<td>73.69%</td>
<td>101.13</td>
</tr>
<tr>
<td>Parastatal funds</td>
<td>0.03%</td>
<td>0.04</td>
</tr>
<tr>
<td>Household funds</td>
<td>26.06%</td>
<td>34.39</td>
</tr>
<tr>
<td>Other private funds</td>
<td>0.0%</td>
<td>0.0</td>
</tr>
<tr>
<td>Donor funds</td>
<td>1.22%</td>
<td>1.67</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
<td>137.23</td>
</tr>
</tbody>
</table>

*Source: Iraq national health account (2008)*

Revenues from natural resources, OOPS, taxes, donations, and loans from international organizations, bilateral and multilateral financing agencies represent the main sources of funding (Ahmad et al. 2005; World Bank 2011; Burnham et al. 2011; WHO 2011b). Public sources of health care are mainly financed through oil revenues. There are no earmarked taxes or contributions to health and entitlement is population rather than contribution based (Iraqi Parliament 2005).

Private sources of financing are playing an increasingly important role as a source of funding for health care, but oil revenues are still the main source of financing. Private household expenditure represented 26% of the total health spending, amounting to a total of US$1 billion in 2007 ($18-$77 per household per month) (WHO 2011a; WHO 2011b; Burnham et al. 2011). Inability to afford medical care represented the second largest reason for not seeking medical attention at 14% (World Bank 2009a). *Table 4.5* shows the categories of the OOPS and their respective percentages.
Table 4.5: Categories of OOPS and their percentages

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine and technology</td>
<td>39.5%</td>
</tr>
<tr>
<td>Ambulatory services</td>
<td>33.7%</td>
</tr>
<tr>
<td>Hospital care</td>
<td>18%</td>
</tr>
<tr>
<td>Transportation</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

Source: Iraq national health account (2008)

There are no reliable figures on the nature and overall size of health donations and loans to Iraq. Several organizations, agencies and bodies donate and provide loans of various sizes (WHO 2011b). Although different sources of funding for the health system are explored, general revenues remain the main source of funds for health care.

4.3.4.2 Pooling

The MoH is the largest pool of funds in Iraq. The Ministry of Finance (MoF) transfers funds to the MoH, which is combined with user charges and other contributions (Ahmad et al. 2005; Farag et al. 2004). Local facilities also retain a proportion of the collected fees. There are no public or private health insurance facilities. Health expenditure represents a quarter to third of the per capita expenditure (PCE) at the poverty level for Iraqi households (World Bank 2011). Hence, in the absence of pre-payment mechanisms for pooling private expenditure, OOPS is regarded as a major impoverishing factor (World Bank 2011).

4.3.4.3 Purchasing

The MoH is both the main purchaser and provider of health services. Funds are transferred from Ministry of Finance (MoF).

Table 4.6: Functional distribution of health care expenditure, 2008

<table>
<thead>
<tr>
<th>Function</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceuticals and other non-durables</td>
<td>36.81%</td>
</tr>
<tr>
<td>Basic medical and diagnostic services</td>
<td>25.45%</td>
</tr>
<tr>
<td>General government administration of health</td>
<td>22.39%</td>
</tr>
<tr>
<td>Inpatient curative care</td>
<td>11.99%</td>
</tr>
<tr>
<td>Health related functions</td>
<td>3.36%</td>
</tr>
<tr>
<td>Health administration and health insurance: private</td>
<td>0.01%</td>
</tr>
</tbody>
</table>

Source: Iraq national health account (2008)
As Table 4.6 shows, health funds in Iraq are mainly spent on pharmaceuticals and other medical non-durables. Administrative costs (including salaries) represent another major category after basic clinical and diagnostic services.

Line item budgeting is the method for purchasing services in the public sector (Ahmad et al. 2005). The private industry uses fee-for-service payment mechanisms (both with and without fee schedules). Neither the public nor the private sectors of the health system use active purchasing mechanisms for paying providers (Farag et al. 2004). Salaries for public employees are determined by the academic achievement of the employee and number of years in service. Similarly, fee-for-service payments for providers in the private sector are set by the Doctor’s Syndicate based on academic qualifications and numbers of years in practice (Kurdistan Doctors’ Syndicate 2004). Payments are not linked to measures of the quality of provided services.

4.3.5 Human Resources

Table 4.7 presents numbers of health workforce over time.

Table 4.7: Numbers of various health staff per 100,000 of Iraq’s population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>50</td>
<td>50</td>
<td>51</td>
<td>50</td>
<td>60.1</td>
</tr>
<tr>
<td>Dentists</td>
<td>9</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>10.4</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>10.5</td>
</tr>
<tr>
<td>Nurses</td>
<td>77.6</td>
<td>66</td>
<td>55.7</td>
<td>56.4</td>
<td></td>
</tr>
<tr>
<td>Paramedical staff</td>
<td>128.5</td>
<td>102.9</td>
<td>99</td>
<td>94.8</td>
<td>110.4</td>
</tr>
<tr>
<td>Midwives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health workers</td>
<td>26</td>
<td>14.6</td>
<td>10.2</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

Source: WHO

Table 4.7 shows that there has been a decrease in the ratio of health workers to the population starting in the 1990s. However, there appears to be an upward trend starting in
2010. More data is needed to explore the possible continuation of such trend over more recent years. Due to differences in the methods of measurement, we were not able to provide comparisons between the figures presented in Table 4.7 and comparable data for WHO’s Eastern Mediterranean Regional Office (EMRO) or the World. However, WHO provides data on the density of health workforce that takes into account the absolute number of the force relative to the population of the country in question (WHO 2016). In 2000, Iraq had a physician density of 5.5 compared to an average of 11.2 for EMRO region. By 2010, Iraq’s physician density increased to 7.7 and the EMRO to 14.7. These numbers show that, over the last 15 years, Iraq consistently had half of the doctor’s density of EMRO. On the other hand, nurses and midwives density in Iraq decreased by half (from 30 to 14) between 2000 and 2010. The same figures for EMRO remained constant at about 23.

Exaggerated generalisations should not be concluded from the numbers provided above. Nevertheless, they can offer some insight into wider health system context into which the BHSP was introduced in the early 2000s. It appears that perhaps there was a trend towards an increase in the number of physicians but a decrease in the number of nurses and midwives during the 2000s. Such trend is probably paradoxical given the claims by the MoH for adopting a primary health care approach. The latter would have potentially entailed recruiting more nurses and midwives. Such recruitment would have also been necessary to staff the increasing numbers of PHCs built during the same period as described in more details below.

### 4.3.6 Infrastructure

**Table 4.8: Indicators on health infrastructure**

<table>
<thead>
<tr>
<th>Infrastructure/ 100,000 population</th>
<th>2003</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>PHCs</td>
<td>5.5</td>
<td>7.4</td>
</tr>
</tbody>
</table>

*Sources: (Cetorelli & Shabila 2014; WHO 2006)*

Table 4.8 shows that there has not been a significant change in the ratio of public and private hospitals in Iraq since 2003. However, the proportion of primary health centres has increased. This statistics might be seen as one of the indicators of a more focus on infrastructure, especially at the primary health care level. The fact that the ratio of both public
and private hospitals has remained the same (in the face of the increasing size of the population) also reflects more infrastructure projects in those categories. However, it appears that more primary health centres were built compared to hospitals in the country during the period under consideration.

4.4 Conclusion

This chapter has attempted to provide an extensive overview of various features of Iraq’s political economy, demography and health system. It did that to explore the context within which the BHSP was introduced. Without understanding such context, it is hard, if not impossible, to gain insight into the processes through which the BHSP was introduced, formulated and designed. The chapter has shown that the Iraq is a wealthy country with an abundance of natural resources particularly oil. However, wars, conflicts, and sanctions undermined the ability of the country in continuing the provision of social services to the population. The chapter also has shown that the country has experienced distinct periods of colonial rule, democratic governances first under the monarchy and then a republic, dictatorship and then democracy again. Different policies were pursued in those periods that were influenced by oil, wars, sanctions and other political considerations. These contingencies have shaped health policy and the health system in the country. The results chapters will further explore the impact of some of those contextual factors on the introduction and formulation of the BHSP.
5 Contextualising Iraq’s BHSP: Similarities and differences with other post-conflict countries

One of the main puzzles that this research is attempting to explore is the ostensible novelty of the BHSP in Iraq’s context. The origins of the new policy could be multiple, complex and interacting among each other. The presence of external origins for Iraq’s BHSP seems one of the possible categories of explanation as indicated by the existence of preceding similar policies in other post-conflict countries. Contrasting Iraq’s BHSP with these equivalent examples may help in starting and testing hypotheses about the latter’s origins. It can also assist with examining the possible elements of transfer involved in its formulation. Identifying similarities between Iraq’s BHSP and its antecedents can offer at least one indicator of its transfer to Iraq (Smith 2004).

The purpose of this chapter, therefore, is to address the first objective of this study, which is examining the extent to which Iraq’s BHSP is similar to, or different from equivalent policies in other post-conflict countries. A natural means of exploring this is to review the BHSP document itself and compare this with equivalent documents relating to previous BHSP initiatives in other contexts. This question will be answered via examining the content of Iraq’s BHSP in depth. Similarities with antecedent policies may suggest an instance of transfer. However, differences with equivalent policies in other contexts may also be compatible with accounts that emphasise the influence of local institutions, ideas and policy actors or, such difference may reflect elements of change during the transfer process. This exercise, therefore, is useful in framing the research questions addressed in the following chapters. It is also helpful in beginning to explore the nature and extent of transferring the BHSP among countries.

To do so, we first thematically analysed Iraq’s BHSP document. Four main themes emerged from the analysis. Those themes touch upon the aims and goals of the policy, the actors involved, the interventions included (or excluded), and the financing principles adopted. Those issues seemed both comprehensive and consistent with this research’s aim and objectives. Then we investigated the similarities and differences between Iraq’s BHSP and the BHSP in three selected post-conflict countries (Uganda, Afghanistan and Liberia)
along the lines of those themes.

Those three countries were selected because they all introduced their BHSP before Iraq. Uganda introduced its BPHS in 1997; Afghanistan in 2003, updated in 2005 and again in 2010 while Liberia introduced it’s first in 2008 and then updated it in 2011. When multiple versions of the same document were available, we included all those versions in the comparison and analysis. Bosnia and Cambodia also introduced BHSPs before Iraq. However, we excluded those two countries for practical reasons. Concerning Bosnia, we were not able to locate an official publication that describes the country’s BHSP. The only document that we can find was an article that discussed the policy but did not allow for a comparison with the other documents (Hrabac et al. 2000). On the other hand, we did not find an English translation of Cambodia’s BHSP. The three selected countries are all post-conflict but located in geographically different regions. They also have different politico-economic contexts, different histories, and different health systems. We did not base their selection, however, on these contextual differences, but rather on the time of the introduction of their BHSPs. The fact that all three countries had introduced their BHSP before Iraq is crucial for this chapter. This allows the exploration of the possibility that Iraq might have borrowed or duplicated its BHSP from examples that existed beforehand. Alternatively, the same actors could have been involved in the development of the BHSP in both settings, albeit in the other context before Iraq. Therefore, it is interesting to explore the similarities and differences between Iraq’s BHSP and the three other countries under consideration.

This chapter consists of five main sections; the first section presents the main findings of analysis using the plagiarism detection software Turnitin to investigate textual similarities between Iraq and the selected countries. The second section explores the aims and goals of the BHSP. The third section examines actors presented in the documents as involved in the development of the BHSP. The third section will investigate interventions included or excluded. The fourth section will review the contents of the packages. Lastly, the fifth section explores the financing methods adopted. Each section first starts with a description of Iraq’s BHSP followed by similarities and differences with the three selected countries.
This section investigates similarities among the selected BHSP in four countries. Before beginning to do so, it is necessary to compare the BHSP with regards to particular features.

Table 5.1 presents such comparison.

<table>
<thead>
<tr>
<th>Country/Feature</th>
<th>Uganda</th>
<th>Cambodia</th>
<th>Bosnia</th>
<th>Afghanistan</th>
<th>Liberia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Package of basic health services for Uganda</td>
<td>Minimum Package of Activities</td>
<td>Basic Package of Health Entitlements</td>
<td>A basic package of health services for Afghanistan</td>
<td>Basic package of health and social welfare services for Liberia</td>
</tr>
<tr>
<td><strong>Author</strong></td>
<td>Ministry of Health</td>
<td>Ministry of Health</td>
<td>Federal ministry of health</td>
<td>Ministry of Public Health</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td><strong>Technical Assistant</strong></td>
<td>WHO</td>
<td>World bank</td>
<td>USAID</td>
<td>USAID</td>
<td>Not clear</td>
</tr>
<tr>
<td><strong>Financial Assistance</strong></td>
<td>Not clear</td>
<td>Asian Development Bank</td>
<td>World Bank</td>
<td>USAID</td>
<td>Not clear</td>
</tr>
<tr>
<td><strong>Other actors</strong></td>
<td>Not clear</td>
<td>NGOs (who were contracted to provide the services). WHO, Medical.</td>
<td>REACH, Management Science for Health</td>
<td>BASIC, UNDP, UNICEF, Mother Patern College of Health Sciences, Psychological Associates of Liberia, CPA ANAMUR, German Emergency Doctors, JFK medical centre, Laboratory Technician Association, Clinton Foundation.</td>
<td>BASIC, UNDP, UNICEF, Mother Patern College of Health Sciences, Psychological Associates of Liberia, CPA ANAMUR, German Emergency Doctors, JFK medical centre, Laboratory Technician Association, Clinton Foundation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country/Feature</th>
<th>Iraq</th>
<th>Somalia</th>
<th>South Sudan</th>
<th>Sierra Leone</th>
<th>Rwanda</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>A basic health services package for Iraq</td>
<td>Essential Package of Health Services</td>
<td>Basic package of health and nutrition services for Southern Sudan</td>
<td>Basic Package of Essential Health Services for Sierra Leone</td>
<td>Service Package for Health Facilities at different levels of service delivery</td>
</tr>
<tr>
<td><strong>Author</strong></td>
<td>Ministry of Health</td>
<td>Dr. Nigel Pearson and Jeff Mitchell</td>
<td>Ministry of Health</td>
<td>Ministry of health and Sanitation</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td><strong>Year</strong></td>
<td>2009</td>
<td>2009</td>
<td>2010</td>
<td>2010</td>
<td>2011</td>
</tr>
<tr>
<td><strong>Technical Assistant</strong></td>
<td>WHO</td>
<td>UNICEF</td>
<td>World Bank</td>
<td>UNICEF, UNFPA, WHO, MRC, MSF-Belgium and Save the Children UK</td>
<td>USAID, MSF/HHSSP, CTD/BTC.</td>
</tr>
<tr>
<td><strong>Financial Assistance</strong></td>
<td>UNDO 1HF-European Fund</td>
<td>World Bank</td>
<td>UNICEF, UNFPA, WHO, MRC, MSF-Belgium and Save the Children UK</td>
<td>USAID</td>
<td>USAID</td>
</tr>
<tr>
<td><strong>Other actors</strong></td>
<td>EPOS, UNDP, UNICEF</td>
<td>Somali health sector, NGOs, UN agencies and donors.</td>
<td>Tearfund, PSI, Malaria Consortium, UNFPA, ICRC, SHTP, MSP, Help Age International</td>
<td>Providers and other stakeholders at all levels in the health sector.</td>
<td>Providers and other stakeholders at all levels in the health sector.</td>
</tr>
</tbody>
</table>
Table 5.1 shows that the packages in the countries covered in the table share several particular attributes. They all share a similar name (basic, essential or minimum package of services). They are all formal government policies endorsed and published by the respective ministries of health. Similar organisations and funding agencies are cited as having provided technical and financial supports to develop the packages.

However, such similarities do not necessarily mean that the packages are identical in their contents. To explore this proposition, we used Turnitin, which is a software package used to assess the originality of student’s academic essays and assignments (iParadigms LLC. 2012). The use of this software can be helpful in investigating the extent of any complete copying or duplication among the countries.

The Turnitin exercise showed that the documents shared textual similarities with each other as well as with other publications. Iraq’s BHSP had an 8% resemblance to the 2005 Afghanistan’s Basic Package of Health Services (BPHS). Turnitin uncovered a total of 135 matches between the two documents. Out of those 10 were sentences or terms that were the same in both documents. For example, Iraq’s BHSP and Afghanistan’s BPHS define the policy exactly the same way as a “standardized package of basic health services that would form the core of service delivery in all primary health care facilities” (Islamic Republic of Afghanistan 2005:1; Ministry of Health 2009:1).

The majority of the matches, however, correspond to tables of interventions included in both packages with minor modifications (please refer to section 5.4 for further discussion). Afghanistan’s BPHS also shared considerable textual similarities with Liberia’s Basic Package of Health and Social Welfare Services (BPHSWS or BPHS). Table 5.2 shows an example of the similarities between the two packages.
<table>
<thead>
<tr>
<th>Liberia-2008</th>
<th>Afghanistan-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnose pregnancy (Clinical diagnosis)</td>
<td>Diagnosis of pregnancy</td>
</tr>
<tr>
<td>Screen for high risk, including short height (&lt;5 ft.)</td>
<td>Antenatal visits—weight, height measurement</td>
</tr>
<tr>
<td>Give tetanus toxoid</td>
<td>Tetanus immunization</td>
</tr>
<tr>
<td>Give prophylactic iron, folic acid and multivitamins</td>
<td>Iron and folic acid supplementation to pregnant women</td>
</tr>
<tr>
<td>Give intermittent preventive treatment for falciparum malaria</td>
<td>Treatment of malaria</td>
</tr>
<tr>
<td>Give Mebendazole for deworming</td>
<td>Treatment of intestinal worms</td>
</tr>
<tr>
<td>Screen for and manage pre-eclampsia or hypertension</td>
<td>Treatment of pre-eclampsia/eclampsia</td>
</tr>
<tr>
<td>Screen for and treat anemia</td>
<td>Treatment of anemia</td>
</tr>
<tr>
<td>Screen (RPR) and manage syphilis and partner</td>
<td>Management of sexually transmitted diseases</td>
</tr>
<tr>
<td>VCT for HIV</td>
<td>Management of sexually transmitted diseases</td>
</tr>
<tr>
<td>Feel for malpresentation or twins</td>
<td></td>
</tr>
<tr>
<td>IEC/BCC on the importance of antenatal care, especially for teenage mothers and high parity women.</td>
<td>Information, education, and communication (IEC)</td>
</tr>
<tr>
<td>IEC/BCC on diet and rest during pregnancy and lactation</td>
<td></td>
</tr>
<tr>
<td>IEC/BCC: birth preparedness and danger signs; safe home delivery; family planning.</td>
<td></td>
</tr>
<tr>
<td>Manage incomplete abortion (Manual Vacuum Aspiration)</td>
<td>Treatment of incomplete miscarriage/abortion</td>
</tr>
<tr>
<td>Manage ectopic pregnancy</td>
<td>Treatment of ectopic pregnancy</td>
</tr>
<tr>
<td>Manage urinary tract infection</td>
<td>Treatment of symptomatic urinary tract infections</td>
</tr>
<tr>
<td>Manage fever / malaria (Rapid diagnostic test)</td>
<td>Treatment of malaria</td>
</tr>
</tbody>
</table>
It is evident from Table 5.2 that, except for minor differences, the shared interventions in included components of the packages for Afghanistan and Liberia are almost identical. The only exception is the presence of a ‘feel for malpresentation or twins’ intervention in Liberia that does not exist in Afghanistan. Also, rather than detailing particular aspects of the interventions to which information, education, and communications are targeted (which is done in Liberia), Afghanistan’s BPHS do not offer specific aspects of such category. Liberia also shared considerable similarities with Sierra Leone. There is a 47% textual similarity between the Liberia’s BPHSWS and the one in Sierra Leone.

Table 5.3: Indicators of textual similarities between Liberia and Sierra Leone’s BPHS

<table>
<thead>
<tr>
<th>Liberia</th>
<th>Sierra Leone</th>
</tr>
</thead>
<tbody>
<tr>
<td>It identifies the services that the MOHSW guarantees will be available to every Liberian citizen. Other services may be available as the result of global initiatives, vertical programs, or private donations but they should be added to, not substituted for, the services contained in the BPHS.</td>
<td>It identifies the services that the MOHS guarantees will be available to the population. Other services may be available as a result of global initiatives, vertical programmes, or private donations but they would be added to, not substituted for the services contained in the Package.</td>
</tr>
<tr>
<td>It implies that a minimum set of health staff with appropriate skills will be present at each of the facility levels</td>
<td>It implies that a minimum set of health staff with appropriate skills will be present at each of the facility levels to provide the services</td>
</tr>
<tr>
<td>It gives guidance for the content of training programs by defining the technical and management competences required at different levels of the health system.</td>
<td>It gives guidance for the content of training programmes by defining the technical and management competences required at different levels of the health system.</td>
</tr>
<tr>
<td>It gives guidance to what will constitute an essential drugs list for each level of the health system</td>
<td>It gives guidance to what will constitute an essential drugs list for each level of the health system</td>
</tr>
<tr>
<td>It is presented in a way that it can be costed out to give an idea of the financial resources that will be required for service provision</td>
<td>It is presented in such a way that costs can be estimated to give an idea of the financial resources that will be required for service provision</td>
</tr>
<tr>
<td>It provides a basis for preparation of operational plans (see previous footnote)</td>
<td>It provides a basis to prepare operational plans and to design Monitoring and Evaluation tools.</td>
</tr>
</tbody>
</table>

In short, the Turnitin exercise has shown that the BHSP documents across the compared countries had texts that included significant elements of duplication. This exercise was useful in quantifying such duplication in particular countries. It was also helpful in
demonstrating which document duplicated from the other. For example, the documents in Iraq and Liberia appear to duplicate from Afghanistan while Serra Leone from Liberia. The utility of the Turnitin exercise is limited, however. It is unable to tell qualitative similarities and differences among the countries. The next section will thematically analyse the contents of Iraq’s BHSP and comparing it with countries that introduced their packages before Iraq.

5.2 Defining problems and setting goals

The purpose of this section is to examine the claimed goals of Iraq’s BHSP and compare them with the three selected countries. It is intriguing that Iraq introduced a BHSP (a package of selective interventions) in contrast to a more comprehensive approach to primary health care. Examining the presented goals of the BHSP in Iraq and comparing them with other countries might help in addressing this puzzle. It is, therefore, necessary to explore and critically engage with the aims and objectives of Iraq’s BHSP. The section will first explore those aims and then contrast them with Uganda, Afghanistan, and Liberia.

Iraq’s document presents some reasons why the BHPS was seen as necessary in the context of Iraq. It explicitly mentions some while others can be inferred from the goals and aims of the BHPS and other sections of the document. For instance in the foreword of the document the Minister of Health identifies issues with the health system that he hopes the BHSP would address. The Minister of Health framed the issues of the existing health system as one of governance (centralised) service delivery and financing (not cost-effective or efficient, inequitable, unsustainable). He then claims that the health system in its current form is unable to respond to what he describes as the complex and growing needs of the population. To answer those issues, the Minister presents the BHSP as a viable solution by stating that “the implementation of BHSP will, therefore, address these problems and ensure the timely delivery of cost-effective, integrated and standardized health services tailored to meet the priority health issues faced by the majority of the population” (Ministry of Health, 2009: II)

As the solution, Iraq’s BHSP is presented as the core of service delivery:

“The BHSP package [is] a standardized package of basic health services that would form the core of service delivery in all PHC facilities.” (Ministry of Health 2009: I)
The Minister of Health also presents the BHSP as part of a trajectory towards successfully ‘reforming’ the health system in the country. In the foreword of the BHSP, the Minister states:

“[The] Basic Health Service Package (BHSP) ...will pave the way for the successful reform of the health care system and establish the foundations of a decentralized primary health care (PHC) system based on the principles of the Alma-Ata Declaration.” (Ministry of Health 2009: II).

It is interesting that Iraq’s BHSP makes an explicit reference to the Alma Ata Declaration. Arguably, given that the BHSP might be viewed as the embodiment of the selective primary health care approach, the latter has been widely seen as a response to the claimed unaffordability of the comprehensive primary health care advocated by Alma Ata (WHO 2008a; Tarimo 1997; Bobadilla et al. 1994).

Furthermore, the MoH views the BHPS as the initial step towards “the devolution and decentralisation of financial and administrative authority to the regional and governorate levels” (Ministry of Health 2009: II). More specifically, Iraq’s BHSP highlights particular aims, goals, and objectives that it argues can help to solve the issues it identifies with the health system (Ministry of Health, 2009:16). Those can be divided into demand and supply side targets. About the demand side, the BHSP claims to improve health status, address priority health problems and promote access. Also, it aspires to target the most vulnerable and under-served population and promote equity. Furthermore, it hopes to ensure that the BHSP is socially and politically acceptable to both communities and the government and enhances consumer satisfaction. With regards to these aims Iraq’s BHSP states:

“In summary, the Iraq BHSP was designed to:

- address priority health problems and improve health status;
- target the most vulnerable and under-served populations and improve equity and physical/economic access;
- Ensure the package is both socially and politically acceptable to the Iraqi population and government.” (Ministry of Health, 2009:16).

From the supply side, the BHSP aims to improve allocative efficiency through better allocation of budgets between primary and secondary care. It seeks to ensure technical and administrative feasibility and secure financial sustainability through making the BHSP
affordable. In relationship to these aspects Iraq’s BHSP states that it is designed to:

- "Improve allocative efficiency in the use of resources by promoting better allocation of the health budget between primary and secondary care;
- secure financial sustainability by ensuring the package is affordable;
- enhance clinical effectiveness and quality of care to improve health outcomes and consumer satisfaction;
- ensure technical and administrative feasibility by considering manpower and operational constraints of the health care system;" (Ministry of Health, 2009:16)

The next paragraphs examine the similarities and differences between the aims of Iraq’s BHSP and the other three post-conflict countries. As described below, all countries share a similar definition of the BHSP and view it as a standardised package of interventions to meet the priority health needs of the population.

Before exploring the similarities and differences between Iraq’s BHSP and Uganda’s PBHS it should be noted that, the latter does not elaborate on the aims, objective and goals of the document. The document limits the discussion of these aspects to a two pages foreword by the Minister of Health of Uganda, which is immediately followed by presenting the components of the package. However, this brief description is useful in uncovering some potentially significant similarities and differences between Iraq’s BHSP and Uganda’s PBHS. Uganda’s PBHS similar to Iraq’s BHSP highlights its utility for prioritisation through the provision of a realistic and standard package of services. It states:

“This Basic Package of Health Services is a standard or guideline that will be used by Health Care Providers, administrative and political leaders and the communities themselves as realistic targets that can be achieved” (Ministry of Health 1997:3)

Similarly, Afghanistan’s BPHS defines itself in a way that is almost identical to the other countries. It states:

“The goal in developing the BPHS was to provide a standardized package of basic services that would form the core of service delivery in all primary health care facilities” (Islamic Republic of Afghanistan 2005:1)

Liberia’s BPHS, on the other hand, states that it is:

“A standardized package of services that will be implemented at each of the five levels of the Liberian health system” (Ministry of Health and Social Welfare 2008:3)
It is evident from the cited quotes that these documents share a similar (or almost identical) definition of the BHSP and present it as a standardised package of interventions.

In addition to similarly defining the BHSP, all documents present the latter as the foundation of a new system based on the principles of primary health care. Afghanistan’s BPHS claims share this foundational nature with Iraq. It states:

“The BHSP is the foundation of the Afghan health system and has been the key instrument in its development” (Islamic Republic of Afghanistan 2005: vii).

Liberia’s BPHS also declares:

“The BHPS is the cornerstone of Liberia’s national health care delivery strategy.” (Ministry of Health and Social Welfare 2008: iii)

One difference between Iraq’s BHSP and the other documents is the explicit reference to the Alma Ata Declaration by the former. Such reference is absent from the other documents. Beside this declared foundational nature of the BHSP in the new health system, all countries appear to view the BHSP as an initial step to achieve the overall vision of the respective MoHs. Iraq’s BHSP states:

“The development of a basic health services package (BHSP) was identified by the MoH as an appropriate initial step to achieving [the] goal....for integrated reform of the existing PHC system (Ministry of Health 2009: I)

Liberia’s BPHS, on the other hand, indicates:

“Implementing this Basic Package of Health Services (BPHS) will be a key step in the pursuit of our vision: a nation with not only improved health, but also equal access to health care” (Ministry of Health and Social Welfare 2008: iii)

In Iraq and Liberia, in particular, the vision appears to contemplate a decentralised primary health care system that their respective BHSP’s claim to achieve. Iraq’s BHSP emphasises such decentralised system as indicated above. Liberia’s BPHS also indicates:

“Two distinct ideas have guided the development of the BPHS. First, the health system must be based on the principles of primary health care. Second, the management of services should be progressively decentralized.” (Ministry of Health and Social Welfare 2008: iii)
It is worth noting that Afghanistan’s BPHS lacks such reference to a decentralised health system. The word ‘decentralisation’ does not feature in any of Afghanistan’s BPHS versions. In short, while all of the documents seem to highlight primary health care as the founding principle of their respective BHSPs, there are subtle departures in this claim. Iraq makes an explicit reference to Alma Ata while the others do not.

In addition to these differences, Iraq’s BHSP seems to differ from the other documents in its depiction of the relationship with the existing health care system, external and non-governmental actors and other post-conflict countries.

While all policy documents underline the foundational nature of their respective packages, they appear to be different in what they mean by that. Afghanistan and Liberia’s BPHSs present themselves as an initial step in rebuilding a new health system. Iraq’s BHSP, on the other hand, is described as using the existing system as the starting point; it presents itself as paving the way for a reformed, re-orientated and a decentralised health system rather than building a new arrangement. Hence, Iraq’s BHSP acknowledges the existing health system and views it as the starting point despite its limitations. It states:

“Despite the limitations, the delivery of the BHSP will build on the existing system in order to meet the immediate needs while initiating change over time.” (Ministry of Health 2009: I)

On the other hand, Afghanistan’s BPHS paints a bleak picture of the current system and uses the BPHS as the first step in rebuilding it.

