Project Title:

Assessing the role of decentralizing health reform in Iraqi Kurdistan Region on addressing the needs of the disadvantaged population in semi-urban and rural areas

Final Technical Report

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BACKGROUND

Decentralization is the transfer of planning, decision making or management functions from the central government and its agencies to field organizations, subordinate units of government, semi-autonomous public cooperation, area-wide or regional development organizations, specialized functional authorities or non-governmental organizations (Cheema and Rondnelli 1983).

Since the late 1980s, most developing counties have started to implement health reforms supported by different international organizations like the World Bank, the International Monetary Fund and other international aid organizations. The aim of these reforms was to address health care issues related to improving efficiency, effectiveness, and equity of health services. While decentralization is seen as a central part of these health reforms in different countries, complete decentralization of a health system is rare. In practice, most countries taking this approach have implemented a variation of the 'deconcentration' form of decentralization (Saide and Stewart 2001; Menson 2006).

Decentralization within the health sector is usually adopted as a part of decentralization at central government level .It is a complex issue depending on many factors, and it is hard to draw conclusions about the success of decentralization of the health systems of different countries because each has particular circumstances. It is also the case that decentralization involves a broad range of structures and similar structures may function differently in different countries. Four main types of decentralization can be distinguished: deconcentration, devolution, delegation and privatization (Mills *et al* 1990).

1-Deconcentration is the most frequently used form of decentralization in developing countries. It includes transferring some administrative authority from central government ministries to locally-based offices. But since it does not normally involve transferring political power, it is regarded as the least extensive form of decentralization (Mills *et al* 1990).

2-Delegation has been described by Cheema and Rondinelli (1983) as transferring of decision-making and management authority for specific functions to organizations that are not under the direct control of central government ministries. This is therefore one step further along the spectrum in that a degree of delegated political authority is transferred alongside administrative authority

3-Devolution is defined as the creation or strengthening of sub national levels of government (often termed local government or local authorities) that are substantially independent of the national level with respect to a defined set of functions (Mills *et al* 1990). Here, there is a grant of political authority to the devolved bodies at least within their areas of authority.

4-Privatization is the transferring government responsibility for producing goods or supplying services to private organizations (profit or non-profit making enterprises) with variable degrees of regulations from the government to the services provided by these private organizations (Cheema and Rondinelli 1983).

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The precise distinction between these aforementioned forms of decentralization is not entirely clear, so that in practice some reforms lie in a grey area between two categories. This means that decentralization reforms in any country may have unique features and not fall clearly into any of the boxes proposed above (Mills *et al* 1990).

As a result of the increasing administrative load on the centre, the authorities in Kurdistan region decided to implement decentralization reforms to develop administrative and decision making capacity at district level. Previously the centre had lacked the resources to control and supervise all these districts. These changes started in the 1998 with the transferring of limited authority to these districts (Directorate of Health, Erbil 1998). Change was implemented first in Soran district because it was believed that certain preconditions for successful implementation already existed there, like the availability of adequate human and financial resources, and buildings. Later the reforms were rolled out in other districts including Barzan, Shaqlawa, Choman and Dashty Hawler. The transfer of authority was gradual. First simple administrative authority was passed to the District Health Offices, then later financial authority was passed across by 2005 (Directorate of Health, Erbil 2005)

Rationale

Decentralizing health system is an important health policy trend and has now been adopted by many of the countries around the world each with its particular form. As a result of the increasing administrative load on the directorates of health, the health authorities in Iraqi Kurdistan region decided to implement decentralization reforms to develop administrative and decision-making capacity at district level. This system has operated in Iraqi Kurdistan for many years but until now no empirical study has been carried out to review the policy, to assess the extent to which it has been successfully implemented and to evaluate its impact on the health of the population.

Objectives

The overall aim of the research