“The country faced some of the worst health statistics ever recorded worldwide...there was a great need to provide basic, life-saving health services...therefore,..., the Afghan Ministry of Public Health began a process to determine its major priorities for rebuilding the national health system and identify the health services so important to addressing the greatest health problems that they should be available to all Afghans” (Islamic Republic of Afghanistan 2005:1)

It appears that Liberia’s BPHS also aims at starting a new health care system. It states:

“The Ministry’s objective in implementing the BPHS is to structure and jumpstart a health care delivery system for all Liberians...[And]...build a new health
Afghanistan and Liberia’s BPHS view themselves not only as a guiding tool for stakeholders in their respective countries but also as a blueprint for other post-conflict countries. Afghanistan’s BPHS, for instance, states:

“...these remarkable efforts and achievements benefit the Afghan people and make Afghanistan the blue-print country for post-conflict health reconstruction.” (Islamic Republic of Afghanistan 2005:7)

Liberia’s BPHS, like Afghanistan, views itself as “an international model of post-conflict recovery in the health field” (Ministry of Health and Social Welfare 2008: iii). This aim of Liberia’s and Afghanistan’s BPHS is absent in Iraq’s BHSP.

Finally, the particular classification of the health facilities in Afghanistan is seen as a tool to overcome the “dizzying array of names for types of health facilities” (Islamic Republic of Afghanistan 2005:2). In Iraq, on the other hand, a similar well-defined classification of health organisations did exist before the introduction of the BHSP, which only added community health houses to the existing structure (WHO 2006).

To conclude this section, it appears that the BHSP in the countries under consideration share considerable similarities but also differ in how they define problems and set goals. All emphasise the prioritisation utility of providing a package of standardised interventions at well-defined levels of the health system. They all highlight the BHSP as the foundation of a new health system based on the principles of primary health care. They, however, depart in important aspects. While Afghanistan and Liberia’s BPHS stresses their role in rebuilding a new health system, Iraq’s BHSP focuses on reforming, reformulating and decentralising the existing health system. The claimed role of the BHSP as a guiding tool for other actors (NGOs and donors) was another area of difference between Iraq BHSP on one hand and the others on the other. The next section will investigate the depicted relative roles of local and international actors in the development of the BHSP in Iraq and the selected countries.

5.3 Depicting the roles of various domestic and external actors
The aftermath of the Iraq War of 2003 provided the opportunity for a significant number of
actors to play a role in setting the agenda of health policy in the country. An influx of non-governmental organisations, UN agencies donors, consultancy companies occurred almost immediately following the war (Burkle & Noji 2004; Burkle, Jr, et al. 2005). The high number of international organisations added to the already existing international and local actors. The purpose of this section is to examine how key official documents depict the respective contributions of main players, both internal and external, in the introduction BHSP in Iraq and the three other countries as presented in the respective documents.

Iraq’s BHSP recognises the role of a host of players whom it depicts as having helped in planning, designing and finalising it. Those are either internal or external actors. Iraq’s MoH and its related organisations presented in the document as the internal actors. Iraq’s BHSP mentions the Public Health and Planning and Development Directorates, Senior Deputy Minister for Technical Affairs and Senior Deputy Minister for Donor Affairs. The document indicates that those two deputy ministers oversaw the development process of the BHSP. It further states that faculty members of the college of medicine and nursing of the University of Baghdad participated in the policy committees that oversaw the development of Iraq’s BHSP. Finally, Iraq’s BHSP recognises representatives of the Ministries of Finance and Planning and Development Corporation as parties in the discussions. In addition to local actors, some external actors are also presented in the document as stakeholders in the process. Those included WHO, which provided technical support and UN and EU providing financial resources. Interestingly, Iraq’s BHSP document does not explicitly mention USAID, UNICEF and the World Bank, that might be expected to have contributed to its development. However, USAID is described as being engaged in the implementation of the pilot phases of the BHSP (QED group LLC 2013).

Besides local and international actors who are described as having contributed to setting the agenda for, formulation and design of the BHSP, other private for-profit organisations appear to have worked on various aspects of the BHSP. For example, EPOS Health Management group was contracted for the costing of the BHSP during Iraq Public Sector Modernisation Program (I-PSM) Phase I (EPOS Health Management 2009). Oxford Policy Management was also contracted to prepare a roadmap for reforms in health policy in the country as part of the I-PSM (Oxford Policy Management 2011). The roadmap included
references to the BHSP. According to an external evaluation of the I-PSM phase I, this resulted in a “plethora of reports produced in different ways to vastly different standards” (Taylor 2011:7).

This plethora of actors raises questions about their roles and authorities as presented by Iraq’s BHSP document. The MoH is portrayed as having a central role throughout the BHSP document. For example, the BHSP document is forwarded and signed by the Minister of Health. Furthermore, Iraq’s BHSP presents the MoH as the owner of the process of its development. Iraq’s BHSP indicates:

“The MoH acknowledged concerns and undergone a process of reorientation...MoH identified the BHSP as an appropriate initial step to achieving ‘integrated reform’ of the existing system” (Ministry of Health, 2009:1).

It continues to say:

“The vision was that successful implementation and sustainability [of the BHSP] are only possible if it is a “national” rather than a donor-driven product” (Ministry of Health 2009:22-23)

This claimed centrality of the role of the MoH is reiterated when Iraq’s BHSP juxtaposes the MoH to other actors. It contrasts this ‘ownership’ with the ‘merely facilitators and advisory’ role of foreign and external advisors and consultants (Ministry of Health, 2009:22). Iraq’s BHSP states:

“The package was developed by a core team of MoH specialists with expertise in all relevant areas. The role of the consultants (EPOS Health Consultants) under the SPHCS project was merely facilitatory and advisory” (Ministry of Health 2009:22-23)

The MoH further describes the relationship with external advisors and consultants as ‘collaborative’. It indicates that the “capitalization on existing studies and previously completed work” by the MoH itself, made this relationship possible (Ministry of Health, 2009:23). While the document underlines the central authority of the MoH, it nevertheless alludes to the role of external advisers and consultants in helping in the development of the BHSP:

“With the technical assistance of SPHCS consultants, a list was drafted of equipment
and essential drug lists for the agreed upon services to be included in the BHSP” (Ministry of Health 2009:23)

The next paragraphs will explore the presented actors in other BHSP documents and the extent to which their depicted roles contrasts with Iraq’s BHSP.

All of the selected documents share similarities in their depiction of the types of actors, the claimed leading role of the Ministry of Health and the suggested collaborative nature of developing the BHSP. Like Iraq, Uganda’s BPHS presents some internal and external actors and claims that they have contributed to the development of Uganda’s BPHS (Ministry of Health 1997). Internal actors, as presented in the document, include the MoH itself and several of its constituting departments such as the health districts, Health Planning Department, and Quality Assurance Programme. It also recognises some external actors such as WHO and a donor-funded programme (without mentioning the donor). Similarly, Afghanistan’s BPHS highlights the involvement of WHO, UNICEF, UNFPA, and USAID, in addition to the MoPH itself (Islamic Republic of Afghanistan 2005). Likewise, Liberia’s BPHS highlights the participations of organisations such as the Ministry of Health and Social Welfare (MoHSW), UNDP, UNICEF and other academic institutions. Similar organisations have been involved in the planning, developing and evaluating Iraq’s BHSP.

Among this relatively large number of actors, the documents claim a leading role for the MoH in the respective countries. The Minister of Health in all countries had forwarded the documents. They appear to argue that the MoH and its constituting organisations spearheaded the process. Uganda’s BPHS States:

“The health planning department and the quality assurance programme of the MOH are recognised for spearheading the consultative process and documentation that has led to the publication of this first edition of the basic package of health services for Uganda” (Ministry of Health 1997:4)

Likewise, Afghanistan’s BPHS states:

“In March 2002, the Afghan Ministry of Health began a process to determine its major priorities for rebuilding the national health system, and which health services were so important for addressing the greatest health problems that they should be available to all Afghans…it was decided to call these crucial services a Basic Package of Health Services (BPHS)” (Transitional Islamic Republic of Afghanistan
Liberia’s BPHS also appears to claim that the Ministry of Health and Social Welfare (MoHSW) a rational process through which it had decided to introduce the BPHS because it: a rational process through which it had decided to introduce the BPHS because it: a rational process through which it had decided to introduce the BPHS because it:

“Knows that, given its current severe constraints, it cannot do all things at the same time. Accordingly, it has decided to make a Basic Package of Health Services (BPHS) the cornerstone of the national health plan” (Ministry of Health and Social Welfare 2008:1).

Liberia’s BPHS further highlights the ‘vigorous discussions’ held at the MoHSW that led to the development of the BPHS. It states:

“The BPHS for Liberia was developed by consensus after a series of vigorous discussions held at the highest levels of the MOHSW. Few quantitative data about Liberia were available to be applied to the selection of health priorities and, for many areas, agreement was not unanimous. The current version is severely prioritized” (Ministry of Health and Social Welfare 2008:2, 5).

This claimed leadership and ownership role for the respective MoHs is further stressed when the documents discuss the role of external actors. All four documents share similarities in the way they depict the role of external actors. They all present those actors as mainly supporters or collaborators rather than initiators or owners of the process. For example, Uganda’s BPHS recognises the role of WHO in “supporting the initial stages” of the BPHS (Ministry of Health 1997:4). Like Iraq, Afghanistan’s BPHS also highlights a collaborative process to achieve consensus on the package:

“A collaborative process was established, so that all stakeholders would have an opportunity to contribute their ideas and experience. The…BPHS is one that represents a consensus among Afghan Ministry of Health officials, NGOs, international UN agencies, donors, and other partners in the health sector” (Transitional Islamic Republic of Afghanistan 2003:5)

In addition to this claimed collaborative and consensual process, Afghanistan’s BPHS highlights its role in establishing and promoting what it calls understanding among the involved stakeholders:
“The BPHS has created awareness and fostered understanding between the government and its major partners: NGOs, who provide many of the health services, and donors, who provide many of the financial resources for the health system.” (Islamic Republic of Afghanistan 2005:2)

Similarly, Liberia’s BPHS highlights the importance of involving external actors.

“Given the importance of the United Nations agencies...the donors, and the NGOs...open meetings should be held to present to and discuss with them both the theoretical and the practical considerations in the design of the BPHS.” (Ministry of Health and Social Welfare 2008:11)

In addition to these differences, departures exist that might reflect contextual factors in the countries. Afghanistan’s BPHS present itself as a guiding tool not only for the government but also for NGOs and donors that provide health services and financial resources in Afghanistan. It indicates:

“The MOPH expects all NGOs and others delivering health services in Afghanistan to base the implementation of their health programs upon this document. Hence, those delivering health services to Afghans must first provide the BPHS before adding any other services.” (Islamic Republic of Afghanistan 2005:2)

Liberia’s BPHS also highlighted the above claim:

“As is usually the case, the health sector in post-conflict Liberia is fragmented by vertical programs and global initiatives, and its attempts to implement local priority programs are in real danger of being further distorted. There has been little standardization, or expressions of interest in pursuing uniform policies within the health sector, by the many agencies, public and private, that are currently providing services under an ‘emergency’ mandate.” (Ministry of Health and Social Welfare 2008:12)

Therefore, Liberia’s BPHS indicates:

“It is expected that the NGO sector will apply the BPHS guidelines to its own services and programs” (Ministry of Health and Social Welfare 2008:9).

These demands by Afghanistan and Liberia’s BPHS perhaps could be viewed as a potential reiteration of the claimed ownership and stewardship role of the respective MoHs.
Despite the depicted consensual process, the documents appear to suggest some elements of tension and conflict within and among the involved actors. For example, Afghanistan’s BPHS states that clinicians and donors exerted pressures to include particular interventions. With this regard Afghanistan’s BPHS reports:

“Clinicians have a strong bias to focus on individual health and often pay little attention to other dimensions of successful public health interventions. Other interventions are proposed by donors because they are part of the routine assistance offered by the aid agency involved. Sometimes agencies may transplant a model deemed successful in another country or setting to Afghanistan without necessarily taking the local context into consideration” (Islamic Republic of Afghanistan 2005:3).

In contrast, Liberia’s BPHS highlights the lack of input from other stakeholders. The latter states:

“There was no systematic decision-making process involving all stakeholders, based on locally-available evidence. Instead, consensus was sought among a centrally-located group of leaders and experts.” (Ministry of Health and Social Welfare 2008:11).

To overcome this central decision-making process, Liberia’s BPHS proposes:

“A series of meetings is proposed to solicit the input of the peripheral health staff that will be called upon to work within the confines of the BPHS” (Ministry of Health and Social Welfare 2008:11)

Fundamental differences also do exist among the documents in relationship to the presented dynamics of actor interactions and their relative authorities. In contrast to Iraq, Uganda and Liberia on one hand, Afghanistan’s BPHS explicitly acknowledges the role of external actors as initiators of the BPHS. For instance, it declares:

“WHO initiated the BPHS development process in March 2002 ...? [And] developed the initial framework of the Basic Package” (Transitional Islamic Republic of Afghanistan 2003:3).

Neither of the other documents appears to suggest that the process was initiated by WHO or other actors although Iraq’s BHSP recognises that WHO provided “full technical
support” (Ministry of Health 2009: iii). This explicit mentioning of WHO, as the initiator of Afghanistan’s BPHS seems to be contradictory to the ownership claims discussed earlier for Afghanistan. Arguably related to this, Liberia’s BPHS appears to be the only document that makes an explicit reference to lessons learned from other post-conflict countries. It states:

“Careful analysis and learning from the post-conflict experiences of other countries can help build a new health system” (Ministry of Health and Social Welfare 2008:1).

Such explicit reference to other post-conflict countries does not exist in Iraq’s BHSP or any of the other countries.

This section has highlighted that the documents analysed presented a relatively large number of actors as involved in the development of the BHSP. Those actors included both internal and external ones. All documents highlight the central role of the respective ministries of health as owners or stewards of the process of developing the BHSP. The documents also appear to stress a claimed collaborative and consensual relationship among the actors involved. They also seem to focus on what interventions to include or exclude and at what cost. The upcoming sections will attempt at addressing these points in turn.

5.4 Defining the content of the packages
This section will examine the nature of the interventions included in Iraq’s BHSP and compare Iraq’s BHSP with Uganda, Afghanistan and Liberia. Iraq’s BHSP identifies particular services, tests, medicines and equipment to provide at defined levels of health facilities (Ministry of Health 2009). Iraq’s BHSP describes ten categories of what it characterise as “practical, essential and comprehensive” interventions or services (Ministry of Health 2009:16). The interventions include maternal and child health, communicable and non-communicable diseases, immunisation, mental health, nutrition, food safety, environmental health, school health and health education. Iraq’s BHSP then moves on to describe diagnostic tests (laboratory and imaging) that it characterises as ‘appropriate’ and ‘matching’ to the interventions mentioned above. Next, Iraq’s BHSP presents a “standard list of essential medicines” (Ministry of Health 2009:20). It then presents a set of equipment and label them as necessary, proper and cost-effective to meet the basic needs of health services.
Iraq’s BHSP also describes four standard levels of the primary health care system that are Community Health Houses, PHC sub-centres, PHC main centres and district hospitals.

Iraq’s BHSP indicates that most of the services and interventions included do already exist. It states:

“Most of the services presented in the package are currently being provided but not at all levels and need to be strengthened”(Ministry of Health 2009:16)

Furthermore, Iraq’s BHSP claims that it plans to use the existing system to deliver the BHSP. It indicates:

“Despite the limitations, the delivery of the BHSP will build on the existing system in order to meet the immediate needs while initiating change over time.”(Ministry of Health 2009:1)

Similarly, it claims to derive the essential medicine list from the already existing Iraq’s National Drug List. Iraq’s BHSP states:

“A standard list of essential medicines to satisfy the priority health care needs is selected from Iraq’s National List”(Ministry of Health 2009:20)

Arguably, interventions related to mental health and non-communicable diseases are the only ones that were not provided previously (WHO 2006). Also, Community Health Houses are a new additional level added to the already existing other facilities in the system (WHO 2006). Therefore, one could argue that Iraq’s BHSP merely constitutes a relabelling of the already provided services that are repackaged in standard categories. Such relabelling might have little impact on improving the health status of the population and addressing priority health problems. This is more so given that only a basic costing was done rather than a formal cost-effective analysis for the included interventions. Iraq’s BHSP, however, identifies the latter as the criteria for the selection of the included interventions.

One can make similar arguments about the roles of the included intervention in achieving other goals of Iraq’s BHSP; equity, access, and acceptability. The introduction of interventions at community health houses might be viewed as the only new tool to get services closer to communities and hence improve access and equity for the most vulnerable
and underserved populations. Similar questions could be raised about the goal of timely
provision of quality and standardised care. Iraq’s BHSP does not elaborate on how a
packaged list of already existing interventions would ensure the timely provision of quality
services. In short, Iraq’s BHSP takes mostly existing interventions, claim that they are cost-
effective, package them in distinct categories and standardise them along a mostly established
order of health facilities. The next paragraphs review the commonalities and differences of
Iraq’s BHSP with other countries about these interventions.

All of the countries under consideration share similarities in the classification of the
facilities at which the interventions are provided. They are also similar in the components of
their packages, the particular intervention in each component and the criteria for selecting
those interventions.

With minor differences, all countries share a similar classification of the health
facilities to provide the package. As indicated above, Iraq’s BHSP classifies health centres
into Community Health Houses, Primary Healthcare Centre (PHC)Parish Level (Health
Centre II), Sub-county level (Health Centre III) and County Level (Health Centre IV) and
District Hospitals. It appears that the PHC main centre in Iraq corresponds to Health Centre
III and IV in Uganda. Similarly, Afghanistan’s BPHS defines facilities as Health Post, Basic
Health Centre, Comprehensive Health Centre, and District Hospitals. Likewise, Liberia’s
BPHS describes four levels: Community Health Workers (CHWs), Clinic, Health Centre and
County Hospitals. Liberia’s BPHS, however, does not assign a specific level to CHWs and
Trained Traditional Midwives (TTM), something that Iraq, Uganda, and Afghanistan do. In
addition to those broad similarities in the levels of health facilities, all the packages share
similar components of interventions (Table 5.4).
Table 5.4: Intervention Components in four countries in their respective BHSP

<table>
<thead>
<tr>
<th>Iraq</th>
<th>Uganda</th>
<th>Afghanistan</th>
<th>Liberia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal and Newborn Health</td>
<td>MCH/FP maternal health and FP</td>
<td>Maternal and Newborn Health</td>
<td>Maternal and Newborn Health</td>
</tr>
<tr>
<td>Child health and immunisation</td>
<td>Child health and development. nutrition</td>
<td>Child Health and Immunizations</td>
<td>Child Health</td>
</tr>
<tr>
<td>Communicable diseases treatment and control</td>
<td>STIs services/ Malaria control and case management/ TB and leprosy control and case management/ Infection control</td>
<td>Communicable Diseases</td>
<td>Communicable Diseases Control</td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td>Public Nutrition</td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-communicable diseases</td>
<td>Other clinical cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>Mental health care</td>
<td>Mental Health</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Emergency care</td>
<td>Management of injuries/Rehabilitative services</td>
<td>Disability</td>
<td>Emergency Care</td>
</tr>
<tr>
<td>Food safety, environmental health and school health</td>
<td>Environmental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health education</td>
<td>Health education</td>
<td></td>
<td>Reproductive and Adolescent Care</td>
</tr>
<tr>
<td></td>
<td>AIDS care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Like Iraq’s BHSP, the interventions included in Uganda, Afghanistan and Liberia’s BPHS are tabulated in components and are distributed based on levels of health service delivery. As Table 5.4 shows that, those components are largely similar to the ones in Iraq’s BHSP, with slight differences. For example, while Uganda presents distinct categories for a range of communicable diseases (STI, AIDS, Malaria, TB), the other countries group these diseases under one communicable disease category. More distinctly, Iraq and Uganda appears to be the only ones in the group to dedicate a component for non-communicable diseases (called ‘other clinical cases’ in Uganda). Iraq’s BHSP also includes mental health and non-communicable diseases that are excluded by the others (Afghanistan introduced mental health at a later stage). In contrast, Liberia’s BPHS is the only package that has a component for
Reproductive and Adolescent Care.

Notwithstanding those differences, Iraq’s BHSP share considerable similarities with the other packages in the included components. Besides similarities in the titles of the components, individual interventions grouped under each element are also comparable. For example, Table 5.5 shows the targeted interventions for Tuberculosis services in three countries except for Uganda because we could not find an intervention specific for TB in the latter.

Table 5.5: Comparison of TB services in Iraq, Afghanistan and Liberia

<table>
<thead>
<tr>
<th>Iraq</th>
<th>Afghanistan</th>
<th>Liberia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information, education and communication (IEC)</td>
<td>IEC</td>
<td>IEC</td>
</tr>
<tr>
<td>Short course anti-TB drugs (DOTS)</td>
<td>Short course chemotherapy, including DOTS</td>
<td>Supervision of intensive phase of DOTS</td>
</tr>
<tr>
<td>Tracing TB defaulters</td>
<td>Surveillance of cases of interrupted treatment</td>
<td>Identification of suspected cases</td>
</tr>
<tr>
<td>x-ray for smear-negative patients</td>
<td>X-ray for smear-negative patients</td>
<td>Diagnosis of TB in sputum negative cases</td>
</tr>
<tr>
<td>Active case finding in OPD/Community</td>
<td>Active case finding in OPD/community</td>
<td>Collection of sputum and microscopy for AFBs</td>
</tr>
<tr>
<td>Preventive therapy for children contacts of TB patients</td>
<td>Preventive therapy for children contacts of TB patients</td>
<td>Diagnosis of TB in children</td>
</tr>
<tr>
<td>Detection and Management MDR - (DOTS-plus)</td>
<td>DOTS-plus in multi-drug resistant TB</td>
<td>Management of complications and suspected drug-resistant cases</td>
</tr>
<tr>
<td>Management of complicated severe cases</td>
<td>Inpatient management of severe cases</td>
<td>Management of Complications and suspected drug-resistant cases</td>
</tr>
<tr>
<td>Recording and reporting</td>
<td>Reporting</td>
<td></td>
</tr>
<tr>
<td>Supervision and monitoring</td>
<td>Supervision and monitoring</td>
<td>Supervision of continuation phase of DOTS</td>
</tr>
</tbody>
</table>

As Table 5.5 shows, the wording of the interventions included in this particular component is similar to a large extent, particularly between Iraq and Afghanistan. The same applies to the majority of the interventions under equivalent components.

Despite these similarities between Iraq’s BHSP and the other countries, differences do exist in relationship to the number of interventions. Table 5.6 presents the number of the interventions under each component for selected countries.
Table 5.6: Number of Interventions under components of selected countries’ packages

<table>
<thead>
<tr>
<th>Components</th>
<th>Iraq</th>
<th>Uganda</th>
<th>Afghanistan</th>
<th>Liberia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal and newborn health</td>
<td>76</td>
<td>11</td>
<td>83</td>
<td>66</td>
</tr>
<tr>
<td>Child Health and Immunisation</td>
<td>49</td>
<td>12</td>
<td>39</td>
<td>32</td>
</tr>
<tr>
<td>Nutrition</td>
<td>18</td>
<td>0</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td>81</td>
<td>25</td>
<td>28</td>
<td>51</td>
</tr>
<tr>
<td>Mental Health</td>
<td>14</td>
<td>4</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>Essential Medicines</td>
<td>176</td>
<td>0</td>
<td>142</td>
<td>150</td>
</tr>
<tr>
<td>Non-communicable diseases</td>
<td>48</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disability</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Food Safety, Environmental and School Health</td>
<td>27</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Education</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blood Transfusion Service</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Diagnostic Tests</td>
<td>62</td>
<td>0</td>
<td>34</td>
<td>27</td>
</tr>
<tr>
<td>Reproductive and Adolescent Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Dental Health Care</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>572</strong></td>
<td><strong>73</strong></td>
<td><strong>369</strong></td>
<td><strong>375</strong></td>
</tr>
</tbody>
</table>

As Table 5.6 shows, Iraq’s BPHS includes more components and interventions compared to the other packages. This quantification covers all of the services in all documents except for equipment. Uganda’s BPHS does not provide a list of medications or diagnostic tests; therefore, the relatively small number of interventions in Uganda’s BPHS might reflect this omission.

There seem to be at least three key features for this difference in the number of the interventions. First, Iraq’s BHSP includes additional components that are not present in Afghanistan or Liberia’s BPHS. Those are non-communicable diseases; emergency care; food safety, environmental and school health; health education; and nutrition. Second, Iraq’s BHSP includes more interventions under each component compared to the other packages except for Maternal and Newborn Health (in Afghanistan) and Emergency care (in Liberia). However, Afghanistan and Liberia’s BPHS contain components that are absent in Iraq’s
BHSP (disability and blood transfusion services and Reproductive Health respectively). These additional components do not seem to affect the larger number of interventions in Iraq’s BHSP. Third, the greater number of interventions in Iraq’s BHSP might reflect the bigger pool of existing health interventions in the system compared to Afghanistan or Liberia. One could argue, therefore, that Iraq’s BHSP is more generous regarding the components and the interventions provided under each element.

Despite these differences in the number of the interventions, the other countries appear to adopt similar criteria for selecting included interventions. Only Uganda’s BPHS does not explicitly mention the criteria for the selection of the interventions. Iraq’s BHSP states:

“The main approach was to identify essential services that would yield maximum gains in health for the money spent (cost-effective services). The balance between available resources and the services provided was also an important consideration. A package that includes a wide range of services beyond the available resources would result in poor quality, low utilization and resource wastage. Finally, all services included in the package were identified as addressing Iraq’s health priorities and targeting its most vulnerable populations.” (Ministry of Health 2009:15)

Similarly, Afghanistan’s BPHS presents a list of four criteria for the selection of the interventions:

- “Technically effective services that can be delivered successfully in Afghanistan
- Targeted diseases are those which have imposed a heavy burden on Afghanistan, considering the effect on the individual with the illness as well as the social impact of the disease (such as epidemics and adverse economic effects)
- Sustainability of the services in the long-term as donors reduce support in the years ahead, taking into consideration the government’s ability to maintain a basic level of health services
- The need for equity in ensuring that critical health services are provided to all, especially the poor.” (Transitional Islamic Republic of Afghanistan 2003:8)

Liberia’s BPHS also presents four criteria:

- “Their potential contribution to reducing the burden of morbidity and mortality in Liberia (considering not only their epidemiological burden, but the social and economic burden as well)
- The availability of interventions that have been demonstrated to be safe and effective
- The feasibility of implementing those interventions given Liberia’s current

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It appears that all the documents claim that the interventions were selected based on a rational process that incorporated particular criteria. In summary, those criteria include the claimed cost-effectiveness of the interventions, the sustainability potential of the interventions and their safety and utility for the vulnerable populations.

In conclusion, this section makes it evident that Iraq’s BHSP shares significant similarities with the other documents. All share mostly similar categories of interventions. The interventions included under each category are also relatively similar. All of the packages claim to adopt similar criteria (cost-effectiveness, safe, sustainable) in the selection of the interventions. Nevertheless, interesting differences do exist regarding the inclusion or exclusion of particular components and interventions. Those differences, however, do not rule out the proposition that they might have shared similar origins and/or transferred to each other. Additionally, such differences might reflect the influence of modifications that occurred during the transfer process.

These similarities and differences appear to have implications for funding the BHSP and managing financing trade-offs. Alternatively, such differences might reflect differences in financial priorities in the respective countries. The next section will investigate first Iraq’s BHSP’s financing methods and then the similarities and differences among the documents regarding their financing features.

5.5 Managing financial trade-offs
This section will investigate how Iraq’s BHSP and the selected countries claim to approach health financing functions of resource mobilisation and allocation and their related principles of efficiency, sustainability and equity. Discussing the way that the documents depict managing financial trade-offs is relevant given Iraq’s very different circumstances in comparison to the other countries.

Iraq’s BHSP underlines particular issues with the financing features of the existing health system. It also argues that it can provide solutions to those health financing issues. It
appears that Iraq’s BHSP is attempting to address concerns around how to mobilise resources and how to spend them efficiently at the primary health care level. Regarding resource mobilisation, it seems to integrate the latter with sustainability concerns. To ensure sustainability, Iraq’s BHSP suggests adopting two approaches. In the near future, it advises to:

“Identify possible sources of funds to fill the gap in the short-term (additional MoH allocation or donor funding and initiate national dialogue regarding long-term financing and sustainability issues” (Ministry of Health 2009:96).

In the end, it suggests that Iraq should be:

“Increasing the overall health budget, i.e. Increase government spending on health; reallocating the health budget: shifting the spending from curative to primary health care; and financing the BHSP through an integrated combination of public and private expenditures-households may contribute affordable visit fees and co-payments for drugs and investigations”(Ministry of Health 2009:98).

In contrast, it is more explicit in offering a clear normative position about funding operating costs. In this respect it states:

“[Operating Costs] should be ideally funded from local sources to ensure financial sustainability” (Ministry of Health 2009:98).

Viewing local sources of funding as an ‘ideal’ mean for resource mobilisation is potentially consistent with the decentralisation aims of the BHSP. This claim could be seen as a departure from pooling resources at the central MoH level to local levels (for more on decentralisation, please refer to section 5.2).

In addition to addressing issues of resource mobilisation, Iraq’s BHSP criticises the existing system and offers claimed solutions to resource allocation and purchasing functions of the health system:

“The current structure of PHC is not based on cost-effective interventions that would ensure maximum health gains for available resources. Neither is it capable of responding effectively and efficiently to the complex and growing health needs of the
Iraq’s BHSP presents itself as a solution to many of the problems that it describes. For instance, it states that it aims to:

“Improve allocative efficiency through better allocation of budgets between primary and secondary care, ensure technical and administrative feasibility, and secure financial sustainability through making sure that the BHSP is affordable” (Ministry of Health, 2009:16).

It seems that Iraq’s BHSP recognises the reallocation of resources from hospital services to primary health care services as a tool to improve allocative efficiency. The proposed reallocation of resources appears to be consistent with the desired departure from the hospital-based system of the past (please refer to section 5.2). Besides the claimed cost-effectiveness of the interventions included, the proposed reallocation of resources appears to be a proposed tool to improve efficiency. In short, one of the central issues of the BHSP seems to be how to mobilise resources sustainably and spend them efficiently.

Iraq’s BHSP also touches upon issues of equity and states that it aims to:

“Target the most vulnerable and under-served populations and improve equity and physical/economic access” (Ministry of Health 2009:16).

It further claims:

“All services included in the package were identified as addressing Iraq’s health priorities and targeting its most vulnerable populations.” (Ministry of Health 2009:15)

Arguably, the introduction of new Community Health Houses to rural areas and claiming that all population would have access to the BHSP are also potential provisions that touch upon equity and accessibility in Iraq’s BHSP.

Despite this apparent clarity in highlighting financing functions and their related efficiency, sustainability and equity principles, it seems that contention was not absent from the process. Quotes from documents indicate that the funding of Iraq’s BHSP was one of the contentious
issues in its development. Iraq’s BHSP states:

“The trade-off between what is affordable or achievable and what is ideal was the biggest challenge that the team had to struggle with given the current implementation realities in Iraq” (Ministry of Health 2009:23).

One can pose questions about Iraq’s BHSP solutions to health financing problems it highlights. First, Iraq’s BHSP claims that the interventions it adopted are cost-effective; hence, they would fix the suggested inefficiency of health services in the existing system. However, it does not base the selection of the intervention on a formal cost-effectiveness analysis (interview data for this research). Iraq did not undertake a costing of the package before its introduction but rather after that (EPOS Health Management 2009). Therefore, the efficiency claims of Iraq’s BHSP are questionable given that a basic costing was not done at the formulation stage of the policy. Additionally, most of the interventions included were selected from already existing services. In addition, the allocation of resources from hospital to primary health care services is provided only as an option to ensure allocative efficiency rather than a requirement. Furthermore, the introduction of the BHSP may not be translated automatically into reallocation of resources to primary health care. Second, it appears that Iraq’s BHSP dedicates more space and attention to financial sustainability and affordability for the government than fulfilling the principles of equity and affordability for the population. This focus can be interpreted as an indicator of the priorities of the BHSP. For example, access to care regardless of the ability to pay is not mentioned in MoH’s vision on which the BHSP is based. The vision states:

“An accessible, affordable, available, safe and comprehensive quality health service of the highest possible standard that is financially sound and founded on scientific principles in order to meet the present and future health needs of Iraqi people, regardless of their ethnicity, geographic origin, gender or religious affiliation.” (Ministry of Health 2009:1)

Furthermore, Iraq’s BHSP stresses the importance of local sources of funding for ensuring its financial sustainability. It does so without acknowledging the equity consequences of user fees and co-payments at least as far as the BHSP document is
concerned. Iraq’s BHSP, also, does not provide details about the level of user fees or whether exemptions will be offered based on income or other considerations. In short, the space that Iraq’s BHSP dedicate to efficiency can be an indicator that the latter is more concerned with the efficiency and sustainability of health services and their affordability for the government than the equity implications and affordability for the population of the proposed package. Did the three selected countries share a similar ranking of their financial concerns with Iraq? The next subsections will attempt to address this question.

Iraq’s BHSP and the other selected countries share similarities in particular aspects of financing while depart in others. With regards to resource mobilisation, the documents appear to depart in their stances towards user fees in particular. Uganda’s BPHS recognises what it calls fee-for-services as a source of funding its BPHS. It requires the introduction of guidelines for fee-for-services and suggests alternative sources of financing depicted as being consistent with local realities. Uganda’s BPHS include the following decisions in regards to financing:

a) “Fee for service (FFS) guidelines should be available at each health unit
b) The FFS guidelines shall be implemented in accordance with the national policies and taking into consideration local adaptations
c) All health units should have budgets
d) Alternative local health care financing initiatives should be encouraged”
(Ministry of Health 1997:9).

Afghanistan’s BPHS, on the other hand, does not mention the word user fees, co-payment or cost-recovery in its text. This omission is consistent with abolishing user fees in Afghanistan following its testing as part of a randomised controlled trial (Steinhardt et al. 2011a). In contrast, Liberia’s BPHS recognises cost-recovery for the financing of particular aspects of the package only. It stresses that communities should take responsibility for compensating Community Health Workers (CHWs). It reports in this regards:

“It is clear that CHWs will not be on the government payroll. Instead, again in keeping with the ideas of decentralization and participation, communities will develop their own mechanisms for selecting, compensating, and overseeing the work of this cadre of health personnel.” (Ministry of Health and Social Welfare 2008:14)

In short it appears that the countries differ in their stance toward user fees. Iraq and Uganda seem to recognise their roles in mobilising resources for their respective package.
They do so without specifically mentioning the levels or interventions to which user fees apply. They also do not explicitly present any methods of exemption in the texts of their documents. Liberia, on the other hand, appears to recognise user fees for compensating community health workers only.

While the countries differ in their approach to user fees, they appear more in agreement with regards to using resources efficiently. They all claim that the included interventions in their packages are cost-effective, hence according to them, the overall package is efficient. Like Iraq, Uganda’s BPHS acknowledges that full costing had not been completed before its introduction. It, however, argues that the absence of costing does not affect the utility of the BPHS in prioritisation and resource allocation. Uganda’s PBHS highlights its utility in helping to budget at the primary health care level. It indicates:

“The package is currently being costed but even in the absence of the cost estimate, it is expected that at District and sub-district levels, resource allocation budgeting and prioritisation will be greatly assisted by this document.” (Ministry of Health 1997:9)

It is intriguing that Uganda’s BPHS states the above. During 1995-1996, The World Bank funded a major study in Uganda to determine the burden of diseases and cost-effective interventions (Jeppsson et al. 2004). The results of the study determined the interventions to be included in Uganda’s BPHS (Kapiriri et al. 2003). The study did not use Disability Adjusted Life Years (DALYs) because of the lack of appropriate data. Instead, it used Discounted Life Years (DLYs) (Jeppsson et al. 2004). Following this study, however, an author suggested that budget allocation decision were made almost entirely in contrary to the recommendations of the investigation (Jeppsson et al. 2004).

Afghanistan’s BPHS, similarly, highlights the purportedly cost-effective nature of the interventions included. It claims that one of its objectives was:

“To include services that would be cost-effective [emphasis in origin] in addressing the problems faced by many people” (Islamic Republic of Afghanistan 2005:1)

Afghanistan’s BPHS, unlike Iraq, did a formal cost-effectiveness analysis (Newbrander et al. 2007). Likewise, Liberia’s BPHS stresses the feasibility of the interventions given resource constraints. It emphasises the cost-effectiveness of the
interventions in reducing not only epidemiological but also economic and social burdens of disease. It is unclear from Liberia’s BPHS, however, that the latter conducted a formal burden of illness or cost-effectiveness analysis to determine the interventions included or excluded.

All the countries seem to agree that resources should be used efficiently. They appear to present the depicted cost-effectiveness of the included interventions as a method to achieve efficiency. In addition to cost-effectiveness, Iraq’s BHSP views itself also as a tool to ensure allocative efficiency through providing more resources to primary health care vis-a-vis secondary or tertiary care (please refer to above). Such explicit reference to allocative efficiency is absent from the other documents.

Concerning equity, as shown above, Iraq’s BPHS does not explicitly mention a willingness to provide services to the population regardless of the ability to pay. In contrast, it appears that both Afghanistan and Liberia are more explicit in highlighting the importance of equity considerations in their respective packages. Afghanistan’s BPHS indicates:

“It remains dedicated to the principle of equity and to care being based upon need rather than ability to pay for services” (Islamic Republic of Afghanistan 2005:6).

Similarly, Liberia’s BPHS appears to demonstrate a more emphasis on equity by stating:

“Equitable access to quality health care is a key component of Liberia’s future. Health care cannot be a privilege of only the rich and powerful. Improving the Liberian people’s health and well-being by creating equitable access to quality health care will serve not only humanitarian, but also political and economic purposes” (Ministry of Health and Social Welfare 2008: iii).

As shown above, both Afghanistan and Liberia either abolished user fees or recognised it only for particular interventions. In contrast, Iraq’s BPHS recognises user fees, but it does not specify which level of facilities or what interventions should levy them. This recognition of user fees occurred despite claims of targeting the most vulnerable populations by Iraq’s BHSP.

In conclusion, this section has revealed that all of the documents agree on the
importance of particular financing principles, but there are aspects of both similarities and differences regarding the ways to fulfil those principles. The countries differ in their approach to resource mobilisation and user fees in particular. While Iraq and Uganda adopt user charges and fee-for-services, Afghanistan and Liberia exclude them. In contrast, all documents seem to consider sustainability as a central financing principle. They appear to use the claimed efficiency of what they present as cost-effective interventions (all countries) and reallocation of resources to primary care (Iraq) as a mean to achieve sustainability. In short, it appears that the respective countries viewed the BHSP as a tool to address issues around resource mobilisation on one hand and how to use efficiently those resources on the other.

5.6 Summary
This chapter uncovered broad similarities and interesting differences between Iraq’s BHSP and three other countries. Iraq’s BHSP shares commonalities with the other countries in its primary aims, presented actors, interventions included or excluded, and particular financing principles.

However, significant departures do exist between Iraq’s BHSP and the other equivalent policies. First, there are indications that the main aim for the BHSP was to reform the existing health system rather establish a new one. This different can be viewed as a reflection of the underlying differences between Iraq’s health system and the other countries at the time of the introduction of the BHSP. Second, rather than a steward (which is apparently the case in the other countries), Iraq’s MoH claims to have owned the process of introducing the BHSP. Relatedly, the BHSP is depicted as a guiding tool for NGOs in the other countries but not in Iraq. Contextual differences between Iraq and the other countries regarding the larger number of NGOs in the latter and the greater capacities of the MoH could explain in part such difference. Third, Iraq’s BHSP clearly contained more interventions that other countries. Finally, Iraq surprisingly, recognised user fees to finance the BHSP.

The similarities between Iraq’s BHSP and the three other nations suggest that the BHSP is a global policy that was adopted by Iraq. However, the differences in Iraq’s case are intriguing and deserve a close examination. The following chapters will explore the factors
that might have contributed to this unique case of Iraq.
6 Formulating Iraq's BHSP: examining its multiple origins

The purpose of this chapter is to explore the extent to which internal and external factors (including players) have shaped the BHSP. This purpose corresponds to objective number two of this research (please refer the chapter one on page 26). The chapter uses findings from interview, documents data and occasional secondary data to explore the external and domestic origins of the BHSP.

Researching the BHSP was inspired in part by its ostensible novelty in the context of Iraq’s health policy. First, the BHSP was introduced formally in 2009, six years after the massive political changes following the 2003 war. The war offered the opportunity for a plethora of international actors to play an active role in setting the health policy agenda. The presence of such international players raises questions about the extent to which they played a role in shaping health policies in the post-conflict setting of Iraq using similar policies in other countries. Second, the name suggested something new and different. Packages of health care and the references to the cost-effectiveness of health services are new concepts to Iraq. Furthermore, principles such as decentralisation and prioritisation although not entirely new, were less prominent in health policy in Iraq before the 2003 war. Finally, user fees were recognised as a method of financing the BHSP, which was both puzzling and ostensibly new for financing primary health care in Iraq. It is, however, necessary to explore the extent to which the BHSP, its contents, and its various features can be traced to external versus internal sources.

The first section will start by presenting an account of the debates that surrounded the initiation of the BHSP. The second section will then examine evidence suggesting the internal sources of the BHSP. The third section, in contrast, presents findings that allude to external sources of the BHSP before proceeding to discuss the views of informants about the role of user fees in financing the BHSP and the role of the latter in wider system changes.

6.1 Starting debate about change and future directions

This section examines the debates that preceded and accompanied the introduction and formulation of the BHSP in Iraq as. It contextualises the discussions in the political changes following the 2003 war. It appears that such change had provided the opportunity to examine
the existing system and suggest solutions for perceived problems. In addition to the war, events such as conferences, assessment reports and other documents released by the MoH and international actors also occurred. Those events perhaps had contributed to framing the nature of issues and suggesting solutions to perceived problems. This section uses data from documents and interviewees to explore the presentation of the BHSP as a preferred solution to the perceived problems identified. The main focus of the section is the period immediately following the Iraq war of 2003.

Following the 2003 war, the already crumbling health infrastructure was further devastated as a direct result of the conflict and subsequent looting. During and immediately following the war 12% of hospitals were looted, and 7% more were damaged due to combat (Garfield 2003; Rawaf 2005). Some argue that the looting systematically targeted the health system. Frederick “Skip” Burkle (the first American appointed as MoH adviser) stated “it centered on health care. The looters were able to destroy morale very quickly by looting the health-care system. It was highly organized, focused on hospitals, the public healthcare system, pharmacies, and pharmaceutical warehouses, and it was unrelenting.” (Mason, 2007:8). As a result, during the early years of the war, primary health care services (immunisation, laboratory services, and preventive services) were disrupted (Furber & Johnstone 2004). Some argue that the US invasion in 2003 triggered a complete collapse of the health system at the time (Fleck, 2003b; Kapp, 2003a). Despite these claims, some evidence suggests the contrary. For example, only 27% of the equipment necessary to provide vaccination programmes were destroyed during or following the war (Ni Ma, Imad, Faiza, Mott, & Kirkup, 2003)

It seems that the perceived ‘collapse’ of the system triggered some radical ideas about what to do. Some felt that the task was to rebuild the Iraqi health system from scratch (Fleck 2003a). A senior WHO official indicated that “the first priority was to jump start the Iraqi health system so that it can provide basic functions again…” (Fleck, 2003a:848). Others indicated that the system needed remodelling from its perceived hospital-based approach to one that is based on primary health care. A prominent WHO official at the time indicated that the health system “ought to be based on more of a primary health service that reflects the dual burden of non-communicable and communicable disease” (Fleck 2003b). The joint WHO,
World Bank assessment of 2003 also emphasised the need to create a primary health care system. The assessment believed that “the primary health care approach, when applied to pre and post-natal care, immunization promotion, nutrition and integrated medical care for young children, should result in substantially reduced mortality among pregnant women and children during the transitional period” (UN & World Bank, 2003:6). The MoH also articulated its intention to base the system on a primary health care model as part of its vision for the health system in the country that it published in 2004. In its vision, the MoH argued for a strong primary health care system. It recommended that policy makers “emphasize above all the development of a robust primary health care (PHC) system centered on primary health centers and preventive activities, while strengthening general practice medicine for the short-term and developing a family physician model for the long-term.” (Iraq Ministry of Health, 2004:13).

One of the answers that were discussed at the time as part of re-orienting the system to one based on a primary health care approach was the BHSP. A participant that was questioned for the purpose of this study alluded to the intention of particular actors to start a new health strategy for Iraq:

“[The CPA] wanted to start a whole new health strategy for Iraq under the term of health system reform. Now Under that strategy a lot came up about having a basic health service package and the delivering that package.” [IF_UN_3]

A joint WHO and World Bank assessment in 2003 recommended that “the system should aim to offer equitable services that are accessible, affordable and of adequate quality. It should include an affordable basic service package which immediately becomes available to all” (UN & World Bank, 2003:14). The MoH’s vision of 2004 reiterated this recommendation by indicating: “While remaining cognizant of economic realities, aiming at equity, accessibility affordability and quality of all services, including a basic service package that should immediately be available to all” (Iraq Ministry of Health, 2004:23). It further envisioned “a coordinated delivery system that features a strong primary health care sector from which all Iraqi citizens can choose providers who can deliver an integrated package of quality services, including: preventative care; maternal and child care, including reproductive health; medications; and other basic medical services.” (Iraq Ministry of Health, 2004:5)
An interviewee associated the limited priority to primary health care with the absence of a package of health services and recognised both as one of the challenges of the existing system:

“You do not have a basic package, you do not have a lot of focus in primary health care, and people are not accessing basic services” [NIF_Cons_8]

Another interviewee felt that the introduction of the BHSP was part of an attempt to do something in response to the perceived collapse of the system:

“Because the system and everything collapsed, so they are trying to do something, so probably they thought that that [the BHSP] was a success, and they want to imitate it. Probably that is the reason. Or they got it from some consultants. Like, I don’t know where it came from, but I don’t think it is relevant now” [IM_Ac_1]

To summarise, this section has explored the problems that were highlighted and perceived as important during and immediately following the Iraq war of 2003. The section used documents and interview data to explore the perceived problems and suggested solutions. The Iraq war of 2003 is one of the events offered the opportunity for debates about the existing health system and future directions. The publications of reports and assessments such as the MoH vision and the Joint WHO and World Bank assessment can represent similar events. It seems that the perception was that problems are arising from an excessive focus on hospitals and tertiary care and the need to orient the system to a primary health care based model. Some presented the BHSP as the (or part of the) proposed solutions during this period. What are not clear from the previous exercise, however, are the potential origins of the BHSP itself. The next two sections will attempt to address this issue.

### 6.2 Exploring the local origins of the BHSP

This section presents findings from interview and document data that explore the local origins of the BHSP. First, the section will focus on the substance and content of the BHSP and then it will present the role of internal actors as depicted by the interview and document data used for this study.

#### 6.2.1 Borrowing from and continuation of past models

The BHSP document itself report that “despite the limitations, the delivery of the BHSP will build on the existing system to meet the immediate needs while initiating change over
time.” (Ministry of Health 2009: 1). A WHO country profile reported that “packages of health services to be delivered at PHC do exist in Iraq but these need to be updated [and] there is a need to improve the services provided (quality and quantity) to restore patient’s satisfaction/perception and faith in quality of services delivered at the PHC centers” (WHO, 2006:39). Several informants interviewed in this study also pointed to the existing health system as the source for many of the features of the BHSP. One interviewee stated:

“So much of it [the BHSP] has been already done in Iraq, not under the name of the Basic Health Services Package ...... these activities started to have a name. These were present in the past, and there was a lot to be offered to the population by the system” [IF_UN_3]

This interviewee suggests that much of the activities of the BHSP were either already provided or were used to be offered in the past. The interview also felt that the already existing activities started having a new name. Another interviewee echoed those arguments:

“The idea of the BHSP is not new. It started in Iraq even before the fall of the former regime in 2003...most of the services that are included in the BHSP existed initially at the primary health care level...” [IM_Md_2]

A non-Iraqi former representative of an international health organisation indicated that the county is providing health services at the primary health care level, but as the participant put it, not as a package. This informant claimed that the lack of a package was the trigger behind thinking about introducing a BHSP in Iraq:

“Although they are delivering health services at the primary health care, they are not providing it as a package which the service providers at the primary health care level can use to deliver the services. So that was the initial trigger behind this package so that was the initial trigger behind this package” [NIM_UN_7]

Another informant reiterated this view by dismissing the idea that policy makers might have imitated other countries in adopting the BHSP:

“They were not imitating any other country. Iraq used to have their own health services from before, so it did not start in 2003, you know, to be built, there has been a lot of rehabilitation work after the war, and there has been some inheritance from the previous times of doing business.” [nIF_Bi_3]

Similarly, one participant claimed that they could not find a system in the world that is compatible with Iraq to copy it. Therefore, they were left with no choice other than
introducing modifications in the existing system:

“We could not find a system in the world to import it as it is to Iraq. Therefore, we needed to do modifications.” [IF_Bi_6]

Although this interviewee acknowledged the ‘rehabilitation’ work that has been done after 2003 but also underlined the ‘inheritance’ from the past. The same informant went further and stated:

“The design is pretty much based on historical patterns. Whatever the primary health care services were providing, they have kind of framed those services without any analysis about what is needed and what the priorities should be. This analysis is pretty much missing here because you see a lot of attention to ad hoc or fancy or sexy type of services as opposed to those which are clearly or obviously the major causes of mortality and those that are keeping Iraq way behind meeting the millennium development goals. So this analysis I do not think has been there” [NIF_Bi_5]

There is an explicit reference by the above interviewee to the importance of historical patterns and their replication in the BHSP. Furthermore, the interviewee specifically alluded to the inheritance from the past in shaping the features of the BHSP and the current primary health care system in general. The quote also suggests that the contents of the package were decided without an analysis of what the priority needs is. The quotes presented above seem to highlight the perceived importance of the existing system and persistence from the past in shaping the BHSP. However, those quotes did not offer concrete examples of such continuity.
Comparison between the BHSP and these preceding packages in Iraq, therefore, can substantiate arguments about continuity and reveals areas of change that might have occurred. The Public Health Act of 1981 (PHA) formally recognised a package of what it termed ‘essential health services’ in the country (Government of Iraq 1981). Although Iraq amended the PHA on several occasions, it remains the law of the land and it continues to guide recent health legislations (Iraq Council of Representatives 2014). It is, therefore, appropriate to compare the BHSP with the PHA to investigate the extent to which the former resembles the latter Table 6.1. While the similarities may shed some light on the inheritance from past legacies, differences might be useful in beginning to explore elements of changes introduced by the BHSP.

Table 6.1: Comparison between essential (1981) and basic health services (2009) in Iraq

<table>
<thead>
<tr>
<th>Public Health Act 1981</th>
<th>BHSP 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal, child and family health care</td>
<td>Maternal and Newborn Health</td>
</tr>
<tr>
<td></td>
<td>Child health and immunisation</td>
</tr>
<tr>
<td></td>
<td>Immunization</td>
</tr>
<tr>
<td>School health care</td>
<td>Food safety, environmental health and school health</td>
</tr>
<tr>
<td></td>
<td>Communicable diseases treatment and control</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Health education</td>
<td>Health education</td>
</tr>
<tr>
<td>Mental and psychological health</td>
<td>Mental health</td>
</tr>
<tr>
<td>Visual and auditory health</td>
<td></td>
</tr>
<tr>
<td>Dental health</td>
<td>Non-communicable diseases</td>
</tr>
<tr>
<td></td>
<td>Emergency care</td>
</tr>
</tbody>
</table>

Table 6.1 reveals that there are strong consistencies in the broad range of services covered by the two packages. One interviewee supported the existence of those similarities by stating:

“The components of primary health care were almost all there before the package came” [NIM_UN_7]

The components included in the table under the PHA are termed ‘essential health services’ (Government of Iraq 1981). They all exist in the BHSP. However, there are differences between the two packages. While the PHA recognises dental, visual and auditory health services as standalone components, the BHSP categorises them under non-
communicable diseases. Also, the BHSP includes non-communicable diseases and emergency care that were not addressed in the PHA. Furthermore, although the PHA mentions communicable diseases, it does not list them under ‘essential health services’ but rather in a separate chapter. Finally, the PHA includes other services that are not listed under ‘essential health services’ such as health surveillance, funeral services, drinking water, animal breeding in neighbourhoods and insect control. The PHA appears to be more comprehensive given that it includes interventions that are broader in scope (drinking water, insect control and health surveillance). These differences, nevertheless, do not preclude the argument that the BHSP perhaps represents a later stage in the evolution of the PHA.

The classification of health facilities that the BHSP adopted appears to be also similar to existing structures. The data used in this comparison is derived from the BHSP document that describes the existing structures and the proposed new ones (Ministry of Health 2009). The BHSP appears to replicate at least some of the aspects of the existing structure of primary health care facilities. The BHSP classification continues the use of previous divisions of primary health care facilities into sub- and main centres. In both the BHSP and the previous structure, such division is based on the absence of doctors in the sub-centres as opposed to their presence in the main centres. The BHSP, however, does not clarify whether it continues the further sub-classification of main centres into their existing categories (for a description of the existing structures of the PHCs please refer to page 106). In contrast, the changes that the BHSP adopts are the inclusion of Community Health Houses and District Hospitals within its structure. Iraq's BHSP defines Community health houses as structures that "will be staffed by male and female community health workers who will have an advisory and supportive role in strengthening the link between the community and the PHC centres." (Ministry of Health, 2009:21). They did not exist in the primary health care structure of the country previously, and it can be viewed as a genuinely new level added by the BHSP (WHO 2006). District hospitals, on the other hand, did exist before the introduction of the BHSP, but they were not considered as part of a package of health services (Ministry of Health 2009). Their introduction in the context of the BHSP, therefore, represents a change in the classification of the existing system rather than a genuinely new level.
The comparison between the BHSP and existing services and structures appear to be in line with some of the claims made by some interviewees of this research. One of the interviewee’s indicated that this existing structure was used to develop the BHSP:

“Here, what I have seen is a completely different picture [from the post-communist countries where this adviser from Albania had experience. Because primary health care project, the one that we AID [USAID] is involved is not really defining a primary health care package of services but it is taking the existing ministry of health primary health care package and is within the parameters of their definition, and they are trying to pick and choose the most essential services to work on improving the quality of those services and increasing access to those services” [nIF_Bi_5]

Although the above quote appears to select elements of existing services to design the BHSP, it seems that the latter was also shaped by adding elements to it from elsewhere. The next section will explore these external origins. For now, it suffices to say that the evidence presented above appears to suggest some degree of continuity from the past and continuity of existing structures in the BHSP.

6.2.2 The role of domestic actors

Findings from the data collected for this research points to the evolving function of the MoH and internal bureaucrats and experts within the MoH in relationship to the introduction and formulation of the BHSP. An interviewee described the initial status of the MoH immediately following the 2003 invasion:

“When the invasion took place in 2003, the ministry of health was practically run not by Iraqis but by the CPA” [IF_UN_3]

Another informant felt that the various international organisations and agencies influenced the MoH under the CPA:

“That was at a time when Iraq was influenced or receptive to the technical knowledge of UN, or World Bank or IMF or whatever” [NIM_UN_7]

The interviewee nevertheless reported changes in the status of the MoH by the time of the introduction of the BHSP:

“But then the actual development of the basic package, by that time we did have a well-established ministry of health, and they took the leadership, and all decisions were agreed and taken by the ministry of health” [NIM_UN_7]
One informant described the formulation of the BHSP as a joint work between the CPA and MoH:

“This was a joint work, not only from the CPA but also people in the ministry of health, and you know….I am very proud to say that those people were actually the technocrats of the Ministry of health” [IF_UN_3]

Document findings provide some corroboration for those claims by indicating that “[The] BHSP was developed by the MoH with the technical support of WHO” (UNDG & WHO 2010). A participant reported that a joint core group of MoH officials and WHO experts developed the package:

“In June 2008, the government and WHO developed a core group which started developing this package” [NIM_UN_7]

Another external interviewee commented on the significant participation of internal experts and decision-makers in the formulation of the BHSP:

“Our implementer have been working really very closely with the ministry of health. So none of these decisions, starting from the prioritisation of services was done without the really heavily involvement of the experts and decision makers at the ministry of health” [nIF_Bi_5]

These quotes appear to suggest that there was a short period when the MoH was run practically by the CPA and influenced by international actors. However, by the time the BHSP was introduced the MoH was seen as being well-developed and as having regained its authority.

The interviewee quoted above went on to suggest that the political changes following the 2003 war enabled internal experts to become influential in the decision-making process. The informant also claimed that decisions made by those experts were ‘educated’ ones and that they had support from the CPA:

“The political leaders were moved away soon after the invasion, and only the technocrats who knew the ins and outs of the health services and the health system were now in charge. So the decision was a very educated one, and it had support from the CPA...so after the invasion, the technocrats filled the positions, the directors and
Another interviewee reiterated the alleged support from the CPA for internal experts and bureaucrats:

“Mr. Haveman [CPA’s MoH adviser] really ensured that there was an Iraqi input into every decision that was made and that did not occur in other ministries...the Iraqis that we worked with had a particular idea that was always there. But they were always at the table in the ministry of health, and Mr. Haveman made a conscious decision from about December 2003 until the transition to make sure that the minister of health had buy-in into every single decision, some of the other ministry advisers would tell the ministers we gonna do this and you know if you do not like it, my way or the highway. Mr. Haveman never had that approach...there was a real tendency to try to turn the control over because ultimately we knew that we are going to be transitioning sooner or later. And Mr. Haveman did not see any upside for holding on up to the last minute” [NIM_USG_12]

So according to this interviewee, the CPA adviser seems to have played a role in ensuring that the Iraqi bureaucrats at the MoH had an influence not only in daily activities but also in setting the agenda for policy making. The interviewees above claim that political changes following 2003 allowed some internal actors (bureaucrats and technocrats), who might have been constrained by political circumstances before 2003, to exert more influence. According to the interviewee, technocrats were able to exert such influence through filling leadership positions that became vacant following the removal of former politicians (Baath regime) and the support of new ones (CPA advisers). Furthermore, the interviewee suggests that those technocrats were knowledgeable of the ‘ins and outs’ of the system.

One individual echoed the claims that bureaucrats at the MoH were knowledgeable and that their skills and expertise were incomparable to similar persons in other contexts:

“Those technical people from the ministry of health were really brilliant. Like I work mostly in Africa, and seriously it is incomparable, (laughs). So all of those bright people were at the table, so we did not bring the knowledge of the problem, we did not....but what we brought was the process and how to think about it and how to prioritise what you wanted to do.” [nIF_Cons_8]

Another interviewee also suggested that decision-making by internal bureaucrats was strong (arguably reflecting their knowledge and expertise) and that external advice was limited and not so much influential:
“I think what I am seeing here actually [is that] the decision-making at the ministry of health level is pretty strong, and it is not very much influenced by external advice...Now the role of the external factors seems to be into some technology transfer” [nIF_Bi_5]

This view was echoed by another informant who claimed that external actors (WHO in this case) suggested ideas and provided technical support, but according to the participant the ownership and leadership remained with the MoH:

“Whatever we do, it is not that we do for us for WHO. We are actually telling the partners that this is an idea that we are bringing. This is how we technically support you but then the ownership and the leadership is with the government so the program, the package or project is for the government rather than the WHO” [NIM_UN_7].

One participant went further to suggest that the final decision was with the decision makers at the MoH. The interviewee below appeared to highlight the significance of governmental authority, whatever the influence or power of external actors:

“The first and final decision is for the ministry of health to do. If you see the proposals of the international organizations, you see that those proposals are designed to meet the needs of the ministry of health and the decision makers. It is the decision makers who are welcoming and allowing the organisations to come and go and work. We cannot, for example, sign a memorandum of understanding or an agreement if the ministry of health doesn’t agree.” [IF_Bi_6]

Another informant also commented on the alleged willingness of internal actors to review, comment on and question even what the interview called ‘technical knowledge and evidence’:

“We would bring them the technical knowledge. We would bring them the evidence. We would bring them the feasibility of what works and what does not work, and they review it and question it in many cases and ultimately they would agree after a lot of reviews, and that was why the process took more than expected to tell you the truth.” [NIM_UN_7]

One non-Iraqi WHO informant commented on the frequent changes in the leadership at the MoH and the parliament as a reason for the long time it took for the introduction of the BHSP:

“When you saw the outcome of the BHSP in 2009 it started in 2003. It was with 5 ministers of health, it was the parliament and the parliament health committee”
Another interviewee highlighted the delay in the implementation of external advice (the BHSP in our case) and claimed that recommendations and advice from international actors were delayed or not even implemented:

“So if you look at the recommendations and advice provided by the international organizations, they are not implemented for long periods of times. This is the case because the system is centralised, and it is managed from the top to bottom. Look at the idea of the BHSP, for example, it started since 2004, but it has not been implemented even now. So advice is not implemented fast enough” [IM_Md_2]

To conclude this section it appears that the existing health system shaped much of the content and the features of the BHSP. The section demonstrated that the BHSP has replicated many of the existing interventions and structures. It appears that many of the interventions included in the BHSP were provided in the past. The section also revealed that the existing system probably provided a source for the proposed new structure introduced by the BHSP. It seems that the MoH was able to regain quickly its control over the agenda-setting process. This development is interesting when viewed in the context of the relatively large number of international organisations which became active in the country following the 2003 war. It is also intriguing given the level of apparent discontent with and criticism of the existing system described in the previous section. The section has also revealed that previous historical models in Iraq (such as the PHA of 1981) cannot explain some of the changes that the BHSP introduced. The next section will highlight those changes and explore their potential external origins.

6.3 Exploring the external origins of the BHSP

This section will present evidence on the role of external factors in the introduction and formulation of the BHSP.

6.3.1 The influence of external models

This subsection presents findings that help in exploring the relevance of external models to Iraq’s BHSP. Findings that are shown in these paragraphs also examine the extent to which other models were copied, emulated, learned from or just used as labels for the BHSP in Iraq.

When asked to consider the relevance of external models in Iraq’s BHSP an external
interviewee argued:

“There are multiplicities of view on this. The extreme version is that everything is very context specific. That the results from one area do not apply to another area that it is you know, there is nothing that you can learn from anywhere else in the world. That is an extreme view, and I think that view is really wrong. I mean it would be crazy to say that you know the experience of a country is completely useless for any other...I think that is...it is not just misguided it is defeatist. It basically says that you will never know, and then all previous knowledge is unhelpful to us. I think there are something that travels quite well, I do not think that human nature and human psychology are so different you know people are still derived by the profit motive (laughs)” (nIM_Md_10).

The same interviewee went on to recommend a careful examination of other experiences and to attempt understanding them and learn from them:

“So my advice generally, I do a lot of policy dialogue, is you will be foolish to take everything that is done elsewhere because it worked here it will work in Nigeria or work in Iraq. That is not smart either. But we all should be experts in what has worked in other countries. And we should try to understand as best as we can what are the conditions that allowed those things to work and to what extent [they can be applied to Iraq] [NIM_Md_10]

An interviewee highlighted a desire by local actors to conform to other models around the world:

“Policy makers may expose to other systems in the world. When you see other systems in the world, you also wish that your system becomes like them as well”. [IF_Bi_6].

One participant reported policy makers were attracted to external models that appeared useful regardless of the local experience and realities:

“Something that looks good and something what other countries are doing rather than what are the needs in-house here.” [NIF_Bi_5]

Another informant argued that Iraq wants to be compared with other advanced settings or join the ranks of developed countries:

“Every government particularly a rich government like Iraq, would like to see that they have, or they are compared with developed governments of the world: US, Canada, UK, Finland, Sweden, countries like that” [nIM_UN_7]

One interviewee felt that the 2003 war was a moment that allowed local actors
acquaint themselves with global benchmarks and attempt to come in line with them:

“[the war was a] critical moments when the Iraqi government sees that has to be somehow in the same line with the international standards such as for instance the millennium development goals.” [nIF_Bi_5]

Findings from interviews and documents presented the BHSP as one of the international models that came from outside the country as this interviewee claimed:

“I am sure about that; I am sure about that [it came from outside]...of course not from inside the country.” [IF_Bi_6]

As an external model, the BHSP was highlighted by another interviewee as the answer to many of health system issues at the global level. The interviewed seemed to suggest that since the BHSP is an effective tool internationally, then surely, according to the interviewee, should also be useful in the context of Iraq:

“The Basic health services package is the solution for the many problems that are faced by the health systems in the world such as Iraq” [IM_USG_14]

According to one informant, the BHSP represented a sophisticated tool that is supported by evidence. Therefore, the participant, argued it is appropriate that governments should financially support the interventions included in such a cutting edge tool:

“I think it [the BHSP] reflects the state of the art in terms of what is proven effective. So if you want evidence based medicine and evidence based healthcare you really need to look at what makes sense for the government to subsidize” [NIMMd_10]

An informant argued that the BHSP should, therefore, be implemented in countries including Iraq:

“We were playing with the idea that yes we do need that in Iraq. And definitely I pretty much believe that a basic health service package should exist in countries” [IF_UN_3]

Findings from documents show that the MoH had decided early on (around 2004) to introduce the BHSP using international models and standards to guide it. The MoH’s vision of 2004 demanded policy-makers to “establish a system where the health fund pays providers for delivering defined packages of basic services” (Iraq Ministry of Health, 2004:17). The vision further recommends that the: “Determination of the composition of these packages
should draw on the experiences of other countries” (Iraq Ministry of Health, 2004:17). The vision also refers explicitly to international models and standards in the development of the BHSP. It stated that “more than 45 separate technical documents were provided by staff to support consideration of international models and standards for health system strengthening” (Iraq Ministry of Health, 2004:12). It also appears that the presence of organisations such as WHO enabled and facilitated the exposure of Iraqi policy-makers to international standards. An interviewee from WHO stated:

“We as technical advisers bring them ideas based on global evidence and say these are the global evidence, standards, protocols and norms of work that WHO was doing in country A, B, C, and we believe, based on our experience, that it will be worthwhile also to introduce it in Iraq” [nIM_UN_7]

The same informant cited the need to align the BHSP with international norms as one of the reasons why developing the BHSP took a long time in Iraq by stating:

“It took almost two years to develop the package. Why two years, because one there was not a previous experience in Iraq along the same lines, and it has to align the components of the package to the international standards” [NIM_UN_7]

Some interviewees also reiterated the examination of other models around the world in the development of the BHSP. One participant specifically claimed that actors examined Afghanistan’s BPHS and used as a model for Iraq:

“At that time, I think we looked at previous work in other countries. I can remember Afghanistan and one other country which we looked at very closely...for Afghanistan, we had the document actually, the Basic Health Service Package document to review. We have interacted with the Afghani health systems, and we have experience about the implementation of the package in Afghanistan,” [IF_UN_3]

Another informant echoed the statement above about the use of Afghanistan as a model for Iraq. The quote below highlights the experience of the interviewee who worked both in Afghanistan and Iraq:

“I can also refer to my own background. When I was working as a region adviser, I found it very intriguing to learn about Afghanistan’s work. In Afghanistan also there was work going on the Basic Health Service Package which was in early 2000 but before that was also in other African countries [NIF_UN_13]
One interviewee went further to argue that Afghanistan’s BPHS functioned as a model for other nations:

“Yes, the fact is it was used by others. I know for example that Liberia they almost copied it totally as it was. But in Afghanistan, the purpose was to deal with Afghanistan. So its development was not intended as a blueprint or a laboratory for other countries. So it was developed specifically for Afghanistan” [NIM_Cons_16]

The quotes above suggest a desire to conform to the international standard of the BHSP. However, other interviewees ruled out the notion of copying completely a particular model from one country into another. With this regards an informant reported:

“I do not think they looked a complete model, because of a simple reason that the idea of a basic services package like this can be looked at but not the model, because every single country have their own system and their own way of looking at it and their own definition of basic package of services.”[NIF_Bi_5]

Another interviewee also expressed scepticism about the possible copying of the BHSP from other ready models:

“Although I don’t have a lot of experience in other countries, but I am not sure the BHSP was copied from other countries” [IM_Md_2]

These doubts about the possible copying of the BHSP from other countries into Iraq were reiterated by another informant. The latter suggested that the BHSP was not installed by international actors using ready models, but rather that it was implicit in the existing Iraqi health system:

“This is not something that we implanted here or done by foreign groups but is something that is pretty much implicit within the existing structures of the ministry of health.” [nIF_Bi_5]

One interviewee went further to doubt the possibility of copying a policy such as the BHSP into:

“There is no possibility to import any system from the world. It is impossible to import a system from outside the country.” [IF_Bi_6]

Some attributed the lack of complete copying to notions of national differences and uniqueness:
“Maybe partly national pride, it says we are different, whatever works somewhere else it does not apply to us because we are different. Yes sometimes that is true, but other times it is really not” [NIMMd_10]

Other interviewees indicated that Iraq may have learned from some aspects of the BHSP in other countries (particularly Afghanistan) rather than using a ready model as a blueprint:

“I am not sure that you could say [that Iraq borrowed its BHSP from Afghanistan]. Maybe looking at some of the content of the package itself, and it could be something that can be learned you know...many of the services included in it are maternal and child health services which are largely supported within a context of most of the basic packages” [NIMCons_9]

One informant argued that even the supposedly original model of Afghanistan did not develop as one uniform package but rather was drawn up from multiple sources.

“They were components, for example, they cited from Latin America some good family planning programs and some immunization programmes. I don’t think that they were packages per se, but they were components of what ultimately became the BPHS. So there were some cost-effective programs that had the impact they said that we need to come up with not just funding a bunch of vertical programs but something that is integrated and far more a big picture view. So that might be slightly misstated, but they were not complete packages by themselves, but they were components of what ended up to be the basic package, citing different examples of what had happened in different places in the world”[NIMCons_16]

Another participant felt that the claimed successes of Afghanistan experiment with the basic package of health services may have inspired actors in Iraq:

“The idea of the basic health service package came later after the success it had in Afghanistan, and its ability to advance the health services in that country to a great extent and also to extend the health services to the rural areas, because those health services existed only in the capital city and not in the rural areas through establishing the health posts (that we call health houses in Iraq). So they saw that there is a great benefit from this kind of policy” [IMUSG_14]

Finally, an informant argued that the BHSP did not introduce any changes, but rather it labelled the existing services with a new name:

“I think the only thing that changed was the term. Now they are calling it a package of services. So I think this is just terms that are introduced most probably by international organizations and actors.”[IMMd_2]
In short, the findings presented in this subsection has highlighted a desire early on following the 2003 war to adopt external models and conform to international standards. The findings suggest that the BHSP was one such international standard. However, the interviewee data also appears to underline an absence of complete copying of the BHSP from other models by Iraq. They rather report elements of learning and inspiration rather than copying entire models. Some interviewees seemed to suggest that Iraq’s BHSP is nothing more than a relabelling of existing services with a new name. The absence of complete copying is supported by the evidence presented in the previous chapter about the differences between Iraq’s BHSP and other similar models. The similarities between those packages, however, might be viewed as evidence supporting the notions of learning, inspiration or emulation.

6.3.2 The role of external actors

This subsection presents findings from interviews and some document data which shed light on the role of external actors in the introduction of the BHSP in Iraq. The subsection also explores the dynamics of interactions among internal and external actors and begins to examine some of the disagreements and tensions among them.

Several interviewees commented on contextual factors that enabled external actors to exert influence in Iraq and domestic actors to build relationships with external ones. An interviewee reported the involvement of a considerable number of external actors during and following the 2003 war:

“Each and every one who was interested in health and working in the area of health was working there. NGOs were mushrooming, and UN organizations like WHO, UNICEF, UNHCR were there, the ones that were actually there, they were providing a lot of support for building the capacity and training, yeah...so many people were there.” [IF_UN_3]

Another informant commented on other contextual factors that arguably allowed internal actors to start relationships with others abroad following the end of Iraq’s isolation from the rest of the world:

“The system has been sort of stagnating for years. So this was sort of re-open the door and establish links between the Iraqi officials and the health officials in other
Findings from document and interviewee data suggest that several of the influential external actors advocated the introduction of the BHSP in Iraq. One interviewee [non-Iraqi from USAID] stressed the role of external actors in advocating the introduction of a BHSP to Iraq by claiming:

“I am sure that the idea was not from the decision makers from inside the country. Because I saw that most of the decision makers are political decision-makers” [IF_Bi_6]

The representative of the World Bank in the Iraq Health Symposium of 2008 stressed the importance of introducing a BHSP. This representative indicated that “the bottom line is to define the basic health package - a minimum package of health services to be provided at each level of care. It is also necessary to translate this basic package into investment and operational requirements, to include physical infrastructure, staffing, equipment, supplies and operating costs” (Tarantino et al. 2008:45). The BHSP also featured in the International Compact with Iraq (ICI) which the country signed with the United Nations in 2007 (UNAMI 2007). One of the items included in the Human Development and Human Security group of benchmarks was to “establish a policy framework that defines the content of a package of essential health services accessible to all Iraqis regardless of their ability to pay” (Government of Iraq 2007:107). An informant (non-Iraqi former WHO representative) also expressed an alleged strong advocacy in part of the WHO for the existence of a BHSP:

“One of the things that we continuously said was that there should be a core package of services that are non-questionable, and that should be provided by the government” [NIF_UN_13]

Another actor (Oxford Policy Management) which developed a roadmap for reforms in the health sector viewed the BHSP as the “key transitional step towards primary health care based on family medicine model” (Oxford Policy Management 2011:16).

Interviewees questioned in this research, however, had different views about who among external actors might have handled introducing the idea of the BHSP. An interviewee claimed that WHO was the organisation responsible for presenting the concept in the first place:
“Actually, it would have been WHO because we have been doing it in many other countries in the region. And when I say the region I mean the eastern Mediterranean region. There are 23 countries which WHO serve as part of this region. It is based in Cairo...when WHO introduced this idea the ministry of health was very comfortable with it and the partners were very comfortable with, and that is why it started, but the ownership and leadership is the ministry of health” [NIM_UN_7]

It should be noted that the above quote is from an interviewee who is affiliated with WHO. The interviewee went on to suggest that the membership of Iraq in WHO allowed the former to realise the ‘strengths’ of WHO and be ‘more receptive’ to its prescriptions (including the BHSP):

“In almost all the cases the government is receptive because they are the governing bodies of WHO they know the strengths of WHO” [nIM_UN_7]

The interviewee also argued that whose experience with the BHSP in the region allowed it to advocate the policy in Iraq. The interviewee elaborated this point by providing examples of the experience of WHO in other countries in the area:

“The BHSP has been done in Oman, and done in Iran, it has been done in Yemen, it has been done in Libya it has been done in Morocco, and it has been done in Afghanistan. And so we wanted to see because Iraq was also recovering from a conflict with a lot of challenges in the health system, not only the migration of professionals from the country, but the infrastructure was also damaged”[NIM_UN_7]

In this informant’s opinion, similar to the other countries in the region that went through conflict, Iraq also experienced damage to its infrastructure and migration of professionals. The interviewee argued that it was necessary to introduce the BHSP similar to the other post-conflict contexts. In short, the quotes above for that particular interviewee appear to suggest that WHO was the sole external actor who has introduced the concept of the BHSP into Iraq.

At least one interviewee did not share the view that WHO was the organisations that introduced the idea of the BHSP to Iraq. An informant (from USAID) claimed:

“I am not sure about whether the idea came from WHO; it is not necessary that WHO is the only organisation. But to exactly tell who was started the idea, I don’t know”
This interviewee reported that the notion of introducing a BHSP has emerged from the discussions and interactions among internal and external actors:

“The interaction between the Iraqi policy makers and the international experts is what produced the idea [of the BHSP]... I think the idea started during these recent years; it happened through the interactions between the international organizations mostly WHO and the staff at the ministry of health... There is an exchange of ideas with those organizations and experts at the international level... there is a continuous discussion between the decision makers in Iraq”. [IF_Bi_6]

Several interviewees highlighted particular features of the interactions among internal and external actors. One external participant characterised those interactions as ‘collegial’ and beneficial for internal technocrats:

“To gain from their experiences and to create linkages and to establish collegial relationships between them so that they can benefit from the experiences outside Iraq.” [NIM_Bi_4]

An external participant felt that the officials at the ministry of health were ‘keen’ on the work that this particular informant was doing in the country. The interviewee also suggested that the MoH was in agreement with this informant’s organisation on the challenges facing the system:

“The ministry was really keen on the work that we did, and I thought that it was well accepted, and my feeling is that we were all in agreement with the challenges” [NIF_Cons_8]

One non-Iraqi informant suggested that internal experts were receptive to ideas from external actors. The interviewee attributed this receptivity to the alleged presence of professionals at the MoH, and that external actor’s suggestions, in this view, were supported by evidence:

“I can tell you that they are even more receptive because we have now more professional people at the ministry of health who know regional experience and global experience and who with evidence are much more convinced than those who do not have exposure.” [NIM_UN_7]

An Iraqi participant shared the view that the presence of experts at the MoH facilitated the understanding between internal and external individuals:
“[The interaction] helped because when you did it all and worked right from the beginning, and you understand what needs to be done. Then you can make a difference” [IF_UN_3]

The same interviewee, however, went on to suggest that the ‘phase’ of what can be termed ‘receptive interactions’ among internal technocrats and external actors did not last long:

“This let's say, phase lasted for less than two years until the new politicians took over and then we were back to square one.” [IF_UN_3]

The quote above attributed the claimed temporary nature of the interactions to the removal of the conditions that enabled originally internal experts to exert influence: the departure of politicians (kindly refer to the previous section). The entry of new politicians has limited (according to this account) the receptivity to external influence and in this interviewee’s terms returned the situation to ‘square one’. The quotes above might give the impression that interactions between external actors and internal technocrats were smooth and passive in part of the latter.

However, an Iraqi participant felt that domestic actors were able to exercise autonomy in the extent to which they adhere to the recommendations of particular external actors:

“So it is true that the external actors provide advice and recommendations, but I am not sure that the government is adhering or working on those recommendations and advice. The situation with the World Bank might be different because the latter provides loans, and there are conditions attached to those loans. But as far as the USAID and WHO go they are not imposing things on the decision makers in Iraq because they are doing simple things such as training and workshops. [IM_Md_2].

The informant above makes a distinction between actors who can impose policies on Iraq and those who cannot. Along the lines of the argument that internal actors had choice, an Iraqi informant highlighted the willingness and ability of domestic actors to debate, question and modified recommendations by external ones:

“Every decision was brought to the steering committee (it was meeting every three months) to review the technical, managerial, administrative work and come to recommendations which then the team members work together to implement. So for example, when the first draft of the Basic health service package was developed it was for 3 days extensive meeting to review each and every components, sector, guidelines
which was included and there were a lot of inputs and the decision was made that we need to test it in the field in certain districts and based on that we incorporate the modifications and changes in another draft.” [NIM_UN_7]

Despite multiple attempts, it was not possible to verify those claims by investigating the changes that might have occurred in the BHSP document as a result of the input from domestic actors. One participant stated the following when asked specifically about copies of initial drafts of the BHSP:

“It was not really a package, the consultant started doing some work but no there was no well-developed package, it was just some initial work that they were doing and then the consultants he or she (he) did not maintain that and maybe had other work to do, and the ministry wanted things to go more quickly as well so that was when kind of stepped in and played more active role.” [NIM_Cons_16]

Furthermore, another interviewee was also asked about initial drafts but responded by saying:

“When the package itself was developed I was not involved in the drafting” [IM_USG_14]

In contrast to the depicted influence of internal actors, an external informant reported ‘babysitting’ or ‘hand-holding’ relationships between external and internal actors particularly at the implementation stage of the process:

“Donors like USAID we are on the ground with the implementers and we have contractors who sit here and then kind of babysit the ministry and hand holding processes with them, and still we find it very very difficult to discuss and then to come to commons sense agreement about what is needed” [NIF_Bi_5]

Other interviewees highlighted some disagreements and tensions during those interactions. A former Iraqi Minister of Health commented specifically on the role of WHO in the process:

“The role of the World Health Organization is not very clear in the third world countries. It is not clear at all. They think that the World Health Organization is sitting in the driving seat in the country, and they are driving the country. The country should be in the driving seat. There were actually disagreements, but then these disagreements were solved. We told them that you are advisers, we have problems, and we have priorities, and you help us with solving those problems and organising those priorities” [IM_MoH_11].

In contrast, an Iraqi informant questioned the role of the government and showed
scepticism about too much control by the latter over the formulation and implementation of the BHSP:

“In Iraq, we entered the headache of the government implementing which is a disaster. Because of course once the government enters it begins with corruption, waste and squandering money from here and there through different ways” [IM_USG_14]

To conclude, this sub-section presented findings from interview and document data that explored the roles of external actors in the introduction and formulation of the BHSP. It showed that there is some evidence to suggest that external actors (WHO according to some accounts) introduced the idea of the BHSP in Iraq. However, the findings also appear to propose that internal experts and technocrats were not passive recipients of the policy. Rather, according to some interviewees, those internal technocrats were able to dispute, debate and provide input throughout the process of formulating the BHSP. They were enabled through the removal of political constraints of previous times, the willingness of the main external actors such as the CPA to invite their input, and their interactions with other external actors. The findings also highlighted some disagreements between internal and external actors. The data showed disagreement in relationship to the ownership of the process.

6.4 Views of external and internal actors on user fees:
As presented in earlier chapters Iraq’s BHSP incorporated user fees as a source of its financing. Such decision is interesting given the expanding share of health in Iraq’s growing GDP and increasingly vocal calls for the removal of user fees at the primary health care level. This section presents findings from interview data and to a lesser extent from documents that provided evidence on the potential internal and/or external origins of user fees in the BHSP. Although references were made to user fees in the documents analysed in this research, however, they did not offer substantive discussions to infer accurate conclusions.

The BHSP introduced the option of charging patients as a way to raise funds for the BHSP by recommending the “financing the BHSP through an integrated combination of public and private expenditures.” It continued to suggest that “households may contribute affordable visit fees and co-payments for drugs and investigations” (Ministry of Health,
2009:98). Before the publishing of the BHSP, the MoH’s vision of 2004 recommended that “all Iraqi citizens should be entitled to equitable coverage under a basic benefits package funded from a public pool of funds. Everyone, except a few exempt categories, would make some type of co-payment when receiving services.” (Iraq Ministry of Health, 2004:28).

Although the two quotes are similar, there are notable departures that should be noticed. The 2004 MoH’s vision argues for exemption categories for co-payments. The BHSP document, on the other hand, did not offer such an explicit recommendation.

User fees, however, were not entirely new in Iraq’s health policy. They were introduced in Iraq six years before the 2003 war and twelve years before the formal introduction of the BHSP. Iraq introduced user fees in the context of tremendous financial and political difficulties introduced by sanctions and wars (please refer to chapter four on page 89). An Iraqi former World Bank consultant emphasised the significance of that context by saying:

“The idea of charging patient money at the primary health care level (and also at hospitals) started in the 90s when there were sanctions, and the public expenditure on the services fell. Then the government did not have a choice but to charge money”

[IM_Md_2]

The subsections below presents the arguments for and against user fees as part of the BHSP by key domestic and external actors.

6.4.1 Arguing for user fees by domestic actors

One domestic informant supported the user fee decision in the context of the BHSP. The participant argued that retaining user charges in the democratic system prove the appropriateness of a decision that was made under dictatorship were appropriate:

 “[User fees] did not start after the invasion. Actually, user charges were in place before the invasion. During the years of sanctions...there was the decision of what they called at the time ‘self-financing’ where health facilities and actually the ministry of health developed some levels of user fees for primary health care services...for hospital services and that was one of the points that was held against the system and the regime, that now people are paying for health services. When the regime changed, actually this policy was adopted and not cancelled which speaks for the value of
putting a user fee against the service because under the democratic rule of the post-invasion era now user fees were imposed” [IF_UN_3].

Several Iraqi interviewees also supported the consideration of user fees as a source of financing the BHSP. They cited several arguments to justify their position on user fees. One interviewee argued that user fees would prevent people from abusing the system:

“I saw that people were abusing the services because the services were free of charge. To me, that was a bad thing, because if you open a service free of charge, and people do not need it, they will still come because they are not losing anything. So putting, you know, a nominal fee or a token and you say that you need to pay to get this service” [IF_UN_3]

So this interviewee expressed some level of suspicion towards the people. The interviewee argued that people will abuse the system if the latter is free. On the other hand, one interviewee claimed that the previous free services ‘corrupted’ people and that health services should not be free:

“The reason [people disagreed on user fees] is because they are used to be corrupted by the previous system that health should be free. It just should not be free Ok.”. [IM_Ac_1]

Another Iraqi interviewee also presented a strong view by completely rejecting free health services. The informant argued that even higher charges (than those currently exist) should be levied on patients so that the latter ‘appreciate’ the services more:

“Free service that the patients come and go without paying a dime was not acceptable at all. It was regarded as a tool for the collapse of the system. On the contrary, we were defending the notion to increase the user charges more so that the citizen realises the importance of the services and not throwing the medicine that they get from the pharmacy in the street” [IM_USG_14]

The interviewee was worried that free services would result in the collapse of the system. The same interviewee went on to suggest that user fees are useful means for mobilising resources and using them to support various functions at health facilities:

“[User fees] will complement the health service financing. No matter how much the proportion of the user fee is to the health budget, it will help to improve the service in a way or another. By spending it in the health centre for more equipment, maybe even expand the service package or cover more people with the lower degree of user fees. So it really helps. I would not decide how it be used, but I believe if we have low
The utility of user fees, in the interviewee’s opinion, were related to the claimed ability to spend the extra resources to buy more equipment or to expand the services. However, the interviewee also expressed concerns about corruption and the possibility of abusing those additional resources for purposes other than improving the services. Another Iraqi consultant at the World Bank supported user fees for their claimed role in improving the quality of provided services and preventing ‘misuse’:

“[free of charge] is the concept that I have issues with. I am not against it 100%, but the important thing that should be observed is quality. The free of charge for the services should not be at the expense of the quality of the services, and it should not be on the expenses of the misuse of services. It is true that it is free in other countries, but if we make it free in our countries we will jeopardise the quality of the services, and we will jeopardise the misuse of services which is huge. Because if you measure it financially and economically, you will find that there is a huge loss in the services because of the misuse of services.” [IM_Md_15]

Similarly, a former Iraqi official at the MoH went further to argue that the lack of user fees is unacceptable and that the latter is the only sustainable source of financing health care. This informant further argued that paying for the services introduces a sense of ownership in part of the patient:

“The only sustainable source of financing in health care is out-of-pocket. All of the other sources of financing are fluctuating. The out-of-pocket source not only provide sustainability to the financing but also it offers ownership to the process and provide a sense of ownership to the person. Because he will think that he owns the services that he is buying, and he has the right to get more, and he has the right to defend that service” [IM_USG_14]

An Iraqi academic also suggested that free health services are ‘useless’, but also argued for taking the ability to pay in consideration in deciding the level of fees:

“[Health] was not supposed to be free because free is useless in health. It also should not be paid according to what is available now. Because the payment should be according to the ability to pay not according for example he is rich or poor you get the same money from them” [IM_Ac_1]

The same interviewee provided the following analogy to support the argument presented earlier:
“Just imagine, if you have a plumbing problem at home, the plumber comes for 15 minutes, how much you will expect, at least 50 dollars, so that is plumbing. If you want to put your soul in the hand of a person, do you think that paying 10 dollars is too much? It is not.” [IM_Ac_1]

An Iraqi consultant at an international financial agency expressed the need to conform to other countries that are considering or have introduced user fees. This participant indicated that Iraq should adopt user fees to finance its BHSP because other rich nations in the region did the same:

“Saudi Arabia, which has so many resources, started talking about free of charge and how they can get rid of it. In Yemen, they are talking about cost sharing because first it introduces a sense of ownership and second to improve the quality of the health services” [Interviewee_15]

In contrast to these opinions, a former minister of health reported a change in his views on user fees. This informant did not deny that he initially supported the idea but later changed his opinion about it:

“Let me tell you how the change happened, because of the increase in the oil production, the improvement in the economic situation of the country, and an increase in the revenues of the state. So it is the moral obligation of the country is to provide the basic services that are health and education. So if you have resources, you do not need to gather resources from the people, on these bases I changed my idea. When you take the money, you should take it from the able people, who usually avoid going to the primary health centres, usually.” [IM_MoH_11]

In addition to this change in opinions, one participant also alluded to resistance from political parties to the notion of charging user fees:

“I noticed that there were some political parties in the ministry of health... for example, the Sadrist were against the idea of taking money from the people. Because they were thinking that it is better to provide those services for free and for the sake of God service. Other political parties were using this about as a political means to show that they are good for the Iraqi people regardless of what that has to mean in terms of the governance of health.” [IM_USG_14]

6.4.2 The views of external actors on user fees

The position of internal interviewees on user fees raises questions about the perspective of external actors with regards to the same topic. When questioned about their role in the introduction of user fees as part of the BHSP, some external interviewees distanced
themselves from the decision. One informant argued that the MoH was behind such decision and that they were against it:

“[user fees] was purely from the government, and we did not agree to it, and that was why it is not implemented to tell you the truth at all of the public sector services…The concern of the ministry of health was till how long we will be subsidising the services, paying from the public sector basket, the community has to take some responsibility.” [nIM_UN_7]

An external consultant who was involved in the deliberations about the BHSP claimed that they did not have a position on user fees and indicated that the decision to include user fees was an ‘internal one’:

“Regarding user fees we had no position on this and this was an internal decision. We had only carried out a broad review of possible mechanisms to finance the sector” [nIF_Cons_17]

One external interviewee also disagreed with user fees and presented several arguments on why they did not make sense in Iraq. The interviewee argued for improving the efficiency of existing services rather than adding extra resources through user charges. The participants also expressed concerns about corruption and abuse of the collected resources:

“To introduce a user fee from scratch, you need to have certain criteria in place. And first and foremost of the criteria is really the need for money. If you have a country where you have the 10% of the GDP going to health before adding money from any other source and the least from the beneficiaries who are not used to pay you have to maximize the efficiency of the use of the existing funding. Because pooling the funding into a pot that is almost full and nobody seems to know what to do with it, it does not seem to be effective and totally not efficient. It fuels corruption rather than addressing any issue. I am against it in only one sense, do not put money where the money has not been absorbed, use that first and then add more. That is my thinking”. [NIF_Bi_5].

Another external interviewee, however, reported that that the latter’s organisation suggested the idea of user fees to the MoH. The participant also claimed that the government had a general acceptance for user fees because, in the interviewee’s opinion, it represented an international best practice:

“We as the implementer of a USAID-funded project discussed the concept [of user fees] with senior officials at the Ministry of Health. There was general acceptance by Iraqi officials. Why? Because it is a well-documented approach as international best
Finally, one of the internal interviewees indicated that the last version of the BHSP represented a compromise to provide a smaller number of interventions while charging for excluded services:

“But because we were aware of the realities of the Iraqi situation, we disputed the idea with them and undertook workshops and other activities. We concluded that we need to provide health services to the Iraqi people but we need to decrease the number of those services and achieve maximum health gains through the cheapest prices, and the services that are not included should be paid” [IM_USG_14].

To conclude, this section has explored the preferences and perceptions of the actors involved in the introduction of the BHSP concerning user fees. The section has revealed that internal technocrats and bureaucrats perhaps supported the recognition of user fees as a source of financing the BHSP. The section also showed that several external actors either distanced themselves from the decision of including user fees or implicitly supported the ruling of the MoH to include those citing international best practices as a justification.

6.5 Summary
This chapter has used findings from interview and document data to explore the origins of the BHSP and the relative roles of external models and internal structures. It also explored the roles of domestic and external actors and their interactions in the process of introducing and formulating the BHSP. It also explored the views of various internal and external actors about the introduction of user fees as part of the BHSP.

The chapter has shown that the Iraq war of 2003 offered the contextual setting for the introduction of the BHSP. The influx of international actors combined with changes in the leadership at the MoH allowed for an examination of the problems of the health system and the offering of perceived solutions. Findings from document and interview data have shown that the BHSP was introduced as an idea early on following the war. External actors (mainly WHO) appear to have suggested the idea of the BHSP as a solution to perceived problems. The removal of former politicians following the changes by the 2003 war and the emergence of internal technocrats at the MoH level appears to have helped with a rapid introduction of the idea of the BHSP into the policy agenda. External actors seem to have offered models
from other post-conflict countries (such as Afghanistan) for Iraq to adopt. However, as the previous chapter has shown, despite interesting similarities, Iraq’s BHSP differs in important aspects from other models around the world. The findings of this chapter have shown that various internal and external factors shed some light on the formulation of Iraq’s BHSP to its final form.

It also seems that local actors were able to debate, dispute and challenge the recommendations of external actors. The chapter has shown that the BHSP has inherited some of its features from prior models in Iraq itself. The chapter has also demonstrated that the existing system offered some of the structures of the BHSP. This persistence and continuity of previous and current features might have been mediated through local actors. The influence of local factors is to the extent that some suggested that what was introduced was the label of the BHSP only. Most of the contents did either existed previously or persisted from prior models. The chapter also highlighted the divergence of opinions on the functions of the main actors, with contested claims about the role of MOH as well as comparative significance and impact of WHO and external actors. In this regard, some have suggested the MoH was capable of debating and adapting the models that were proposed by external actors. Several informants appeared to suggest that the role of external actors was limited to introducing ideas that were later adapted by the MoH and related domestic players.

The chapter demonstrated that domestic and external actors appeared to have different opinions about the user fees as a source of funding the BHSP. Many of the domestic actors interviewed in this research argued for the introduction of user fees and highlighted their utility. Several external actors, on the other hand, either distanced themselves from the decision to introduce user fees or declared no position. Some external actors indicated that the government, rather than external players, made the decision to adopt user fees. One external interviewee, however, seemed to agree with such decision citing international best practices.
Catalysing system-wide change through the BHSP

The purpose of this chapter is to explore the views of external and domestic actors with regards to the extent to which the BHSP was intended for or contributed to system-wide changes. The chapter uses findings from documents and interview data to examine the views and opinions of internal and external actors on several wider systemic effects of the BHSP. In doing so, the chapter aims to explore areas of consistency between the content of the BHSP and preferences of specific actors.

The system-wide effects of the BHSP that emerged from the data corresponded to several themes that will be addressed in turn in this chapter. The first section will present evidence pertaining to the role of the BHSP in debates concerning the relative roles of primary, secondary and tertiary care. The next section situates those debates in the context of discussions about insurance and viewing the BHSP as a benefits package of an insurance scheme. The following section will present evidence about the place of the BHSP in the wider advocacy for privatising health services. Then the role of the BHSP in achieving efficiency objectives will be addressed next.

7.1 Reorienting the system towards primary health care

The focus of this section is on the views of external and internal actors on the approach of the system towards the provision of services various levels of the health system in the context of the BHSP.

Several actors, through interviews and documents, expressed criticism towards the alleged ‘hospital-based’, ‘capital-intensive’ and ‘wasteful’ nature of the health system in Iraq. The joint assessment by WHO and World Bank argued that “the system is based on a hospital-oriented, capital-intensive model that requires large-scale imports of medicines, medical equipment, and even health workers” (UN & World Bank, 2003:1). The Iraqi minister of health at the time reiterated those concerns by describing the system as “basically hospital-oriented with inadequate emphasis on sustainable health development… excessive focus on clinical medicine has led to limited involvement of the government and the health
system in tackling the underlying risks to health experienced by much of the population.” (Alwan, 2004:49). The BHSP document itself provided a similar assessment of the existing system. It stated that “the health care system in Iraq has been based on a hospital oriented and capital-intensive model” (Ministry of Health, 2009:1). Several Iraqi and non-Iraqi interviewees also made similar arguments and presented some explanations for the claimed hospital-based approach. An Iraqi interviewee reiterated the claims presented in the document findings above and suggested that:

“[The health system in Iraq is] based on hospital system, capital intensive not labour intensive, so most of the investment is in the capital investment, building, equipment” [IM_USG_14]

One non-Iraqi informant indicated that the country had a significant infrastructure but not an essential package of services:

“The question on the table was the big big challenge in Iraq is that you have a large infrastructure right? But you do not have a basic package.” [NIF_Cons_8]

The same participant continued to argue that midwives or nurses can provide the majority of services offered at hospitals presumably because of the low cost-effectiveness of services rendered at the latter facilities:

“You have really big and, therefore, heavy infrastructure that treats 80% of the things that can be treated by a nurse or a midwife” [NIF_Cons_8]

One informant further elaborated this point by providing some statistics. The interview indicated that Iraq dedicated a large proportion of its growing GDP to health compared to other countries. However, its indicators were worse compared to nations that spend less. Therefore, in this interviewee’s opinion, this situation called for an improvement in efficiency of the use of existing resources:

“This portion is one of the biggest in the region and beyond (9, 7% of GDP, compared to only 4.5% of DGP in Jordan, and only 2, and 7% in Albania, where I come from). Both these countries have much better indicators than Iraq. This shows that money is not the problem. Under the present circumstances, where Iraq's government revenues due to oil production, are increasing, it is clear that before searching for new sources of income, it is critical to improve the efficiency and absorption capacity for the existing resources” [NIF_Bi_5]
Findings from this research appear to suggest that several key external actors stressed the need for transforming the system to one that is based on a primary health care approach. The joint WHO and World Bank assessment report of 2003 argued that “now [is] an opportunity for policies that prioritise the development of public health services and the creation of a PHC system countrywide” (UN & World Bank, 2003:6). It further advocated for “transforming [the] inefficient centrally planned/curative care-based services to a new system based on primary care” (UN & World Bank, 2003:10). One former director of a key international organisation in Iraq expressed the organisation’s commitment to reorient policies towards primary health care:

“[Our] delegation’s goal was to move the thinking and policy toward primary health care; we issued a two-page document indicating that the health care in Iraq should be based on primary health care” [NIF_UN_13].

One informant referred to her background as experts in primary health care and basic health services packages and as strong supporters of such approach:

“I worked on basic packages of services for a long time. I am a health systems person, so basic packages of health services in primary health care is a cornerstone element of primary health care reform which we have been doing at least in the last (let’s say) 8 years in Albania. So yes, I would say that I have quite an experience in basic packages of services in Albania and other East European post-communist situations and countries” [NIF_Bi_5]

Another external participant raised issues related to the difficulty of convincing the authorities of the importance of the primary health care approach. The informant argued that it is up to the government to accept those proposals and that sometimes the latter does not accept those changes:

“Even if you have loads of investment, not enough as it should but more investment has been done in tertiary care, so if that is something that the government wants to change, because some government do not want to change they want to keep this focus, I think that was the first question, and if the focus needs to change then how it will be changes and how it is financed, well how much does it cost and how it is going to be financed?”[NIF_Cons_8]

Despite those concerns, several Iraqi participants and internal documents appeared to share the desire to shift the approach from a tertiary and secondary hospital based to one of a primary health care orientation. The MoH’s vision published in 2004 recommended that
“health care delivery must shift from a curative model to one that gives first priority to primary health care and public health services.” (Iraq Ministry of Health, 2004:28).

Several Iraqi interviewees echoed those calls for shifting the health system from its alleged hospital-based and tertiary care approach to one based on primary health care (using the BHSP) as its foundation. One interviewee reported that basing the health system on a primary health care approach was one of the recommendations of the early post-2003 period:

“The first recommendation in that conference [2008] was that the primary health care should be regarded as the basis for the health care services in Iraq” [IM_Md_15]

Another participant expressed strong views by arguing for restructuring the health system around primary health care. The participant justified this opinion based on the claim that primary care services serve the bulk of the population:

“I am a primary health care person, and I am a person who believes in structuring all the health system around primary health care and building it from there. Because this is where you serve the bulk of the population…So in an ideal world, this is how health services should be delivered.” [IF_UN_3]

Despite these calls to transform the system into one based on primary health care approach, several interviewees indicated that the system continued functioning as before. A participant reported that the activities that followed were in practice contradictory to the recommendations of more focus on primary health care:

“Most of the activities that followed contradicted the notion that primary health care should be the basis for the health services in the country.” [IM_Md_15]

Another Iraqi participant claimed that the MoH did not have a strategic thinking to transform the health system in the country to one based on primary health care approach. The informant reported that all of the activities that are attempting to do so are conducted by international actors rather than local authorities:

“There is no strategic thinking, for transferring Iraq from the hospital based to primary health care and public health is all international efforts, you have the USAID, World Bank” [IM_USG_14].

An Iraqi official at a bilateral donor agency indicated that decision-makers are talking
about primary health care but continue building hospitals because their effects are quicker and are more ‘visible’:

“It is true that the policy makers and decision makers are talking about primary health care, but they are building a hospital because it is quicker and more visible. This is more rapid than for example providing a family medicine service.” [IF_Bi_6]

One Iraqi informant also contrasted this fast and visible nature of hospital projects to the slow and latent impact of primary health care services and projects. The participant argued that politicians invest more in tertiary and secondary care because the latter help them seem right:

“They focused more on building hospitals and most of the resources are dedicated to secondary and tertiary health services. The reason for that is that primary healthcare services result in outcomes that appear after 10-20 years, particularly in the third world countries. In the third world countries, politicians and others would like to have drastic changes so that they can show those changes and appear good.” [IM_Md_15]

Another Iraqi informant attributed the alleged hospital oriented system to the tendency of decision-makers (and their advisers) to advance clinical services rather than primary health care. The participant also commented on the alleged inferiority of public health doctors in comparison to physicians who work in hospitals:

“The system in Iraq is based on hospital and the senior people who are heading the committees in the department of technical affairs or the advisers to the minister of health or the board of advisers of the ministry, all of them are looking for advancing the clinical services only and when you come to the primary health care services that are foundation of the advancement of the health services from the negative to the positive you see that they are very weak. Even the doctors who are studying public health are not respected in the country, and they do not regard them as doctors.” [IM_USG_14]

The same interviewee went on to suggest that doctors, in particular, were influencing the government to focus on sophisticated technologies and advanced interventions rather than basic primary health care services. The participant criticised the tendency of physicians to advocate the introduction of expensive technologies by stating:

“Our problem with the medical doctors in Iraq who are currently working at the ministry of health and the doctors who are planning for the health services and the
government that is convinced by those doctors, is that we need the services that are provided in the UK and USA in terms of the most advanced operations and very sophisticated procedures (liver and brain transplantation...laughs) those things that have no benefits, because you are spending about one million dollars to live an additional 6 months in a miserable life and then die. But nobody is thinking about supporting primary health care," [IM_USG_14]

Another Iraqi informant reiterated this claimed influence and advocacy by clinicians to focus more on hospital-based and tertiary clinical services. The interviewee, however, also argued that ‘the people of Iraq’ prefer hospitals rather than primary health centres:

“Most of the ministers of health are clinicians, and they are focusing more on the hospitals, they talk about primary health care services, but they do not pay it a lot of attention. But when it comes to the practical situation and when it comes to dedicating resources (you know that Iraq needs 2000 health centres now) it is not appealing to the ministers because the general idea for people in Iraq is that I want to go to the hospital rather than the health clinic because the health services in the clinics are not good. This is because our culture is different because they want a consultant. “[IM_Md_15]

One interviewee claimed that some policy-makers at the MoH went so far to suggest closing all primary health care centres and focusing only on hospitals:

“One of the suggestions by one of the Sadrists who is still working in the ministry of health was that is that we should shut down all of the primary health care centres, and we should only focus on the hospitals because the primary health care centres are nothing and people are not working there. [IM_USG_14]

In short, the interview and document findings appear to suggest that several informants and influential organisation viewed the existing health system as wasteful, capital-intensive and hospital-based. As a solution, they seem to suggest transforming the system to one based on primary health care approach using the BHSP as a model. It appears that one of the main intended effects of the BHSP was to help with shifting the system towards a primary health care-based approach. As the next section shows, such reorientation also involved debates about concepts such as insurance and viewing the BHSP as a benefit package of a wider insurance scheme.

7.2 The BHSP as a benefit package of an insurance scheme
This section explores the views of participants on insurance in the context of the BHSP. It appears that attempts to reorient the health system towards one that is based on a primary
health care approach involved debates about whether the BHSP represented a benefit package of an insurance scheme. Relatedly, such attempts also involved the consideration of insurance schemes for covering secondary and tertiary levels of health services.

As presented in chapter four, the MoH is the central pool for health resources. Limited numbers of private health insurance companies and scheme did exist in Iraq prior to the Iraq war of 2003 (Farag et al. 2004). However, none of those insurance companies offered private health insurance.

Findings mainly from the interview data and also from key documents suggest that actors saw the lack of an official insurance scheme as a shortcoming of the system. A non-Iraqi official working at a bilateral donor highlighted, in a critical tone, the absence of any insurance policy by contrasting that with the government being a source of the health budget:

“Iraq doesn't have any formal health insurance fund or policy. Health budget comes from the government sources as a portion of the overall government budget. [NIF_Bi_5]

An Iraqi official at the same donor agency claimed that the lack of health insurance made the health system in Iraq ‘completely’ distinct from other countries:

“The way the system is financed here seems to be completely different from other countries; they do not have health insurance” [IF_Bi_6]

The participant above went further to suggest that Iraq is the only country in the world that did not have insurance. The interviewee claimed that all countries in the world deduct the expenses of health services from the wages of employees:

“And remember that we don’t have insurance, we are the only country in the world that does not have insurance. All of the countries, the citizen when she or he receives health services, they cut the expenses from the wage that she or he receives because they have health insurance” [IF_Bi_6]

Formal government documents and several interviewees called for the introduction of health insurance. The MoH, in its 2004 vision expected that “health insurance may emerge after the new health system matures” (Iraq Ministry of Health, 2004:28). However, the vision also recommended that “the source of financing should initially be general revenue budget funds” (Iraq Ministry of Health, 2004:28). A former minister of health appeared to view
insurance as a tool to engage people in both the financing and decision-making process by indicating:

“We developed a health reform plan for Iraq, the first point, there were ten points that was in 2008 when we [the minister] first came was the social participation in the planning and the financing of the health system. The idea was to develop a health financing system through health insurance” [IM_MoH_11]

Although the above quotes do not clearly describe the nature of the suggested insurance policies, some findings from document and interview data alluded to private health insurance. The MoH’s 2004 vision encouraged policymakers to “consider carefully the possibility of introducing private health insurance into the system.”(Iraq Ministry of Health, 2004:18). The joint WHO and World Bank 2003 assessment also made references to private health insurance by indicating that “there needs to be an effective regulatory structure… in place for private health insurance” (UN & World Bank, 2003:19). In contrast, but closely related, a former minister of health argued for insurance policies (without specifying their private or social nature) that cover the private sector by indicating:

“So the idea now is to develop a health insurance plan over the next 15-20 years. In the first year, we should establish an institution that is responsible for interacting with the private sector, because the public facilities are insured in principle” [IM_MoH_11]

Iraq’s BHSP document also highlighted the intention of policymakers to consider the introduction of health insurance. The document reported that “the Government of Iraq and the MoH, in specific, are looking into different health care financing mechanisms to ensure long-term financial sustainability. One option is adopting a social health insurance to finance secondary and tertiary care.”(Ministry of Health, 2009:98). It is worth acknowledging, however, that the BHSP document made a distinction between secondary and tertiary health care on one hand and primary health care on the other. It should also be noted that the BHSP explicitly mentions social health insurance (for secondary and tertiary care) rather than private health insurance as pointed out by the other official documents cited above. In contrast to its calls for social health insurance to finance secondary and tertiary care, the BHSP document indicated that “universal access to PHC, through the BHSP, will form the cornerstone of any health system reform to be adopted.”(Ministry of Health, 2009:98). A former minister of health reiterated the need for universal access to the BHSP by indicating that those services should be guaranteed:
“I still think that health insurance is important, but the essential health services should be guaranteed. These services should be provided in a country like Iraq with abundant resources, not excellent but good resources.” [IM_MoH_11]

In this former minister of health’s opinion, the BHSP should be provided free of charge and without considerations of premiums by users. In another word, the former minister did not think that people should be enrolled in an insurance scheme to be eligible for the BHSP.

One non-Iraqi expert at an international financial agency did not make such an explicit distinction between insurance and the BHSP. The informant argued that the BHSP represent an attempt to establish an insurance system through defining a benefits package. The participant also argued that subsidising included interventions in the package by the government is appropriate because those interventions are, in this informant’s opinion, supported by evidence:

“Now coming back to the really big question you asked like you know does the BPHS really makes sense for Iraq....... And this is true for any country that wants to set up an insurance system is you have to define the benefit package, what things are you gonna cover what things you gonna insure against and you know whether you do vast enlargement or best production....That is a good question for every country to deal with because I think it reflects the state of the art in terms of what is proven effective, so if you want to evidence based medicine and evidence based healthcare you really need to look at what make sense for the government to subsidize, right?” [nIM_Md_10]

These findings appear to tell us that policy makers and other actors discussed the concept of insurance during the introduction and formulation of the BHSP. Some interviewees contrasted Iraq to other countries that have insurance and suggested the need for such policy in the country. It appears that actors discussed different types of insurance including social and private health insurance. It also seems that some interviewees saw the BHSP as a tool to define a benefit package to be covered by insurance. Others saw it as a mean to determine a package to be funded and provided by the state with some form of insurance covering secondary and tertiary services.
7.3 Situating the BHSP in the context of wider pressures for privatisation

Evidence from this study shows that these debates about reorienting the system and the role of insurance occurred in a wider context of advocacy for privatisation. This section presents findings from interview and document data that focuses on the ownership of the provided health services. It examines the views of different actors in terms of whether services should be publically or privately delivered. It does that in the context of introducing the BHSP and the depicted role of the latter in such public or private provision of services.

A key informant of this study indicated that the BHSP was a compromise between pressures for privatisation and attempts to reorient the health system towards a primary health care approach. This former director of an international health organisation in Iraq elaborated that in the face of advocacy for privatisation in part of some external actors, the organisation started thinking about introducing a balance of the public and private ownership of services:

“And that was when that we started thinking...about to have a balance on what should be privatised, what should not, what is the role of the government, who should pay and the government should ensure that free services are provided.” [NIF_UN_13]

The same informant argued that primary health care should be the cornerstone of health services and that those primary care services should not be privatised:

“We discussed that primary health care is the cornerstone and these are the services that cannot go for the privatisation of health” [nIF_UN_13].

This informant went on to suggest that the organisation advocated the introduction of a ‘core package of health services’ that should be funded from public resources and should not be privatised. The informant reported that this was when the idea of the BHSP first started:

“According to the constitution (if you look at the Iraqi constitution) was saying that health is a right. So taking the primary health care approach, we came up with the services that are a must, for example, antenatal care is a must, immunisation is a must... dental hygiene is a must, mental health and counselling is a must, and this is where the initial idea of the basic health service package came” [nIF_UN_13]

It is necessary to situate these debates about privatisation and the role of the BHSP in the process in the wider context of Iraq’s health system at the time and the views of key
actors about the issue. Document findings revealed that actors such as the IMF had imposed certain conditions on Iraq in return for financial assistance and debt relief following the 2003 war. Those conditions included economic stabilisation through limiting spending and initiating reforms to transition the country to a market-based economy (please refer to chapter four on page 101) (IMF 2004). The IMF also encouraged the provision of a minimum social support through “focusing on providing the minimum adequate level of social support and carrying out urgent reconstruction projects” (IMF 2004).

In parallel to those conditions by the IMF other external organisations called for a larger role for the private sector in the economy in general. The joint WHO and World Bank assessment of 2003 highlighted “an opportunity to revisit the role of the state, the private sector, and local communities to create a system of social welfare targeted to the poor and vulnerable, render it less dependent on the central government, and include systems for stakeholder participation” (UN & World Bank, 2003:8). The assessment further indicated that “in developing the conditions for growth, the Iraqi government faces the central task of making the transition from a centralized, state-dominated economy to a market-based economy” (UN & World Bank, 2003:9).

In addition to the joint assessment, the International Compact with Iraq (ICI) of 2007 also emphasised the need for a transition from an alleged state economy to one based on the market and the private sector. One of the aims of the ICI was to “allow the private sector a leading role in the economic activity, with a specified role for the Government in regulating this activity and protecting it from the effects of the foreign fluctuation” (UNAMI, 2007:2). The Government of Iraq seemed to translate those recommendations in its National Development Strategy of 2005 (Ministry of Planning and Development Cooperation 2005). Early following the war the vision of the Iraqi government was to “transform Iraq into a peaceful, unified federal democracy and a prosperous, market-oriented regional economic powerhouse that is fully integrated into the global economy” (Ministry of Planning and Development Cooperation 2005: viii). It seems that elements of this general approach to public policy were reflected in the health sector. More specifically the MoH also emphasised a more flexible approach towards the private market by indicating in its vision that “the type of health provider ownership should not be a consideration in health financing. Public money should
be able to be paid to private facilities, and private money could be paid to public facilities. This would allow a seamless, blended health delivery system to develop. In the long-term, public facilities should not subsidize private facilities” (Iraq Ministry of Health, 2004:28)

In tandem with these policies at the economy level, findings from this research suggest that some external actors pushed for enhancing the role of the private sector in both the provision and ownership of health services. A non-Iraqi former director of an international health organisation in Iraq indicated:

“Ok the story is, when I took over in late 2003 there was a provisional government and here was a lot of influence from other stakeholders (non-Iraqis) to push for the privatisation of the health [services]” [nIF_UN_13].

When questioned further about the particular players who advocated such privatisation, the informant above responded by stating:

“I cannot identify one party or the other. But in the new Iraq, quote end quote there was this push by some experts (or so-called experts) from the US and the World Bank for privatisation” [nIF_UN_13].

The same participant indicated that the actors that were discussing the idea of privatisation were having particular justifications about why that should be done in Iraq. The informant indicated:

“When I am sitting around a table with entities representing the US, the UK the EU, the World Bank, WHO and also Iraqis. Now, the money talks, so if you privatise, you will have the money, so that was the attitude.” [nIF_UN_13]

The interviewee further explained that pushing for privatisation by certain players was not unique to Iraq but rather also implemented in other countries in the region such as Lebanon. However, the interviewee argued that the experiences of those countries showed that, despite privatising services, the government still had to pay for them and that such privatisation did not help in improving services:

“First of all, it is not unique for Iraq, but it also applies to the region. The idea is that health is a commodity, and it should be privatised because it has a cost, a high cost... Now, I studied in Lebanon, and I worked in Lebanon, so I have experience there so we should have looked at the experiences of other countries because Lebanon also had a civil war, they were having a lot of non-governmental organisations supporting
health but also the ministry of health is paying for all of the services that are provided at the private sector but still the services are not improving” [nIF_UN_13]

An Iraqi participant agreed with those views and indicated that the American adviser to the ministry of health during the CPA rule was planning on the privatisation of health services. This interviewee stated that the CPA adviser did not believe in ‘social medicine’ but rather believed in personal responsibility for obtaining health care. According to the informant, some Iraqis also supported the adviser in selling some of the health services to private entities:

“The Basic health service package from the beginning was not present as an idea initially, when Jim Haveman came (the first minister of health under the coalition provisional authority) he started with a limited programme to support public health, the problem was that Haveman is personally is a hard republican and does not believe at all in social medicine, that the government provides health services, he thinks that individuals should be responsible for that. So, in the beginning, he started thinking about the privatisation of the health services and selling the services to private entities, and he was supported in that by some of the other Iraqi Republicans” [IM_USG_14].

In short, the above quote indicates that perhaps the BHSP itself is the outcome of a compromise between at least two competing visions by external actors. One that is as pushing for privatisation depicted as represented by the US and other international agencies, and one that wanted to protect primary health care and used the BHSP as a tool to do so.

7.4 Achieving efficiency objectives through the BHSP

This section presents findings related to the perspective of actors on the role of the BHSP in wider functions of the health system such as cost-effectiveness and standardisation.

7.4.1 The role of the BHSP in achieving cost-effectiveness

One of the major criticisms directed at the existing system around 2003 was the alleged inefficiency and the neglect of the use of evidence-based, cost-effective interventions. Several key external and internal actors shared those views. A joint assessment by WHO and World Bank in 2003 suggested that “the health care system is inefficient…” (UN & World Bank, 2003:1) moreover, “although the system ran fairly effectively, little health service data was collected. This led to a lack of cost-effective public health interventions, and services only partially matched population health needs” (UN & World Bank, 2003:2). The minister
of health at the time also argued that “there is lack of emphasis on cost-effective public health interventions” (Alwan, 2004:49). The BHSP document echoed these assessments by claiming that “[the system] has limited efficiency…” (Ministry of Health, 2009:1). Moreover, it indicated that “the current structure of PHC is not based on cost-effective interventions that would ensure maximum health gains for available resources.” (Ministry of Health, 2009: II).

One Iraqi interviewee working at an international health organisation at the time of the introduction of the BHSP attributed this claimed lack of use of measures such as cost-effectiveness to ‘endless resources’:

“[The previous system] was a great waste of the resources of Iraq. But at that time there wasn’t this mentality of you know being efficient, being cost-effective, because the resources were really endless” [IF_UN_3]

Another Iraqi official at a bilateral donor agency also emphasised the availability of abundant resources reporting that the lack of resources was not a problem. Rather, in this interviewee’s opinion, the problem was policies and systems. The interviewee compared Iraq to countries that do not have the resources to provide essential services such as vaccination:

“You know that we in Iraq and Kurdistan have no problem in financial resources, what is a problem is the policy and health system. We are not like other countries in the world for example that we do not have money to vaccinate or health care for pregnant.” [IF_Bi_6]

Findings from documents and interview data suggested the need for enhancing the efficiency of provided services through the inclusion of cost-effective interventions. Both external and internal actors and documents reviewed in this research appear to have shared such views. The MoH argued in its 2004 vision that primary health care “should be strengthened and effectively linked to increase cost-effectiveness and improve access to basic health services.” (Iraq Ministry of Health, 2004:28). The vision also recommended the identification of the “most cost-effective interventions to tackle [communicable and non-communicable disease]” (Iraq Ministry of Health, 2004:23). The Joint World Bank, WHO assessment recommended that “[the] system must become accessible to all Iraqis, and be equitable, effective, efficient and financially sustainable” (UN & World Bank, 2003:5). One Iraqi interviewee reiterated those recommendations by stating that “If they want to provide timely and effective services those services need to be cost-effective.” [IM_USG_14]
A non-Iraqi participant argued that the inclusion of cost-effective interventions would improve the prioritisation advantage of the BHSP by stating:

“So what is the advantage of having a basic package of health services a BPHS? To my way of thinking one, it says that there are a few priority of services which are of such high impact and cost-effectiveness...etc. That they should get a first call on resources, it is not to say that other things are not important it is just that these things are priorities, if everything is a priority then nothing is, right?” [NIM_Md_10]

One Iraqi informant expressed contradictory views to the one expressed above about the limitless resources. This participant argued that because of limited resources, some form of prioritisation is needed arguably through the inclusion of cost-effective interventions in a package of basic or essential services:

“In the end, you have limited resources, financial resources, human resources, you have to provide services, you have a limited population and access is limited, you need in this context to prioritize the services that are of utmost need to the population, it does not matter what you call them (basic, primary, essential package) whatever the name is, at the end you cannot provide all of the services to all of the people at all times, in all of the primary health centres, whether in Iraq or any other country” [IM_Md_15]

7.4.2 The role of the BHSP in achieving standardisation:

Closely linked to this proposed prioritisation through cost-effective exercise is the provision of standardised services at all levels of health facilities. Several informants described the delivery of health services before 2003 as lacking standardisation and uniformity (Ministry of Health 2009). A non-Iraqi informant stated:

“Although components of primary health care were almost all there before the package came, they were not practiced in a structured manner in the primary health care centres” [NIM_UN_7]

Some interviewees saw the BHSP as a tool to provide such standardisation. One Iraqi informant even compared this standardisation to similar exercises in the military domain:

“As a prototype, I think the BHSP is nothing more than prioritisation through standardisation of the health services, I think these are the ways that are used by the armies since old ages, most of the people who are doing definitions and standardisation are the armies, for examples the battalions are having definitions for the things that are existing, and they exist in every battalion exactly the same. So there is a standard list, definitions are clear, and there is a chain of command, so they
used the military example.”[IM_USG_14]

Another Iraqi participant likened the BHSP to a legal document or a constitution that everyone has to adhere to:

“Once you have the basic health service package and all people, all providers and all public decision makers are on the same page, and they work from this page, and use this document (BHSP) as their... let’s say...as their constitution for primary health care then they can have the decisions in their own hands once they do not offend the approach or do a lot of damage to it.”[IF_UN_3]

Findings from documents and interviews also highlighted the concept of decentralisation. One of the criticisms directed at the existing health system early following the 2003 war was its claimed centralised nature. The joint need assessment by WHO and The World Bank in 2003 claimed: “The health care system became increasingly politicised, centrally controlled, and poorly suited to respond to changing population health needs.” (UN & World Bank, 2003:5). The BHSP also offered a similar assessment of the existing health system: “Iraq has a centralized model of health care management where decisions (like staff appointments, procurement of supplies) that affect the operation of health facilities at the district level are made at the central MoH level.”(Ministry of Health, 2009:96). Both internal and external Interviewees also supported the alleged centralised nature of the health system. One Iraqi interviewee stated:

“The decisions are made in a centralised manner. The ministry of health is a much centralised institution. There is the minister of health, and then the directorates of health and then the directors of hospitals and health centres. So it is a big bureaucracy” [IM_Md_2]

Another Iraqi interviewee further elaborated on this point by focusing on the financing functions of the health system by indicating that “everything is centrally covered and budgeted.”[IF_Bi_6].

It seems that aiming to achieve standardisations occurred in the wider context of attempting to decentralise the system. The emphasis placed on standardisation presumably reflected a view that some minimum standards were seen as necessary to preserve equity of coverage and access across localities in which significant decentralisation was being pursued. Several documents and interview data emphasised the need for more decentralisation of the
health system. The joint assessment by WHO and the World Bank in 2003 argued for “change from a highly centralised management structure in the MOH with the development of a programme for decentralised implementation of health actions.” (UN & World Bank, 2003:12). The MoH of 2004 echoed those calls by recommending that “the health system should be decentralized” (Iraq Ministry of Health, 2004:28) and aspiring to “develop a decentralized system of public health delivery” (Iraq Ministry of Health, 2004:23). The vision, however, made a distinction between the decentralisation of budgeting and other managerial duties on one hand and the centralisation of financing on the other. It recommended to “centralize the health financing function” but “decentralize the health management functions” (Iraq Ministry of Health, 2004:23). In another word it called on policy makers to “design a finance system characterized by centralized funding and decentralized budgeting.”(Iraq Ministry of Health, 2004:17).

One Iraqi interviewee also echoed those calls for shifting the system from its previous centralised nature to one more based on decentralisation:

“Definitely, the system needed revision, it needed reform, it needed reorganisation, and I believe that it needed and still needs a lot of decentralisation.” [IF_UN_3]

The BHSP document claimed that its implementation will start the process of such decentralisation. It suggested that the introduction of the BHSP will “enable Iraq to meet the benchmarks of National Development Strategy (NDS 2010-2014, International Compact with Iraq ICI), Millennium Development Goals (MDGs) and the 2005 constitution of Iraq, which stipulates the devolution and decentralisation of financial and administrative authorities to the regional and governorate levels”(Ministry of Health, 2009:II). An interviewee also stressed the utility of the BHSP in assisting this change towards decentralisation:

“So I think BHSP helps decentralisation. Although decentralisation is not only a Basic health services package as you know, it is a whole issue.”[IF_UN_3]

In short, the document and interview findings presented above suggest that the alleged central nature of the health system was regarded as one of the unfavourable features of the existing system. Policy makers, therefore, saw the BHSP as a tool preserve some degree of consistency by providing a minimum standard of services across a newly decentralised
system.

To conclude this section, the document extracts and interview data presented above appear to present a particular understanding of the nature of the problems in the existing health system. Those problems are defined and framed around issues of inefficiency, capital intensive, hospital-based, lack of cost-effective interventions, lack of standardisation and centralisation. These framing of challenges co-existed with a possible perception of the collapse of the entire health system. It was in this context that the idea of the BHSP was introduced and later formulated.

7.5 Summary
This chapter has used findings from document and interview data to explore the views and perceptions of respondents about the system-wide effects of the BHSP. The chapter demonstrated that there was a relative consensus about the need to shift the health system towards a primary health care approach. The BHSP was viewed as a tool to achieve this goal. However, there were also debates about how to the BHSP is perceived to perform that function and what would are the intended and probable effects of the latter on related functions.

Some interviewees considered the BHSP as a tool to introduce the concept of insurance into the Iraqi health system. Several internal players deemed such policy necessary since Iraq lacked one and that the country should learn from other nations that have insurance. Some external actors viewed the BHSP as a benefits package of an insurance policy for the government to subsidise. Interviewees also appeared to agree on the other aspects of efficiency utilities of the BHSP that can be achieved through the adoption of cost-effective interventions, decentralisation, and standardisation.

The findings presented in this chapter, however, appeared to disclose less agreement among internal and external actors on the ownership of services. Some external actors seem to have advocated and planned for the privatisation of health services. The intention to privatise health services occurred in the larger context of transforming Iraq to a market-based economy that was advocated by actors such as the IMF and the World Bank immediately following the 2003 war. However, it appears that some other external (and internal) actors
disagreed about privatisation. The BHSP, according to some interviewee, represented the minimum social services that the government should provide while allowing the private sector to own and operate the rest of services.


8 Discussion

The last three chapters presented the empirical findings of this research. This chapter will present a brief description of the results in an order that corresponds to the result chapters. The sections will also attempt to explain the significance of the findings and relate them to existing literature and knowledge.

8.1 The external origins of the BHSP

This section will briefly summarise the main findings of the study in relationship to the external origins of Iraq’s BHSP and the role of external actors in transferring the BHSP. It relates those findings to similar research in the literature. It also attempts to examine the meanings of those results given the available literature. It then examines the transfer of the BHSP in relationship to the available policy transfer literature.

One of the major findings of this study was that Iraq’s BHSP share considerable similarities with equivalent policies in other countries. The analysis of the BHSP in four countries (Uganda, Afghanistan, Liberia and Iraq) has uncovered such similarities. The policies in those countries are similar not only in their titles but also in aspects of their contents and substances. These findings support, to some extent, the suggestion that the BHSP is perhaps a global health policy that was introduced particularly in post-conflict countries around the world. The literature (especially with regards to post-conflict countries) contains references to learning from similar policies in the design of a particular country’s BHSP. Newbrander and colleagues, for instance, indicated that “the BPHS provided a package adapted to Afghanistan and based on the available evidence” (Newbrander et al. 2014: S7). Similarly, they suggested that “other fragile states…used the Afghan BPHS as a model, such as Liberia, South Sudan, and Somalia” (Newbrander et al. 2014: S24). Roberts and colleagues also claim that “the Basic Package of Health Services contracting approach builds upon previous initiatives in Cambodia and a number of other low-income countries” (Roberts et al. 2008:58). Others made references to learning from prior models of packages of health services in developed countries without explicitly specifying the nature of that learning or presenting evidence for it (Tarimo 1997; Health & Fragile States Network 2009). Finally, Ham (1997) likened the policy process of priority settings to an exercise in policy learning.
where policymakers experiment with various pre-existing tools and adapt and adjust those tools during the process (Ham 1997).

Similar to the publications cited above, this research also claims that Iraq’s BHSP was shaped by elements from existing models in other countries. However, this study, unlike the ones referenced above, did undertake a systematic comparison among the BHSPs in various countries. It did so to explore the extent to which Iraq’s BHSP duplicated elements of existing models from other nations. It is also the first to find considerable similarities among those packages. However, this study has also shown that Iraq’s BHSP is different in significant aspects from equivalent policies in three conflict-affected countries. The BHSP in Uganda, Afghanistan and Liberia were used to restore rapidly and scale up services to war-affected populations, jump-start a new health system and coordinate donor activities (Roberts et al. 2008; Peters et al. 2007; Newbrander et al. 2014; Waldman & Newbrander 2014; Waldman et al. 2006; Dalil et al. 2014; Haidari et al. 2014; Newbrander et al. 2007; Waters et al. 2007b). In Iraq, the MoH claimed that the policy was used mainly to reform the existing health system.

The findings of this study seem to suggest that Iraq’s BHSP perhaps reflects the evolution of primary health care from comprehensive to selective approaches. Such evolution has been seen in many other contexts and at the global policy level. As presented in the background chapter, the Alma-Atta Declaration, and the comprehensive primary health care movement inspired Iraq’s PHA of 1981 (Government of Iraq 1981). The latter included most of the elements of a comprehensive primary health care model including education, nutrition, safe water, sanitation and mental health. However, this study has found that the BHSP perhaps represents a triumph of the selective primary health care approach. For example, Iraq’s BHPS did not include many of the features of the comprehensive primary health care model outlined above such as safe drinking water, sanitation, nutrition and others. Iraq’s BHSP can be seen to reflect many of the principles of the selective primary care approach as outlined in the WDR of 1993 regarding its emphasis on cost-effectiveness and efficiency. The report recommended the introduction of packages of basic health services around the world (World Bank 1993; Bobadilla et al. 1994; Musgrove 1993; Bobadilla & Cowley 1995).
The findings of this study uncovered various views on the role of external actors in introducing the BHSP to Iraq. Iraq’s BHSP document claims that the role of external actors was limited to facilitation in contrast to an alleged ownership of the process by the MoH. Some interviewees, however, attributed the introduction of the idea of the BHSP to external actors and expressed scepticism about the ability of the MoH to initiate and implement such a programme. Nevertheless, many seemed to agree that once the BHSP appeared on the health policy agenda, the MoH and its experts played a role in shaping it accordingly to their preferences. Findings from this research suggest that probably there was not a single policy agent responsible for introducing the idea of the BHSP. Rather, it seems that the concept emerged through discussions between internal and external actors and learning from models existing elsewhere.

To the best of our knowledge, this study is novel with regards to examining the relative roles of external and domestic actors in the agenda setting and policy formulation stages of the policy cycle respectively. The literature tends to focus on only one of those stages at a time. It also tends to focus on the role of only one group of actors at a time. For example, many stress the role of external actors in introducing and designing policies in developing countries (Walt et al. 2004; Ogden et al. 2003; Lush et al. 2003a; Macrae et al. 1996; Okuonzi & Macrae 1995; Jeppsson et al. 2005; Armada et al. 2001; Legrand & Vas 2014; Eccleston & Woodward 2014; Bock 2014; Stone 2000; Stone 2008; Stone 2010). Few explored the relationship between internal and external actors (Shiffman et al. 2004; Ngoasong 2011) while other studies focus on internal actors (Clavier 2010; Ugyel & Daughbjerg n.d.). While previous literature tends to concentrate on the role of external actors in policy making, this study has shown that, in this case, domestic policy actors were also influential. This might be because previous literature neglected local factors. It is also likely to reflect the fact that the government in Iraq is a more competent and capable entity than is the case for the fragile or low-income states in which previous research has been concentrated.

The study also explored the processes through which the BHSP has emerged on the policy setting agenda in the country. It demonstrated that some form of transfer was probably involved in the introduction of the BHSP. Such transfer perhaps occurred through various
rather than a single modality or mechanism. First, it appears that this transfer involved some elements of learning from the experiences of other countries (Stone 2001; Evans 2009; Bennett & Howlett 1992; Hall 1993; Stone 1999; González Block 1997). Policy-makers and other players were not only aware of the experiences of particular countries but also had the documents that described the BHSP in those countries. Key policy makers and bureaucrats at the Iraqi MoH participated in conferences and other events that might have functioned as venues for sharing knowledge and learning with others. This finding is ostensibly consistent with the literature on learning from lessons of other countries (Dolowitz & Medearis 2009). It appears that policymakers in Iraq limited lesson drawing to one country such as Afghanistan. Such undue focus on a single regional case occurred because the main actors and individuals in Iraq had previously been involved in similar activities in Afghanistan. It appears that the relative availability of documents from Afghanistan and interactions with Afghani policy-makers helped their counterparts in Iraq to overcome the challenges of searching for all available solutions to perceived problems. Time, resource, capacity and institutional factors appear to have constrained a more systematic investigation (Meseguer 2005; Dolowitz & Marsh 2000; Ettelt et al. 2012). Therefore, it seems that some actors that were involved in Iraq’s BHSP deemed Afghanistan’s experience as the only or one of the few relevant experiences to guide Iraq’s BHSP.

Second, evidence gathered for this research shows that the introduction of the BHSP potentially involved different mechanisms or degrees of transfer (Dolowitz & Marsh 1996; Dolowitz & Marsh 2000; Padgett & Bulmer 2005; Dolowitz & Medearis 2009). It appears that actors used various degrees of copying (or duplication), inspiration, emulation and synthesis (Bennett 1991) (Jones & Newburn 2002; Wolman 1992; Bennett 1997; Dolowitz 1997; Padgett & Bulmer 2005). The evidence presented through the Turnitin exercise has shown that at least some degree of copying or duplication is evident (Lee & Strang 2006). Iraq’s BHSP appears to have duplicated sentences and interventions from Afghanistan’s BPHS. However, Afghanistan’s BPHS was not transferred wholesale or in its entirety to Iraq. The Turnitin exercise has demonstrated this incomplete transfer. Differences between Iraq’s BHSP and similar policies in other countries (including Afghanistan) also suggest that Afghanistan’s BPHS was not transferred wholesale to Iraq. However, in consistency with the
literature, this study found some evidence that Afghanistan’s experience with the BHSP inspired policymakers in Iraq. Similarly, it appears that the transfer of Iraq’s BHSP involved elements of emulation. Finally, it also seems that policy makers synthesised the BHSP through picking and choosing various components from a range of external and internal models. These findings are consistent with the evidence from elsewhere about such modes of transfer as emulation, inspiration and synthesis (Dwyer & Ellison 2009; Sharman 2010; Padgett 2011; Gilardi 2012).

Third, this study suggests that the transfer of Iraq’s BHSP took place through various modalities. The transfer was effected via modalities that were neither purely voluntary nor completely coercive. Rather, the introduction of Iraq’s BHSP involved different combinations of modalities of transfer. Desire to conform to international norms (the selective primary health care approach), adopt global evidence (provided by WHO) and compete with other countries might have also shaped the introduction of the BHSP. Furthermore, membership in international organisations (WHO), the signing of international agreements (ICI) and implementing donor-funded projects (SPHCS and I-PSM) might have encouraged Iraq to introduce the BHSP. In agreement with the literature on ‘elite networking’ and membership in international organisations, Iraq’s obligations under those international agreements perhaps functioned as a modality of transfer (Greenhill 2010; Holzinger & Knill 2005). Finally, conditions attached to Iraq’s debt relief programme appear to have contributed to a more coercive transfer of the BHSP into Iraq.

To conclude this section, this study suggests that Iraq’s BHSP emerged through interactions among and between internal and external actors. The nature and pattern of similarities between Iraq’s BHSP and other equivalent policies provide clear evidence that the country has copied, emulated, inspired by or synthesised elements and lessons from those equivalent policies. The transfer to Iraq occurred through diverse modalities and mechanisms. The availability of various models in other countries and the involvement of different modalities and mechanisms of transfer explain in part the unique case of Iraq’s BHSP. However, those factors do not seem to explain satisfactorily all elements of this case. The preferences and interests of domestic policy actors also seem to have played a role in the adoption and design of the BHSP policy. The next section will examine the findings of this
study from that aspect.

8.2 The domestic origins of the BHSP

This section will summarise and interpret the major results of the study in relationship to the internal origins of Iraq’s BHSP and the role of national actors in introducing and formulating the BHSP. It relates those findings to similar studies in the literature.

The analysis of Iraq’s BHSP demonstrates significant elements of continuity. The findings revealed that various institutions in the form of policies, rules, organisations and interest groups that were established in the past have shaped the contents and features of the BHSP. The legacies of those institutions might have manifested themselves in the BHSP. In other words, the BHSP represents a combination of old elements of previous and current institutions (Esping-Anderson, 1990:124). For example, the components of the BHSP and its particular interventions had precedents in the existing health system. The proposed new levels of health facilities were also built upon the existing structures. Furthermore, user fees were on the policy agenda and were implemented before the introduction of the BHSP. However, this does not suggest that the BHSP did not include any new ideas, technologies or processes. Rather, the examination of what is new or old helps in understanding what was potentially transferred and how it occurred.

One of the major findings of this research is that the technical content of the BHSP reflects, in multiple respects, the characteristics of the wider health system. The BHSP replicated some of the features of the existing health system and inherited others from the past. The BHSP was perceived by several interviewed domestic actors as a tool to reform, reformulate and reorient the current system rather than introduce a new one. While the previous literature on BHSPs has not focused on this dimension of the policy apparatus, these findings are consistent with are in line with the path dependence literature in other disciplines (Pierson 2000; Pierson & Skocpol 2002; Pierson 1993; Arthur 1989; Yu 2008; Mahoney 2000; David 1985). They also contribute to the few studies on path dependence in health policy in developed countries or international organisations (Greener 2002; Hockley 2012; Wilsford 1994; Gomez 2013; Hacker 2004; Hacker 1998; Rochaix & Wilsford n.d.; Altenstetter & Busse 2005). This study, therefore, has contributed to the literature on the
inheritance from past policies and replication of elements of the existing system in new policies.

This study also revealed that internal actors in the context of Iraq’s BHSP played a considerable role in the formulation of the BHSP. While the evidence presented here suggests that external players have initially proposed the idea of the BHSP, it was domestic actors who took the lead in its formulation. The finding that external actors acted as transfer agents is consistent with the literature on policy transfer and health policy transfer in particular (Stone 2000; Stone 2008; Stone 2010; Le Grand & Vas 2014; Eccleston & Woodward 2014; Bock 2014; Ogden et al. 2003; Pfeiffer 2003; Armada et al. 2001; Rechel & Khodjamurodov 2010; Bennett et al. 2015; Nay 2012; Lush et al. 2003a; Walt et al. 2004; Cliff et al. 2004; Sridhar 2009; Oliveira Cruz & McPake 2010; Hanefeld 2010; Dodd & Olivé 2011; Kapilashrami & McPake 2013). Few studies in health policy and systems research, however, have examined the role of internal actors in shaping policies that are introduced by external actors (Lipsky 2010; Erasmus & Gilson 2008; Lehmann & Gilson 2013; Dalglish, Surkan et al. 2015). This study is among few that highlight the importance of the role of national actors in formulating health policies that are introduced by external actors (Hiscock 1995; Buse & Walt 1997; Jeppsson et al. 2005).

This study is also one of the very few which employs an explicit policy transfer lens to examine the introduction and formulation of health policies such as the BHSP (Bennett et al. 2015; Tambulasi 2011). The results of this study, however, do not corroborate the claims made by some of the studies on health policy transfer. The latter proposes what it calls loops where policies are developed at the local level, packaged at the global scale and then transferred back to local contexts (Walt et al. 2004; Lush et al. 2003a; Ogden et al. 2003). This study found limited evidence of such transfer. It, nevertheless, identified indications about the transfer of a label such as the BHSP (Ogden et al. 2003). By the latter, we mean using a terminology of a policy that was developed elsewhere to describe a new policy in another context that might not be entirely similar in their technical contents. The health policy transfer literature also claims that policies have an origin and an end, and they move in one direction at a time. In this regard, the results of this study do not corroborate the findings of other studies in different contexts. In the case of Iraq’s BHSP, there were multiple internal
and external origins for the policy. Therefore, this study contributes to the health policy transfer literature by accounting for the complexity and fluidity of the transfer process.

The study has shown, in particular, the influential role of the MoH and its bureaucrats and experts in formulating the BHSP. Available evidence suggests that the Iraq war of 2003 and its consequences provided what is termed a ‘window of opportunity’ (Kingdon 2010). The removal of politicians as a result of the war allowed domestic bureaucrats and technocrats to exert more influence in the policymaking process. Findings from interview data and documents suggest that internal actors (the MoH in particular) played a key role in formulating the BHSP. Apart from a short period around 2003 when other players seem to have managed to introduce the idea of a BHSP, the rest of the process appears to have been influenced mainly by the MoH. External interviewee mostly praised internal technocrats and bureaucrats for their knowledge and capabilities. Internal documents, on the other hand, claimed that external consultants and advisers were mere facilitators and assistants to internal technocrats rather than owners of the process. These findings are different from the conclusions of studies that address health policy transfer questions. The latter tends to depict domestic actors as passive recipients of international prescriptions, losing control over the policy process (Buse & Walt 1997) coerced into adopting global policies (Okuonzi & Macrae 1995) or ‘dis-embed’ MoHs from local realities as a consequence of external factors (Jeppsson et al. 2005). Only a few studies demonstrated that domestic actors can be influential in formulating health policies in low and middle-income countries (Hiscock 1995; Tambulasi 2011). The evidence presented in this study suggests that Iraq’s case was different in that domestic actors exerted considerable influence in shaping the policy formulation process. In such situations, the uncritical application of the concept of local ownership of policy development might risk the replication of less favourable domestic structures, institutions, and behaviours.

The findings of this study offered some insight into the nature of the interactions between domestic and external actor in this specific conflict-affected setting. Some of the results of this research imply that the relationships between national and external actors were ‘collegial’ and based on cooperation and partnership. However, there is some evidence to suggest that tensions, conflicts and negotiations were not absent from those interactions. It
appears that interactions among internal and external actors were not sustained over prolonged periods of time or smooth processes without tensions or conflicts. For example, it seems that there were disagreements between internal and external actors about who is in ‘the driving seat’. Some interviewees appeared to suggest that the internal actors were probably more influential in defining the problems. External agents and organisations were perhaps seen as sources of solutions rather than owners of how problems are identified and presented. However, some evidence suggested that this claimed strong influence by internal technocrats perhaps would not have been possible without the willingness of the main external actors to allow the former to exert such influence. The findings of this research, therefore, suggest that the dynamics of interactions among internal and external actors is perhaps more complex than the unidirectional relationship proposed by the policy transfer literature.

To conclude this section, although the BHSP is a global health policy that international actors introduced into the policy agenda in Iraq, domestic institutions and actors influenced its formulation during the transfer process. This study, therefore, refuted the notion of a single origin or a unidirectional movement of a policy that dominates the policy transfer literature (Schon 1973; Freeman 2002; Reich 2002; Lee & Goodman 2002). Rather, the study revealed multiple origins and a multidirectional transfer of the BHSP in Iraq. Domestic institutions, the study shows, contributed to the final formulation of the policy. Internal actors also shaped the policy process through ideas, arguments and counterarguments.

8.3 Financing the BHSP

Findings from document and interview data presented a particular account of the financial and economic issues of the health system in Iraq. Those accounts presented the BHSP as the solution to many of the perceived problems. The paragraphs below presents a brief summary of the findings of this research, interpret them and report on their significance in the face of existing knowledge. Those are organised under the mobilisation, pooling, purchasing and ownership financing functions of the health system.

The identification of user fees as a source of financing the BHSP was one of the puzzles that this research aimed to explore. The study showed three major findings in relations to this aspect of the financing of the BHSP. First, user fees were not new in the context of Iraq’s
primary health care system. This continuity occurred despite the political change and removal of the previous regime which introduced it. It also happened in the face of mounting evidence in support for their abolition. Furthermore, user fees occurred despite the presence in Iraq of international actors who publicly advocated their abolition as a source of financing primary health care. Finally, at the time of the recognition of user fees, Iraq was enjoying increasing oil revenues. Most of the scholarship in this area identifies external actors as the advocates, initiators or implementers of user fees in those contexts (Okuonzi & Macrae 1995; Nolan & Turbat 1995; Colclough 1997; Kim et al. 2002; Ruger 2005; Yates 2009; Dahlgren 1991; Foltz 1994; Creese & Kutzin 1997). Revealing the historical antecedents and inheritance of user fees in Iraq’s BHSP makes this study unique among the literature that examines the introduction of this policy in low and middle-income countries.

The existence of historical antecedents for user fees, however, does not necessarily entail their automatic inheritance in a new policy such as the BHSP. Hence, the second finding of this research which explored the preferences of national actors to user fees is significant. The study has shown that interviewed internal technocrats and bureaucrats almost unanimously supported the introduction of user fees as a source of financing the BHSP. On the other hand, most interviewed external actors distanced themselves from the decision to include user fees in the BHSP. Only one external interviewee supported MoH’s decision to include them, citing claimed international best practices as a justification. Again, this is inconsistent with the literature on user fees in LMIC that tends to associate the policy with external actors and organisations. Clearly, externally driven constraints such as the terms of IMF loans and debt relief programme may have created restrictions on the fiscal space leading to pressure for non-state forms of financing. However, the interviewed internal actors made a series of arguments for the inherent utility of user fees in addition (or regardless) of those fiscal pressures. Those arguments were related to the claimed role of user fees in addressing issues of moral hazard, resource mobilisation, quality of services, sustainability, appreciation of services and other moral arguments. Those justifications are consistent with similar ones that were historically put forward by the advocates of user fees (Ferranti 1985; World Bank 1987; Griffin 1988; Litvack & Bodart 1993; James et al. 2006).

The MoH’s position on user fees, however, was not constant throughout the process of
formulating the BHSP. The MoH’s vision of 2004 recommends universal coverage of all Iraqis under the BHSP and suggests exemption from co-payments to particular categories of patients. The BHSP, on the other hand, requires co-payment without specifying exemptions. These variations perhaps reflect changes in the leadership of the MoH or their positions on this particular topic. However, they might also represent an outcome of changes in the influence of the main external actors. It appears that the influence of external actors who were more supportive of exemptions was stronger initially, but was perhaps diminished over time. These findings suggest that eventually the pro-user fees orientation of domestic actors prevailed as the influence of external actors diminished.

Another finding of this research is related to pooling of resources as part of the BHSP. This study suggests that the concept of insurance was used and transferred as a label during the introduction and formulation of the BHSP. The idea of insurance is new to the context of Iraq. The latter did not have a health insurance system before the BHSP as funding either came from the government or in the 1990s from mainly out-of-pocket expenditure (WHO 2006; Farag et al. 2004). Initially, several documents (the MoH vision of 2004 and the Joint WHO and World Bank assessment of 2003) argued for the introduction of private health insurance. The BHSP document itself does not mention private health insurance but suggests social health insurance to fund secondary and tertiary health care. Many of the external and internal actors highlighted the lack of health insurance as one of the shortcomings of the health system. Some presented the BHSP as a solution to the lack of insurance because they viewed the former as the benefits package of an insurance scheme. Also, it appears that there were discussions about premiums (user fees, co-payments), providers of services (private, public) and pooling of resources (the government, a private institution or a semi-private one). Some actors saw the BHSP as a means of defining what might be included in a national insurance programme. Some evidence suggests that the intention was to allow for the privatisation of secondary and tertiary care or financing those services through private health insurance. The BHSP introduced the terminology of insurance without establishing such a scheme or without significant changes in the pooling functions of the health system. In other contexts (the former Soviet Union and Eastern European countries in the 1990s) reforms in pooling of resources were one of the objectives of introducing Basic Packages of Health
Services in those settings (Kutzin, Jakab, et al. 2010). However, few studies only highlighted the potential role of the BHSP in such objective in fragile and conflict-affected states (Ljubić & Hrabac 1998).

This study revealed that the introduction and formulation of the BHSP have also touched upon the purchasing functions of the health system. It appears that one of the justifications that were provided for the introduction of the BHSP was the elimination of the ‘wasteful’ nature of the health system. The health system was perceived by the authors of the BHSP document as capital intensive and hospital based. The BHSP was claimed to assist in transforming the system to one that relies on the provision of ‘cost-effective’ primary health care interventions. That would decrease the cost of the system and would improve efficiency. So it seems that cost was perceived by the authors of the BHSP document one of the main drivers for adopting the BHSP. These justifications are similar to ones put forward by the advocates of the State Guaranteed Benefit Packages in Central Asia and the former Soviet Union following the transition of the early 1990s (Gottret et al. 2008; Kutzin, Jakab, et al. 2010; Rechel et al. 2012; Borowitz & Atun 2007). However, unlike the case of Iraq, those arguments were made in the context of a shrinking fiscal space resulting from a financial crisis associated with the transition to market economy.

Another claimed character of the existing system that the BHSP was hoped to tackle was the alleged centralised nature of the system. It appears that the goal was to introduce not only managerial and administrative but also financial decentralisation through the BHSP. In other contexts, decentralisation has been achieved, for example, through contracting out the BHSP to NGOs (Palmer et al. 2006; Siddiqi et al. 2006; Arur et al. 2010; Loevinsohn 2000; Dalil et al. 2014; Roberts et al. 2008; Blaakman et al. 2013; Trani et al. 2010). This model was not adopted in Iraq.

This research also revealed interesting findings about ownership of health services in the conflict—affected setting of Iraq. The introduction and formulation of the BHSP involved debates on concepts such as privatisation, personal responsibility and the role of the state in health. The evidence suggests that the American-led CPA and its adviser’s exerted pressure to privatise health services in the immediate post-conflict context of Iraq. Some interviewees
claimed that they used the BHSP as a tool to protect primary health care services from privatisation. Those interviewees suggested that the BHSP was an attempt to carve out a space for the largely publicly financed services against that wider privatisation trend. However, those claims probably lose credibility should one consider the original aims of the BHSP as depicted in the WDR of 1993. In the latter, the BHSP is viewed as a tool to guarantee primary health services by the state while privatising the rest of secondary and tertiary services (World Bank 1993; Bobadilla et al. 1994).

To conclude, the previous section reviewed the findings of this research exploring the relationship between the BHSP and the financing functions of the health system. The section revealed that user fees in the context of the BHSP perhaps originated from internal actors and institutions. The local origin of user fees is inconsistent with the existing literature. Furthermore, the BHSP introduced the concept and label of insurance without substantially establishing a system of pooling of resources. Finally, it appears that the BHSP was viewed as a tool to reorient the ownership of services through keeping primary health services in the public ownership while privatising other services.

8.4  Contribution of this research to health policymaking in conflict and non-conflict affected settings

This study found that actors offered justifications (through interview and document data) for the introduction of Iraq’s BHSP that are consistent with the ones presented in the wider literature on BHSP in non-conflict settings. Those justifications are mainly related to efficiency, effectiveness and sustainability considerations (World Bank 1993; Bobadilla 1998; Bobadilla et al. 1994; Bobadilla & Cowley 1995). However, this study was not able to identify more specific justifications pertaining to introducing the BHSP in conflict-affected or post-conflict countries. At the time of the introduction of the BHSP, Iraq had an extensive health infrastructure, a growing economy, and a significant share for health in its GDP. Unlike Afghanistan, Uganda and Liberia, Iraq did not appear to need a rapid scale-up of services. The post-conflict status of Iraq does not seem to entirely justify the introduction of a policy that was used in other post-conflict settings. While the BHSP had a similar technical content to those in other conflict-affected jurisdictions, it was perceived to play a very different role in the health system of Iraq compared with these states.
The findings of this research contribute mainly to the health policy literature in post-conflict, conflict-affected and fragile settings. But, as indicated above, the role of the BHSP in Iraq was not restricted only to its relation with conflict. Therefore, the results of this study are of relevance to health policymaking in non-conflict affected settings as well. That is the case because of two particular reasons: First, the BHSP was introduced in non-conflict settings as well as conflict-affected contexts (for more on this point please refer to the literature review chapter). Second, as the results of this study have shown, some elements of Iraq’s BHSP were inherited from the past and existed prior to the conflict. Below is a discussion of how we think the findings of this study contribute to the wider literature on BHSP in non-conflict affected settings.

As shown in the literature review chapter, some authors argue for a strong consideration of the local context prior to introducing the BHSP in non-conflict settings. The findings of this research seem to support those recommendations for conflict-affected settings as well. In certain circumstances, the conflict could be so severe and protracted that it destroys the existing system and create an opportunity for a new one to be started. That certainly happened in Afghanistan. But it is not necessarily the case in every conflict. For example, the Iraq war of 2003 did not result in the complete collapse of the health system. Therefore, recommending the BHSP for every conflict-affected setting without careful examination of the local features of the existing system is perhaps misguided. As in non-conflict settings, the existing system (or what have remained of) should be carefully explored prior to introducing the BHSP. For example in the case of Iraq, the existing system that survived despite the conflict was one that is dominated by an oil revenue funded (and tax-based) structure. However, a policy like the BHSP was introduced despite claims by authors such as Waddington that it works better in insurance-based systems (Waddington, 2013). This is potentially one of the reasons why the BHSP was only transferred as a label in Iraq. This risk can happen as well in non-conflict affected settings with similar features.

Nevertheless, considering the local context should not necessarily mean that the BHSP could never be tried in an otherwise non-insurance-based system. The findings of this study have shown that when appropriately formulated, the BHSP can be successfully
introduced in non-insurance-based conflict-affected systems. In such settings, one of the benefits of the BHSPs is that donors and aid agencies (theoretically consumers as well) are clearly aware of the nature of the interventions that their money is paying for. Furthermore, the conflict-affected system might not be an insurance-based one, but the presence of donors introduces a situation that could potentially make the BHSP an appropriate policy. Similar to insurance companies, donors can function as purchasers that are concerned about the content of the benefit package that they offer. In addition, a policy such as the BHSP can aspire policymakers to work towards achieving the goals and objectives of the policy. In the case of Iraq, it seems that the BHSP functioned as a tool to introduce terminologies and language that potentially aspired policymakers to achieve particular goals related to effectiveness, efficiency and equity. Unlike non-conflict settings where opportunity for reform are arguably rare, conflict can offer a window through which political instruments such as the BHSP can be used to frame reforms and changes in the system.

The findings of this study suggest that there must be a middle ground in the debate involving the appropriateness of the BHSP. One extreme being that the BHSP is appropriate for health systems destroyed by conflict because they can be allegedly be built from scratch. The other extreme being that the BHSP is inappropriate for tax-based systems in non-conflict settings. The findings of this study do not seem to be entirely consistent with literature on BHSP in non-conflict setting with regards to the latter point. In the setting of Iraq, the conflict provided a window of opportunity for an inappropriate policy to be introduced and function as an inspiration. Although the conflict provided an opportunity for change, the inheritance of elements of the existing health system made the introduction of the BHSP both inappropriate and difficult. For such policy to be entirely successful in both the particular conflict-affected context of Iraq and non-conflict settings, more evaluative studies have to be conducted to assess their effectiveness in such settings.

In addition to the interpretations provided above, the findings of this study reveal that transparency and accountability were highlighted as objectives for the introduction of the BHSP in the conflict-affected setting of Iraq. The argument is that consumers would know which services they would expect when a BHSP is in place. On the other hand, donors would
also know what services they are paying for. The BHSP, in the latter case, was seen as a practical tool for defining the terms of a contract. This utility of the BHSP has been applicable in the case of Afghanistan, where there were multiple providers sometimes competing for the provision of services. However, this might not be the case in other conflict-affected setting such as Iraq. In the latter, the dominant provider was still the government in the post-conflict period and there were no competitions among many providers for signing contracts with a purchaser. In fact, in Iraq case, the government continued to be both the provider and the purchaser at the same time.

Such objectives were also emphasised in relation to the formulation of the BHSP in Iraq. Many interviewees underscored the importance of local ownership in developing the BHSP. These findings are consistent with literature on BHSPs in non-conflict affected setting which seems to recommend similar objectives. However, it is important to highlight some issues with such recommendations that the Iraq case revealed. It appears that it is less likely that populations affected by conflict have the resources or the time to examine debate and provide input on the content of the BHSP. In the case of Iraq, we were not able to identify an Arabic or Kurdish translation of the BHSP, for example. This can be true for non-conflict settings as well were involving the wider population in designing the BHSP might not be priority for policymakers. In such settings, the emphasis appears to be on ensuring ownership by ministries of health.

In relationship to the latter point, this study have shown that ownership of the process of formulating the BHSP might not necessarily translate into better financial protection and more equity of access for the wider population. In the case of Iraq, ownership by the MoH resulted, among other consequences, in the continuation of user fees. This finding is of relevance to the literature on BHSP in non-conflict settings. Such literature emphasises the importance of ensuring local ownership. However, as the study have shown, it is important not to assume that ownership by local institutions such as the MoH will always lead to policies which advance goals such as equity of access and social protection.

In most cases, such ownership is undermined in post-conflict countries by weak institutions and government. We believe that the Iraq’s BHSP policy offered a case where
those concepts are challenged on two fronts; First, weak institutions (such as the MoH) is not necessarily a feature of ALL post-conflict settings. Iraq’s MoH quickly regained power in the immediate post-conflict period of 2003 and was able to take ownership of the at least the BHSP policy formulation process. Second, ownership in itself cannot be taken as an inherently good thing. In the case of Iraq, ownership meant that powerful bureaucrats were able to control the policy process without adequate accountability and transparency. This situation perhaps occurred because the wider political structure was less well developed to introduce such accountability.

Finally, one of the findings of this research is that the post-conflict context of Iraq offered a window of opportunity for health systems reform. The Iraq war of 2003 made possible for problems to be more salient and talked about. Also, the conflict can be viewed as a historical juncture where certain policies and ideas were advanced and were put on the health policy agenda. The changes that occurred in the leadership of the MoH, allowed for existing and new bureaucrats to initiate steps that were otherwise difficult to undertake. Also, the plethora of international actors allowed the borrowing and exposure to ideas that were foreign prior to the 2003 war. The post-conflict period provided the setting where debate and negotiations occurred among various actors resulting in the introduction of the BHSP in the form that was announced in 2009. These findings are consistent with similar ones in the literature on health policy in post-conflict settings (Witter et al, 2017; Bertone, et al, 2014). However, to the best of our knowledge, this is the first study to specifically examine the opportunities offered by conflict for health policy reforms in primary health care and more specifically in relation to BHSP.

In addition to finding evidence for the window of opportunity or multiple streams model, the findings of this study were consistent with other policymaking models. One such model that is of relevance to the findings of this research is the incrementalism theory. There is evidence to suggest that policymakers in Iraq picked and chose from various existing and new ideas, structures and instruments to formulate the BHSP. Debates, negotiations, compromise and sometimes coercions occurred as the BHSP was developed. The process also involved rational justifications based on values that actors adopted and referred to.

Despite their utility in shedding light on various aspects of the BHSP policy process,
those theoretical models were less able to explain the dramatic policy change of the BHSP in Iraq. Kingdon’s policy stream model was the one that was the most useful in explaining why the BHSP was introduced in the post-conflict context of Iraq. However, it was not able alone to explain the whole process either. Therefore, this study used the policy transfer framework to provide further analysis of the policymaking process involved in Iraq’s BHSP.

### 8.5 Problems and limitations

This section reports on the practical and conceptual limitations of this research. The main limitations were related to difficulties in getting access to relevant documents or key individuals that would have offered different or richer accounts of the case. For example, despite multiple attempts, it was not possible to access copies of earlier drafts of the BHSP. Several key individuals who participated in developing the BHSP were asked for access to copies from previous drafts of the BHSP. Despite the fact that those individuals participated in the research as an interviewee, they never responded to the request on earlier drafts. Such drafts would have been useful in examining the changes that might have occurred to the document during the policy formulation process. The inability to access those copies is attributed to several factors intrinsic to this research and others outside the control of the researcher. Perhaps it would have been possible to obtain those copies should the researcher have been able to overcome the security challenges and visit the MoH’s headquarters in Baghdad. However, other barriers to obtaining official documents in Iraq do exist. The experience of this researcher and others demonstrates that there is a limited culture of transparency and documentation in Iraq in general and within the MoH in particular (SIGIR 2008). Furthermore, part of the MoH documents were reported to have been lost during fire incidents and security raids during the period where the BHSP was formulated. With this regard an informant reported that “in June 2003 the ministry was on fire, I mean literally the building had smoke coming out of the top of it” (BHSP_1nterviews_12 Military Assistant to the Senior Advisor for Health).

In addition to limitations related to obtaining relevant documents, there were difficulties in accessing key individuals for interviews. To start with, it was not easy to identify the individuals who participated in introducing, designing and formulating the
BHSP. This difficulty was mainly because the available documents on Iraq’s BHSP did not mention names. Rather, those documents only listed the organisations represented in the discussions on the BHSP. Therefore, it was challenging to locate and identify the individuals within the represented organisations. When identified, the contact information of some of the potential interviewees was not available in the public domain. Furthermore, some of the selected individuals moved to other jobs or locations after their engagement with Iraq’s BHSP. Some of those were either not willing to discuss the topic or did not adequately remember the discussions around the BHSP to offer useful insights. The challenges mentioned above meant that the researcher had to depend mainly on already selected and interviewed individuals in identifying other potential interviewees.

The reliance on snowballing techniques for the identification of other interviewees introduced certain limitations. Snowballing (and purposive sampling) presented the risk of including a particular group of informants while excluding others. For example, it was not possible to locate individuals or groups outside the formal structures of the MoH, international organisations, and consultancies. Civil society activists, for instance, might have been able to provide useful insights that would have been helpful in shedding further light on the questions under investigation. It appears that the BHSP’s formulation process did not involve civil society, the public, journalists and other activists. The lack of participation from wider groups restricted input to a closed circle of individuals and inhibited potential criticism from a wider audience. Those factors meant that the interviewees of this research were confined to a closed pool of potentially like-minded elites.

Interviewing those elites also posed some challenges and was not without difficulties. As mentioned above, most of the interviewees were prominent individuals within the MoH, international organisations, academia, and consultancies. This introduced challenges in how to approach them, request interviews, pose questions, interrupt and probe their answers. For example, when preparing for a meeting with a former minister of health, I had to plan for how I dressed, how to address the interviewee and the tone of my voice. However, in this particular case, the interviewer was friendly and allowed for probing into the answers. On the other hand, another high-ranking official in the MoH treated the interview as a lecture about the BHSP and related topics. This particular interviewee did not offer much opportunity for
questions and probing into the answers.

Some of the other limitations are related to the particular technique that I used in the research (Skype interviews) that were discussed in more details above. It is necessary, however, to mention here one particular difficulty in interviewing through Skype. Approaching individuals to conduct interviews through Skype arguably offered them greater opportunity to reschedule or even cancel interviews at short notice. Rescheduling or cancelling interviews probably would not have been as easy should the interviews were conducted through face to face. For example, a former minister of health and current high ranking WHO official rescheduled the interview five times before cancelling it altogether.

8.6 Direction for future research
This paragraph presents recommendations related to questions that future research might consider. A possible area for further research includes examining the extent to which health systems emerging and affected by conflict differ from each other. Future research into the implications of those differences for policies advocated by international actors might also be usefully considered. Moreover, experimenting with theoretical frameworks such as path dependency might be useful to explore the extent to which historical health system characteristics affect future outcomes. Another avenue for further study would be research into the specific interactions between internal and external actors. Relatedly, without further research into the roles and preferences of local actors, it will not be possible to explain the outcomes of policymaking adequately in conflict-affected settings. Relatedly, it is necessary to critically examine concepts such as ownership of policymaking by local actors. Finally, it is also relevant to investigate whether a more developed version of the policy transfer framework would account more appropriately for introducing policies in conflict-affected contexts.

To summarise this chapter, the primary conclusion of this study is that the BHSP is the outcome of the combination of old (existing) and new (introduced) ideas, technologies and instruments. The existing health system offered ideas, technologies and processes that were maintained and reproduced. New ideas, technologies and processes were transferred as well. This combination of the new and the old produced a BHSP in the final version that the
MoH officially announced in 2009. The study also revealed that the introduction of the BHSP involved various influences from internal and external actors, modalities and mechanisms of transfer. It appears that the BHSP was transformed and changed as it was transferred to Iraq. This transformation seems to have occurred during the deliberations between internal technocrats and external experts and among them as well. External experts might have offered the knowledge about the idea of the BHSP and might have provided models (such as Afghanistan). Internal technocrats, however, do not appear as passive recipients who did not question or modify the policy during its transfer. On the contrary, it seems that the latter exerted considerable influence in arriving at the final version of the BHSP. In one sense, internal technocrats appear to have functioned as a medium through which local factors (institutions, interest groups and laws) might have shaped the BHSP. User fees and its inheritance from the past might represent one of the examples of such continuity mediated by internal technocrats. Evidence presented in this section has also shown that actors were changing their opinions and positions as they were transferring (and transforming) the policy. This study, therefore, has revealed that neither the policy transferred nor the actor involved in their transfer was fixed and constant.
This research was intended to explore the processes through which the BHSP was conceived and designed in Iraq. More specifically, the study had several objectives that included exploring the extent to which external models and local precedents contributed to shaping health policies in a post-conflict setting. Relatedly, it also examined the interests and preferences of local and external actors in introducing user fees as part of Iraq’s BHSP. Finally, the study also investigated the extent of policy transfer in the formulation of Iraq’s BHSP.

This study is the first to undertake a systematic comparison among the BHSPs in diverse countries. This comparison has found considerable similarities (as well as differences) between Iraq’s BHSP and equivalent policies in other nations. The similarities between Iraq’s BHSP and other comparable policies suggest that the policy (or part of it) was probably copied, emulated, inspired by or synthesised elements and lessons from those policies. The transfer to Iraq occurred through various modalities and mechanisms. The findings of this research suggest that Iraq’s BHSP was not introduced by a single external actor and was not entirely copied from a single external model. Rather, this study has found that Iraq’s BHSP emerged through interactions among and between internal and external actors. It also has found that the policy was shaped by elements from multiple domestic and external models.

One of the major themes that emerged from the analysis in this study was that Iraq’s BHSP has retained significant elements of continuity from prior models that existed in the country. Rather, this research has found that Iraq’s BHSP has replicated some of the features of the existing health system and inherited others from the past. This study also revealed that internal actors in the context of Iraq’s BHSP played a considerable role in the formulation of the BHSP. While it appears that external players initially suggested the idea of the BHSP, it was domestic actors who took the lead in its formulation.

Another major contribution of this research was an increased understanding of debates around user fees in Iraq. This project has highlighted continuity and change in Iraq’s health system pertaining to user fee policies. The study has found that user fees had earlier
precedents in the country’s health system. The study has also shown that interviewed internal technocrats and bureaucrats almost unanimously supported the recognition of user fees as a source of financing the BHSP. Moreover, most interviewed external actors distanced themselves from the decision to include user fees in the BHSP. With regards to other financing concepts, the study suggests that the BHSP introduced the concept and label of insurance without substantially establishing a system of pooling of resources. Finally, it appears that the BHSP was viewed as a tool to reorient the ownership of services through keeping primary health services in the public ownership while privatising other services.

9.1 Contributions to the literature
This research has made three potential contributions to the literature on health policymaking in post-conflict, conflict-affected and fragile settings.

Firstly, this research attempted to address the dearth of knowledge on health policymaking in the post-conflict setting of Iraq. Arguably, this study is the first in-depth examination of formulating a health policy in such context. It is also the first to engage in a comparative analysis of the BHSP across multiple post-conflict and conflict-affected countries. Therefore, this research would contribute to broadening the knowledge base of health policymaking in Iraq. It would also potentially assist with researching a similar topic particularly in the currently conflict-affected countries of the MENA region. Such contribution can be potentially fulfilled through a critical application of this study’s methodologies. It would also be accomplished by attempting to explore the questions that this research leaves unanswered (for a discussion of unanswered questions please refer to the section on the direction of future research in chapter eight on page 198).

Secondly, this study has shown that it is possible to overcome some of the practical challenges of access in difficult circumstances. Due to security concerns, the researcher was not able to access certain locations to conduct interviews or obtain documents. Such restrictions on access introduced limitations that are described below. However, they also offered the opportunity to experiment with innovative technological tools such as Skype. Reflecting on the use of those tools would potentially contribute to strengthening the theory and practice of their applications in research. Such applications are particularly relevant to
conducting research in similarly challenging and conflict-affected circumstances of the MENA region.

Thirdly, this research has critically applied the arguably underutilised policy transfer framework in studying health policymaking in fragile settings. We were able to identify only one study that explicitly used the policy transfer framework in a post-conflict setting (Strong 2003b). Therefore, using such framework will shed more light on its utility for exploring questions related to policymaking in post-conflict settings. It will also potentially contribute to advancing the framework through uncovering and attempting to overcome some of its limitations. For example, the findings of this study seriously question the notion of a solitary origin or a unidirectional movement of a policy (Schon 1973; Freeman 2002; Reich 2002; Lee & Goodman 2002). Rather, the study revealed multiple origins of the BHSP in Iraq.

9.2 Implications and recommendations
This study appears to support the argument for a change in the way that health systems emerging from conflict are approached. First, it is not helpful to homogenise diverse health systems under such broad categories such as post-conflict, conflict-affected or even fragile terminologies. It appears that international actors often artificially categorise countries under such broad terminologies. While those nomenclatures are useful to highlight particular features of those settings, they also obscure crucial historical, demographic and health system characteristics. Overlooking such characteristics could result in introducing policies that are probably inappropriate. They also imply opportunity costs resulting from resources that can be invested more fruitfully in other ways. If better alternatives are not currently possible, a more cautious use of those terminologies is needed to reflect a nuanced understanding of the diverse health systems it attempts to represent.

Second, one of the major implications of this study is the need for a better and deeper understanding of local contextual factors that shape health policymaking in post-conflict, conflict-affected and fragile settings. International actors often advocate taking those contextual factors into considerations and usually claim to do so. However, this study suggests that in the context of Iraq, understanding the local context by international actors was perhaps superficial. While instruments such as need assessments that are often conducted
in early post-conflict periods are seen as tools to examine the local contexts, they demonstrate certain shortcomings. In the case of Iraq, such instrument appears to overlook significant historical features of the health system such as the existence of a BHSP-like structure and user fees. We suggest that had the instrument engaged in a deeper understanding of Iraq’s health system, an expensive policy such as the BHSP perhaps would not have been needed.

Third, and related to the point above, this research identifies a need for greater grasp and comprehension for the changing roles and influences of internal actors during health policymaking in conflict-affected settings. The literature tends to depict internal actors as passive recipients of externally imposed policies. Research rarely explores the roles and influences of such actors during health policymaking in conflict-affected settings. Even less adequately studied is the interactions between internal and external actors and the complexities involved in such interactions. While such omission might be justifiable in poorly resourced health systems that are devastated by conflict, that is perhaps not the case in the context of Iraq. The latter had a rich history in health policymaking and a health system characterised by considerable capabilities. Bureaucrats and experts with long institutional memories and extensive professional and political network undertook such policymaking. Overlooking the role of those domestic actors could result in challenges for preserving the consistency and coherence of newly suggested policies. Such coherence might be undermined by the tendency of local actors to replicate existing systems and the difficulty with unlearning old behaviours.

Given the ongoing crisis in the MENA region and the possibility of similar conflicts in the future, this research has implications for future policy action. It appears that policymakers in conflict-affected settings should pay a closer attention not only to current health system features but also to historical trends of policymaking. A deeper understanding of the roles and influences of local actors and their interactions with external ones is also needed. A richer grasp of the local context, including the latter’s similarities and differences with similar ones, have implications for the outcomes of introducing policies that proved successful in other settings. Therefore, a more comprehensive need assessments conducted in health systems emerging from conflict that incorporate those aspects would be a productive investment.
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10 Appendices:

11 Appendix 1: Semi-structured interview guides

A. The stakeholders involved in the introduction of the BHSP, alliances, networks and preferences.
   - What are the justifications for the BHSP in Iraq and other post-conflict settings?
   - What problems the BHSP was designed to tackle?
   - Why do you think the BHSP and its financing methods are important for the country?
   - What do you think/ how do you feel about the BHSP? (initial vs. later thoughts and feeling)
   - How the idea of the BHSP started? What is the role of WHO/World Bank/Other actors in starting the idea?
   - Who was involved in proposing the BHSP?
   - To what extent were specific actors (USAID, World Bank, UN, etc.) involved?
   - How did internal pressure act in comparison to external ones;
   - How were the specific components of the BHSP designed?

B. Can you describe the chronology of events leading to the introduction of the BHSP?

C. The financing of the BHSP, why user fees, whose idea was it?
   - How is the decision-making process about the financing of the BHSP went?
   - Who was involved in the decision making?
   - What do you think about user fees in financing the BHSP?
   - What are the purposes of the user fee component of the BHSP?
   - Were other contexts used as an example for guiding the introduction of user fees?

D. Changes in the initial design following the introduction. What was the nature of those changes, who proposed them and what were their purposes.
   - Whom were the influential parties involved in the design of the BHSP and it user fee component?
   - Can you describe the process through which the BHSP was designed?
   - Were there any proposed changes by the participating parties? Can you describe those proposals?
   - Whose proposals were more influential and effective, why?

✓ Can we have another Skype call to follow up on this?
✓ Do you have any documents or any data you would like to share?
✓ Do you think there are other people to talk to?
### Appendix 2: Contacted and interviewed participants and their organisations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contacted</th>
<th>Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hawler Medical University</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>2. MoH</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>3. WHO</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>4. USAID</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>5. USAID</td>
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<td>Y</td>
</tr>
<tr>
<td>6. WHO</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>7. EPOS</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>8. Abt Associates</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>9. World Bank</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>10. MoH</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>11. MoH</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>12. World Bank</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>13. US government</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>14. World Bank</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>15. WHO</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>16. Oxford Policy Management</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>17. MoH</td>
<td>Y</td>
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<tr>
<td>18. MoH</td>
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<td>19. World Bank</td>
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<td>20. MoH</td>
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<td>Y</td>
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<tr>
<td>21. Harvard School of Public Health</td>
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<tr>
<td>22. Harvard School of Public Health</td>
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<td>N</td>
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<tr>
<td>23. Columbia University</td>
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<tr>
<td>24. Oxford Policy Management</td>
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<tr>
<td>25. Oxford Policy Management</td>
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<tr>
<td>26. MoH/WHO</td>
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<td>N</td>
</tr>
<tr>
<td>27. WHO</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>28. WHO</td>
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<td>N</td>
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<tr>
<td>29. WHO</td>
<td>Y</td>
<td>N</td>
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<td>30. WHO</td>
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<td>31. WHO</td>
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<td>32. World Bank</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>33. World Bank</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>34. US government</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>35. US government</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>36. US government</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>37. Hawler Medical University</td>
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<td>N</td>
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<tr>
<td>38. MoH</td>
<td>Y</td>
<td>N</td>
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</table>
## Appendix 3: list of documents used in the analysis

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
<th>Description/Notes/Author</th>
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<tbody>
<tr>
<td>Package of basic health services for Uganda</td>
<td>1997</td>
<td>MoH-Uganda</td>
</tr>
<tr>
<td>Minimum Package of Activites/Cambodia</td>
<td>1998</td>
<td>MoH-Cambodia</td>
</tr>
<tr>
<td>Basic Package of Health Services/Burma</td>
<td>2000</td>
<td>MoH-Burma</td>
</tr>
<tr>
<td>A basic package of health services for Afghanistan</td>
<td>2003</td>
<td>MoH-Afghanistan</td>
</tr>
<tr>
<td>A basic package of health services for Afghanistan</td>
<td>2005</td>
<td>MoH-Afghanistan</td>
</tr>
<tr>
<td>A basic package of health services for Afghanistan</td>
<td>2010</td>
<td>MoH-Afghanistan</td>
</tr>
<tr>
<td>Basic package of health and social welfare services for Liberia</td>
<td>2008</td>
<td>MoH-Liberia</td>
</tr>
<tr>
<td>A basic health services package for Iraq</td>
<td>2009</td>
<td>MoH-Iraq</td>
</tr>
<tr>
<td>Essential Package of Health Services/Senegal</td>
<td>2009</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Basic package of health and nutrition services for Southern Sudan</td>
<td>2010</td>
<td>MoH-South Sudan</td>
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<tr>
<td>Basic Package of Essential Health Services for Sierra Leone</td>
<td>2010</td>
<td>MoH-Sierra Leone</td>
</tr>
<tr>
<td>Service Package for Health Facilities at different levels of service delivery</td>
<td>2011</td>
<td>MoH-Rwanda</td>
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<tr>
<td>Constituting the Basic Health Services Package</td>
<td>2012</td>
<td>costing of Iraqi FSIP by IFCS</td>
</tr>
<tr>
<td>Iraq Public Sector Modernization Programme: Health Sector Road Map</td>
<td>2011</td>
<td>Road map by Oxford Policy Management</td>
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<tr>
<td>Mid-term Performance Evaluation of USAID / Iraq Primary Health Care Project</td>
<td>2013</td>
<td>QED group LLC evaluation</td>
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<td>Flow of Funds - Health Care Sector in Iraq</td>
<td>2014</td>
<td>Abt associates</td>
</tr>
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<td>Ministry of Health Bil</td>
<td>2014</td>
<td>Official Iraq government policy document</td>
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<tr>
<td>Vision for the Iraq Health System</td>
<td>2014</td>
<td>Official Iraq government policy document</td>
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<td>Health System Profile Iraq</td>
<td>2006</td>
<td>WHO</td>
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<tr>
<td>FACT SHEET ON THE INTERNATIONAL COMPACT WITH IRAQ</td>
<td>2007</td>
<td>UN</td>
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<td>CBO Report for Congress Received Through the CBO Web Iraqi, Farm, and Debt Relief</td>
<td>2005</td>
<td>CBO</td>
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<td>Tentative Implementation of the System</td>
<td>1992</td>
<td>Colonial Office</td>
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<td>The Road to Economic Prosperity for a Post-Saddam Iraq</td>
<td>2003</td>
<td>The Heritage Foundation</td>
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<td>Report of the Financial Mission appointed by the Secretary of State for the Colonies to Algeria</td>
<td>1925</td>
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<td>Report of the National Health Mission to Iraq</td>
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<td>Nutrition Mission to Iraq for UNICEF</td>
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<td>Harvard Study Team Report: Public Health in Iraq After the Gulf War</td>
<td>1994</td>
<td>Harvard</td>
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<td>Iraq: Request for Stand-By Arrangement — Staff Report</td>
<td>2006</td>
<td>IMF</td>
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<td>Iaea Contribution</td>
<td>2005</td>
<td>Official Iraq government policy document</td>
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<td>The illness and constitution of the Kurdish Doctors' Syndicate</td>
<td>2001</td>
<td>Doctors' Syndicate</td>
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<td>Report by His Majesty's Government in the United Kingdom of Great Britain and Northern</td>
<td>1930</td>
<td>Colonial Office</td>
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<td>Report to the Secretary-General on humanitarian aid in Kuwait and Iraq in the interwar period</td>
<td>1931</td>
<td>UN</td>
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<td>UN Security Council Resolution 661</td>
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<td>WHO Iraq 2011 Review</td>
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<td>Iraq's National Health Account 2008</td>
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<td>Confronting poverty in Iraq: new findings</td>
<td>2011</td>
<td>World Bank</td>
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<td>Iraq Household Socio-Economic Survey - HISSE 2007</td>
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<td>Third Interim Strategy Note of the The World Bank Group for Iraq</td>
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<td>Node</td>
<td>Child nodes</td>
<td>Description</td>
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<td>------</td>
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<tr>
<td>User fees</td>
<td>with</td>
<td>evidence about whether actors are supporting user fees</td>
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<tr>
<td></td>
<td>neutral</td>
<td>do not have any particular position on user fees</td>
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<tr>
<td></td>
<td>mixed</td>
<td>have mixed views on user fees</td>
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<tr>
<td></td>
<td>history</td>
<td>what is the history about user fees</td>
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<td></td>
<td>harmonization</td>
<td>the convergence of policies about user fees</td>
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<td></td>
<td>decision making on user fees</td>
<td>who, how and what decision is made about user fees</td>
</tr>
<tr>
<td></td>
<td>against</td>
<td>who are against user fees</td>
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<tr>
<td></td>
<td>why not</td>
<td>(what arguments those who are against user fees bring to support their views)</td>
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<td>BHSP development process</td>
<td>the origin of the BHSP</td>
<td>What are the origins of the BHSP, where it did come from and who are the main actors who advocated it?</td>
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<td></td>
<td>the main actors</td>
<td>Whom are the main actors involved in the development of the BHSP in Iraq?</td>
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<tr>
<td></td>
<td>revolving door</td>
<td>(those actors who moved from one organization to the other from those that were involved in the development of the BHSP)</td>
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<tr>
<td></td>
<td>internal actors</td>
<td>(those actors that are affiliated with Iraqi organizations and institutions)</td>
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<td></td>
<td>external actors</td>
<td>(those actors who are part of organizations from outside the country)</td>
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<tr>
<td></td>
<td>Coalitions</td>
<td>(coalition that are involved in the development of the BHSP in Iraq)</td>
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<td>technology</td>
<td>the use of technology and its transfer to Iraq</td>
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<td>the pre-existing health system</td>
<td>properties related to the health system in Iraq that were important in the development of the BHSP</td>
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<td>policy translation</td>
<td>evidence about policy translation in the data</td>
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<tr>
<td></td>
<td>virtual policy making</td>
<td>(policy making through means other than physically sitting together with a group of people)</td>
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<td></td>
<td>Use of existing structures</td>
<td>(How the existing health system does affects the development of a new policy that is transferred to the country,)</td>
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<td></td>
<td>picking and choosing</td>
<td>(choosing attributes, contents, organizations of a new policy by the actors rather than using the whole policy as it is)</td>
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<tr>
<td></td>
<td>no centrally managed hierarchy</td>
<td>(the lack or limited presence of centrally managed hierarchy in the process of the policy development)</td>
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<td>Negotiation</td>
<td>(evidence of negotiation in the development of the policy)</td>
</tr>
<tr>
<td></td>
<td>multidirectional interaction</td>
<td>(how multiple actors interact in multidirectional ways to shape the new policy)</td>
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<td></td>
<td>interpretation</td>
<td>(How different actors have different understanding to the same concept)</td>
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<td></td>
<td>Evolution</td>
<td>(Evidence of change (mutation) in the policy as it is developed,...)</td>
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<td>policy transfer</td>
<td>Evidence of the transfer of a piece of policy across places...</td>
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<td>language, terminology and translation</td>
<td>What are the interesting terms and language that was used?</td>
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<td>justifications</td>
<td>what are the justifications for the introduction and development of the BHSP in Iraq</td>
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<td>do international standards and best practices used as a justification for the introduction of the BHSP</td>
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<td>the hierarchy of decision making that affects the development of the BHSP</td>
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<td>how the BHSP is financed</td>
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<td>experience of other countries</td>
<td>how the experiences of other countries are affecting the development of the BHSP</td>
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<td>What evidence and how it is used?</td>
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<td>decision making</td>
<td>how the decision making process affects the development of the BHSP</td>
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<td></td>
<td>Priorities</td>
<td>(what are the priorities of the decision makers)</td>
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Appendix 5: Turnitin originality report

Basic Health

From PhD Thesis
(26 intellectual playground)

Processed on 02-Jun-2014 8:16 AM
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Word Count: 23568

Sources:

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Appendix 6: Approval from Iraq MoH's Scientific Committee

IRAQ MoH/ Scientific Committee,

Date: 29 July, 2013

RE: Financing of the Basic Health Services Package in Iraq: A Case Study of Policy Translation

To the University of Edinburgh/ Global Health Unit

We have been informed about the research plans of Goran Abdulla Sabir Zangana at the University of Edinburgh, Global Public Health Unit. Examining the Basic Health Service Package and its financing methods is an important topic for Iraq.

The study entitled, Financing of the Basic Health Services Package in Kurdistan: A Case Study of Policy Translation, has been thoroughly reviewed by our committee. We think it is well planned and do not see any ethical issues with it.

We approve this research. If you have any questions please contact >>>>>>>>

Sincerely,

Chair of Scientific Committee,

Dr. Neif Al-Heimiawy
email: n.heimiawy@yahoo.com
00964 770 191 2781
July 29, 2013
Appendix 7: University of Edinburgh’s Self-Audit Checklist
University of Edinburgh,
School of Social and Political Studies
RESEARCH AND RESEARCH ETHICS COMMITTEE

Self-Audit Checklist for Level 1 Ethical Review

The audit is to be conducted by the Principal Investigator, except in the following cases:

Postdoctoral research fellowships – the applicant in collaboration with the proposed mentor.

Postgraduate research (PhD and Masters by Research) – the supervisor. Note: All research postgraduates should conduct ethical self-audit of their proposed research as part of the proposal process. The audit should be integrated with the student’s Review Board.

Taught Masters dissertation work and Undergraduate dissertation/project work – in many cases this would not require ethical audit, but if it does (for example, if it involves original fieldwork), the dissertation/project supervisor is responsible for conducting the audit on behalf of the programme director.

1. Protection of research subject confidentiality

Are there any issues of CONFIDENTIALITY which are not ADEQUATELY HANDLED by normal tenets of academic confidentiality? YES/NO

These include well-established sets of undertakings that may be agreed more or less explicitly with collaborating individuals/organisations, for example, regarding:

(a) Non-attribution of individual responses;
(b) Individuals and organisations anonymised in publications and presentation;
(c) Specific agreement with respondents regarding feedback to collaborators and publication.

2. Data protection and consent

Are there any issues of DATA HANDLING and CONSENT which are not ADEQUATELY DEALT WITH and compliant with established procedures? YES/NO

These include well-established sets of undertakings, for example regarding:

(a) Compliance with the University of Edinburgh’s Data Protection procedures (see www.recordsmanagement.ed.ac.uk);
(b) Respondents giving consent regarding the collection of personal data;
(c) No special issues arising about confidentiality/informed consent.

3. Moral issues and Researcher/Institutional Conflicts of Interest
Are there any SPECIAL MORAL ISSUES/CONFLICTS OF INTEREST? YES/NO
(a) An example of conflict of interest would be the researcher compromising research objectivity or independence in return for financial or non-financial benefit for him/herself or for a relative of friend.
(b) Particular moral issues or concerns could arise, for example where the purposes of research are concealed, where respondents are unable to provide informed consent, or where research findings would impinge negatively/differentially upon the interests of participants.

4. Potential physical or psychological harm, discomfort or stress
(a) Is there a SIGNIFICANT FORSEEABLE POTENTIAL FOR PSYCHOLOGICAL HARM OR STRESS? YES/NO
(b) Is there a SIGNIFICANT FORSEEABLE POTENTIAL FOR PHYSICAL HARM OR DISCOMFORT? YES/NO
(c) Is there a SIGNIFICANT FORSEEABLE RISK TO THE RESEARCHER? YES/NO

5. Bringing the University into disrepute
Is there any aspect of the proposed research which might bring the University into disrepute? YES/NO

6. Vulnerable participants
Are any of the participants or interviewees in the research vulnerable, e.g. children and young people? YES/NO

Overall assessment
If all the answers are NO, the self audit has been conducted and confirms the ABSENCE OF REASONABLY FORESEEABLE ETHICAL RISKS. The following text should be emailed to the relevant person, as set out below:

Text: “I confirm that I have carried out the School Ethics self-audit in relation to [Goran Abdulla Sabir Zangana] proposed research project [Iraq’s Basic Health Services Package: Exploring the local and external influences on the formulation of a post-conflict health policy] and that no reasonably foreseeable ethical risks have been identified.”

**Research grants** – the Principal Investigator should send this email to the SSPS Research Office (ssps.research@ed.ac.uk) where it will be kept on file with the application.

**Postdoctoral research fellowships** – the Mentor should email the SSPS Research Office (ssps.research@ed.ac.uk) where it will be kept on file with the application.

**Postgraduate research** (PhD and Masters by Research) – there is no need to send the Level 1 email. The ethical statement should be included in the student’s Review Board report.

**Taught Masters dissertation** work and **Undergraduate dissertation/project** work – there is no need to send the level 1 email. The dissertation/project supervisor should retain the ethical statement with the student’s dissertation/project papers.

If one or more answers are YES, risks have been identified and level 2 audit is required. See the School Research Ethics Policy and Procedures webpage http://www.sps.ed.ac.uk/admin/info_research/ethics for full details.
Appendix 8: Consent form

CONSENT FORM / RESEARCH PROJECT

Title of Research Project: Financing of the Basic Health Services Package in Iraq: A Case Study of Policy Translation

Principal Investigator: Goran Abdulla Sabir Zangana

What you should know about this study:
- You are being asked to be interviewed as part of a Case Study of Policy Translation with regard to the Financing of the Basic Health Services Package in Iraq.
- This consent form explains the research study and your part in the study.
- Please ask questions at any time about anything you do not understand and feel free to ask us to repeat anything that you want us to repeat.

Purpose of Research Project:
You are being asked to be part of a research study. The purpose of the study is to explore and examine the views of policy makers in Iraq and other stakeholders at local, regional and international levels about the topic of the study.

Why you are being asked to participate
You are being asked to participate because you are regarded as a policy maker or a key player in the health care system or the political system in Iraq or a stakeholder who is part of a local, regional or international organization.

Procedures:
We are conducting a research study to find out about the opinions and views of policy makers in Kurdistan and Iraq about the financing of the BHSP. You are being asked to be part of this research study. You are chosen to participate in this study because of your previous experience and/or current positions within the government, parliament or civil society/international organizations in Iraq.

If you agree to be in the study you will be interviewed and asked to answer specific questions about the topic. The questions will ask you about your personal opinion and knowledge.

If you don’t agree to be interviewed, you may choose so now and the process of interviewing will not begin.

Risks/Discomforts:
The interview includes questions that ask you about your personal views and opinions. Everything you say will be kept confidential. If for any reason you wish to stop participating in the interview you are free to do so at any time.

Anticipated Benefits:
This information will help the researcher better plan future interviews on the same topic.

Sharing of New Findings:
In the future if you have any questions about the study, you should contact the researcher, whose contact information is provided below.

**Confidentiality:**
As part of doing the interview, the researcher will record your name, address and your organization and keep this information separately from the transcripts of the interview. Names and addresses and any other information that can be used to identify you will be kept separately from the results of the interviews. Only the researcher and no-one else will be able to see this information. Every effort will be made to protect the confidentiality of this information.

**Transcripts:**
- You will be provided with the transcripts of your interview if you wish so.

**Who do I call if I have questions or problems?**
Contact Dr Goran Zangana at 07584867623 or at g.a.s.zangana@sms.ed.ac.uk if you have any questions about the study.

**What does the signature on this consent form mean?**
- You have been informed about this study’s purpose, procedures, possible benefits and risks.
- You have been given the chance to ask questions.
- You have voluntarily agreed to be in this study.

**Do you agree to participate in this study?**

____________________________________
Signature of Investigator

____________________________________
Date
### Appendix 9: characteristics of the selected literature

<table>
<thead>
<tr>
<th>Author</th>
<th>Type</th>
<th>Settings</th>
<th>Aims</th>
<th>Methodology/methods</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahmadzai et al. 2008</td>
<td>Journal Article (The international journal of tuberculosis and lung disease)</td>
<td>Afghanistan</td>
<td>Scaling up TB DOTS</td>
<td>Quantitative: Secondary quantitative data</td>
<td>Afghanistan has achieved progress in scaling up TB DOTS. Scaling up NTP’s is possible in challenging environments</td>
</tr>
<tr>
<td>Aleshina 2007</td>
<td>Ph.D. Thesis (University of California, Berkeley)</td>
<td>East Timor</td>
<td>Explore the impact on efficiency, equity and utilisation of Clinic reconstruction</td>
<td>Quantitative: quasi-experimenta</td>
<td>Increased efficiency, no increase in utilisation, no impact on equity</td>
</tr>
<tr>
<td>Alonge et al. 2014</td>
<td>Journal Article (Health Policy and Planning)</td>
<td>Afghanistan</td>
<td>Examine the distributive effective of different contracting types on primary health care services between the poor and non-poor in rural Afghanistan</td>
<td>Quantitative</td>
<td>Certain types of contracting improves equity</td>
</tr>
<tr>
<td>Ameli &amp; Newbrander 2008a</td>
<td>Journal Article (Bulletin of World Health Organisation)</td>
<td>Afghanistan</td>
<td>Examine the effects of contracting on health service utilization and quality on the costs of the BPHS</td>
<td>Quantitative</td>
<td>Access can be extended through contracting mechanisms in post-conflict settings in the presence of security problems.</td>
</tr>
<tr>
<td>Anwari et al. 2015</td>
<td>Journal Article (Conflict and Health)</td>
<td>Afghanistan</td>
<td>Piloting a people-centred governance intervention</td>
<td>Mixed methods: exploratory case study</td>
<td>Health system governance can be improved in fragile and conflict affected environments</td>
</tr>
<tr>
<td>Arur et al. 2010</td>
<td>Journal article (Health Policy and Planning)</td>
<td>Afghanistan</td>
<td>Comparing utilisation changes between different types of contracting</td>
<td>Quantitative</td>
<td>Contracting-in and out are associated with substantial double difference increases in service use</td>
</tr>
<tr>
<td>Beaston-Blaakman et al. 2011</td>
<td>Journal article (International journal of public administration)</td>
<td>Afghanistan</td>
<td>Provide an example of public administration reforms through the Health economic and financing directorate (HEFD) at MoPH</td>
<td>qualitative</td>
<td>Afghanistan faces significant challenges in health service provision and policy</td>
</tr>
<tr>
<td>Beesley et al. 2011</td>
<td>Journal article (Health Policy and Planning)</td>
<td>Southern Sudan</td>
<td>Reviewing the methodology of the provision of technical assistance to the MoH for the formulation of a human resource plan</td>
<td>Qualitative</td>
<td>The failure to implement the recommendations of a survey was due to the lack of capacity in part of the MoH to translate solutions to identified problems into action</td>
</tr>
<tr>
<td>Bertone et al. 2014</td>
<td>Journal article (Conflict and Health)</td>
<td>Sierra Leone</td>
<td>Examining the trajectory of policies on human resources for health and its determinants</td>
<td>Qualitative: stakeholder analysis, document review and interviews</td>
<td>A window of opportunity for policy change might not arise immediately in the post-conflict period</td>
</tr>
<tr>
<td>Bewley-Taylor 2014</td>
<td>Journal article (International Journal of Drug Policy)</td>
<td>Afghanistan</td>
<td>Exploring the formulation of the first version of the National Drug Control Strategy</td>
<td>Qualitative: document review and interviews</td>
<td>The policy is 'divorced’ from local realities, perhaps authored by external actors with limited internal input, symbolism trumped effectiveness and realism, the policy is an example of policy transfer</td>
</tr>
<tr>
<td>Bhushan et al. 2002</td>
<td>Policy brief</td>
<td>Cambodia</td>
<td>Determine the feasibility, impact and cost-effectiveness of government contracting with NGOs.</td>
<td>Quantitative</td>
<td>The contracted districts consistently outperformed the control districts</td>
</tr>
<tr>
<td>(Blaakman et al. 2013)</td>
<td>Journal article (Global Public Health)</td>
<td>Afghanistan</td>
<td>Examine economic trade-offs in the provision of the BPHS through two alternative approaches of contracting</td>
<td>Quantitative</td>
<td>An approximate 60% increase in costs yielded a 16.8% increase in technical efficiency in the delivery of the BPHS</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>(Buuse 2012)</td>
<td>Thesis: (MSc)/University of Amsterdam</td>
<td>Northern Uganda</td>
<td>Examine the degree to which the Village health Team was able to increase access and availability of health services</td>
<td>Qualitative</td>
<td>The programme was only partially able to achieve its goals of increasing access and availability of health services to people living in rural areas</td>
</tr>
<tr>
<td>(Carvalho et al. 2013)</td>
<td>Journal article (Health Policy and Planning)</td>
<td>Afghanistan</td>
<td>Assess the health outcome and cost-effectiveness of strategies to improve the safety of pregnancy and childbirth</td>
<td>Quantitative</td>
<td>Family planning is the most effective individual intervention to reduce maternal mortality</td>
</tr>
<tr>
<td>(Claxton et al. 2010)</td>
<td>Report: World Vision</td>
<td>Somalia</td>
<td>Explore the feasibility of negotiations of Global Fund’s TB project for health assistance in a fragile state</td>
<td>Qualitative</td>
<td>A shift in international assistance policy from negotiations with state actors, to a more inclusive framework which includes a broad spectrum of parties</td>
</tr>
<tr>
<td>(Cockcroft et al. 2011)</td>
<td>Journal article (BMC Health Services Research)</td>
<td>Afghanistan</td>
<td>Explore the public’s views and experience of health service following contracting</td>
<td>Quantitative</td>
<td>People preferred private services, experiences were similar in different contracting approaches, and unofficial payments were made.</td>
</tr>
<tr>
<td>(De Vries &amp; Klazinga 2006)</td>
<td>Journal article (European Journal of Public Health)</td>
<td>Bosnia and Kosovo</td>
<td>Explore mental health reforms in post-conflict settings</td>
<td>Mixed</td>
<td>Foreign influence stimulates the initiation of reform but it can threaten the sustainability of reforms</td>
</tr>
<tr>
<td>(Durham et al. 2015)</td>
<td>Journal article (Human Resources for Health)</td>
<td>Afghanistan , CAR, DR Congo, Haiti, Palestine, Somalia</td>
<td>Examine the profile of HRH in settings where the latter is a less coherent and cohesive entity and where the public health subsector is less dominant</td>
<td>Qualitative</td>
<td>Reliance on information provided by the state provides a partial and inadequate picture. Conceptual tools reflecting the situation on the ground are needed.</td>
</tr>
<tr>
<td>(Earnest 2011)</td>
<td>PhD thesis (Curtin University)</td>
<td>Kosovo</td>
<td>Examine the challenges of planning and executing post-conflict reconstruction</td>
<td>Mixed methods</td>
<td>Poor quality of planning and implementation, management practices and processes of international actors do not work effectively in community service delivery, need to understand complex political environment and ability to coordinate effectively.</td>
</tr>
<tr>
<td>(F. Homan et al. 2010)</td>
<td>Journal article (Prehospital and Disaster Medicine)</td>
<td>Kosovo</td>
<td>Examine challenges in implementation and sustainability of family medicine-based antenatal care</td>
<td>Quantitative</td>
<td>Providers showed mastery of the components of the intervention</td>
</tr>
<tr>
<td>(Haidari et al. 2014)</td>
<td>Journal article (Eastern Mediterranean Health Journal)</td>
<td>Afghanistan</td>
<td>Examine the readiness of stakeholders in Afghanistan for sustaining delivery of BPHS without external assistance</td>
<td>Qualitative</td>
<td>Sustainability is questionable as stakeholders are sub-optimally organised, uneven ownership, divisive positioning, influential actors are lukewarm and most supportive are less influential.</td>
</tr>
<tr>
<td>(Howard et al. 2013)</td>
<td>Journal article (BMC)</td>
<td>Afghanistan</td>
<td>Examine Stakeholders</td>
<td>Qualitative</td>
<td>Significant improvements in service coverage and</td>
</tr>
<tr>
<td>Reference</td>
<td>Article Type</td>
<td>Country/Countries</td>
<td>Title</td>
<td>Methodology</td>
<td>Findings</td>
</tr>
<tr>
<td>-----------</td>
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<tr>
<td>al. 2014)</td>
<td>Health Services Research</td>
<td></td>
<td>perspectives on intervention for Sexual and reproductive health delivered through the BPHS workforce (gender balance, numbers, training and standardisation). Weaknesses in access, usage, staff retention, workload and accountability.</td>
<td>Qualitative</td>
<td></td>
</tr>
<tr>
<td>(Ir et al. 2010)</td>
<td>Journal article (Health Policy)</td>
<td>Cambodia</td>
<td>To examine how knowledge on health equity fund intervention is used to inform policy</td>
<td>Qualitative</td>
<td></td>
</tr>
<tr>
<td>(Jones et al. 2015)</td>
<td>Journal article (BMJ)</td>
<td>South Sudan</td>
<td>Explore perceptions of achievements, challenges and lessons during health system strengthening</td>
<td>Workforce limited and access to medicine insufficient, service delivery is poor</td>
<td></td>
</tr>
<tr>
<td>(Kevany et al. 2012)</td>
<td>Journal article (Medicine, Conflict and Survival)</td>
<td>South Sudan</td>
<td>Observe and review the key challenges to M&amp;E systems</td>
<td>Development and implementation of M&amp;E procedures in post-conflict settings requires extensive adaptations</td>
<td></td>
</tr>
<tr>
<td>(Jones et al. 2015)</td>
<td>Journal article (BMJ)</td>
<td>South Sudan</td>
<td>Qualitative</td>
<td>Workforce limited and access to medicine insufficient, service delivery is poor</td>
<td></td>
</tr>
<tr>
<td>(Kevany et al. 2012)</td>
<td>Journal article (Medicine, Conflict and Survival)</td>
<td>South Sudan</td>
<td>Qualitative</td>
<td>Development and implementation of M&amp;E procedures in post-conflict settings requires extensive adaptations</td>
<td></td>
</tr>
<tr>
<td>(Khalil 2013)</td>
<td>Journal article (public health)</td>
<td>Fragile states</td>
<td>Reviewing the literature on contracting</td>
<td>Literature review</td>
<td></td>
</tr>
<tr>
<td>(Kolaczkinski 2005)</td>
<td>Journal article (Tropical Medicine and International Health)</td>
<td>Afghanistan</td>
<td>Documenting experience of RBM support during initial post-conflict reconstruction</td>
<td>Success depends on individual properties of countries (levels of government backing, familiarity with engaging private providers, M&amp;E schemes)</td>
<td></td>
</tr>
<tr>
<td>(Kolaczkinski 2005)</td>
<td>Journal article (Tropical Medicine and International Health)</td>
<td>Afghanistan</td>
<td>Qualitative</td>
<td>(i) technical support is needed for a number of years (ii) the role and responsibilities of support staff need to be clear to all RBM partners; (iii) part of this role should be to act as focal point, in an attempt to improve on coordination and (iv) support staff should be seconded to the MoH.</td>
<td></td>
</tr>
<tr>
<td>(Kolaczkinski 2005)</td>
<td>Journal article (Tropical Medicine and International Health)</td>
<td>Afghanistan</td>
<td>Qualitative</td>
<td>(i) technical support is needed for a number of years (ii) the role and responsibilities of support staff need to be clear to all RBM partners; (iii) part of this role should be to act as focal point, in an attempt to improve on coordination and (iv) support staff should be seconded to the MoH.</td>
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<tr>
<td>(Kolaczkinski 2005)</td>
<td>Journal article (Tropical Medicine and International Health)</td>
<td>Afghanistan</td>
<td>Qualitative</td>
<td>(i) technical support is needed for a number of years (ii) the role and responsibilities of support staff need to be clear to all RBM partners; (iii) part of this role should be to act as focal point, in an attempt to improve on coordination and (iv) support staff should be seconded to the MoH.</td>
<td></td>
</tr>
<tr>
<td>(Lanjouw et al. 1999)</td>
<td>Journal article (Health Policy and Planning)</td>
<td>Cambodia</td>
<td>Examine the context and process of aid coordination</td>
<td>Qualitative</td>
<td></td>
</tr>
<tr>
<td>(Martins et al. 2006)</td>
<td>Journal article (Plos Medicine)</td>
<td>East Timor</td>
<td>Examine the enabling factors for the implementation of TB control program</td>
<td>Qualitative</td>
<td></td>
</tr>
<tr>
<td>(Mauch et al. 2010)</td>
<td>Journal article (Health Policy)</td>
<td>Somalia, Afghanistan, DR Congo, Haiti</td>
<td>Draw on the experience of four fragile states in tuberculosis control</td>
<td>TB programmes can function in fragile states but face considerable problems in access.</td>
<td></td>
</tr>
<tr>
<td>(Mercer et al. 2014)</td>
<td>Journal article (international journal of health services)</td>
<td>East Timor</td>
<td>Qualitative</td>
<td>Ministries of health can facilitate an effective transition of NGO support from crisis to development if they are allowed to plan and manage the process</td>
<td></td>
</tr>
<tr>
<td>(Mejeres 2013)</td>
<td>Master thesis (Harvard School of Public Health)</td>
<td>Liberia</td>
<td>Qualitative</td>
<td>Vast implementation barriers including lack of knowledge in part of providers</td>
<td></td>
</tr>
<tr>
<td>(Najafizada et al. 2014)</td>
<td>Journal article (Conflict and Health)</td>
<td>Afghanistan</td>
<td>Describe facilitators and challenges to the BPHS, community health workers, explore gender dynamics</td>
<td>Community health workers play an important role in post-conflict countries contributing to health system strengthening</td>
<td></td>
</tr>
<tr>
<td>(Newbrande</td>
<td>Journal article (Global)</td>
<td>Afghanistan</td>
<td>Examine why the BPHS</td>
<td>Mixed</td>
<td>Translating policy into practice, focusing on</td>
</tr>
<tr>
<td>Reference</td>
<td>Source</td>
<td>Setting</td>
<td>Description</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Patel et al. 2014</td>
<td>Public Health</td>
<td>19 countries</td>
<td>Explore the influence of GHIs on the health systems of conflict-affected countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patel et al. 2009</td>
<td>Multiple countries</td>
<td>Analyse official development assistance for Reproductive health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palmer et al. 2006</td>
<td>Afghanistan</td>
<td>Examine the experience of Afghanistan with contracting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pavignani &amp; Durao 1999</td>
<td>Mozambique</td>
<td>Review actors and their interactions in donor aid and coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pavignani 2011</td>
<td>Multiple</td>
<td>Condensed description of some African HRH recovery processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percival et al. 2014</td>
<td>Multiple</td>
<td>How gender sensitive is the reconstruction and reform of health systems in post-conflict countries?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percival &amp; Sondorp 2010b</td>
<td>Kosovo</td>
<td>Examine the selection and outcome of health reform measures and processes in post conflict settings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petit et al. 2013</td>
<td>Liberia</td>
<td>Explore perceptions of providers and policy makers on the implementation of the BPHS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rechel &amp; Khodjamurodov 2010</td>
<td>Tajikistan</td>
<td>Examine the introduction of the basic benefit package and co-payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pfeiffer 2003</td>
<td>Mozambique</td>
<td>Examine the relationships between international aid workers and their local counterparts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roome et al. 2014</td>
<td>Multiple</td>
<td>Review published literature on health force in post-conflict settings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rothmann et al. 2010</td>
<td>East Timor, Sierra Leone, DR Congo</td>
<td>Generate better understanding of the basic requirements for a SWAp in post-conflict settings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seddiq et al. 2014</td>
<td>Afghanistan</td>
<td>Examine the processes that enabled TB programme to achieve</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Priorities, clear definition of delivered services and helping MoH to expert stewardship.

Engagement should be supported by more context specific policies.

Inequity in disbursement of reproductive health between conflict affected countries and non-conflict affected countries.

Contracts with NGOs are probably the only way to get systems moving quickly.

Coordination has paid off, progress required intense and sustained work. Incremental approaches are crucial. The initiative have come mainly from donors with the MoH receptive and reactive.

The highest hurdles lie outside of the health domain (political and administrative).

Success is undermined by the external nature of reform, compressed time period and weak state capacity.

Limited understanding of the BPHS, suboptimal delivery, need for dialogue between health providers and policy makers.

External agencies have both strengthened and weakened national health governance, efforts by international actors were fragmented, limited technical and institutional capacity of MoH.

Relationships has fragmented the health system, undermined local control of health programs and increased local social inequality.

Less is known about distribution.

SWAp is not a universally accepted approach, it is not a panacea, it moves in an iterative process involving trial and errors, challenged by the existence of diverse aid modalities, fragile governments and unpredictable donor policy and behaviour.

Public health programmes can be effectively implemented in fragile states through high political commitment and strong local leadership.
<table>
<thead>
<tr>
<th>Author(s) (Year)</th>
<th>Type of Source</th>
<th>Location</th>
<th>Methodology</th>
<th>Research Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sergio (2007)</td>
<td>PhD Thesis (Queen Margret University)</td>
<td>Guatemala</td>
<td>Analysis of community participation within a health sector reform process</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Shuey et al. (2003)</td>
<td>Journal article (health policy)</td>
<td>Kosovo</td>
<td>Examine the process of developing health policing in Kosovo</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Sondorp et al. (2009)</td>
<td>Report (Centre for global development)</td>
<td>Afghanistan</td>
<td>Describe different contractual approaches and explore the evidence on their effectiveness</td>
<td>Quantitative</td>
</tr>
<tr>
<td>Speakman et al. (2014)</td>
<td>Journal article (BMC women’s health)</td>
<td>Afghanistan</td>
<td>Analyse midwifery education development and implementation</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Steinhardt et al. (2011b)</td>
<td>Journal article (health policy and planning)</td>
<td>Afghanistan</td>
<td>Examine the effects of fee removal on facility quality and utilisation</td>
<td>Quantitative</td>
</tr>
<tr>
<td>Tapps et al. (2015)</td>
<td>Journal article (global public health)</td>
<td>Afghanistan</td>
<td>Explore the conditions that affect availability and utilisation of intrapartum care</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Warsame et al. (2015)</td>
<td>Journal article (international health)</td>
<td>Somalia</td>
<td>Examine approaches to health system strengthening</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Woodward et al. (2014)</td>
<td>Journal article (human resources for health)</td>
<td>Liberia, West Bank, Gaza, Sierra Leone, Somaliland</td>
<td>Explore the personal experiences of health workers using e-health innovations</td>
<td>Qualitative</td>
</tr>
</tbody>
</table>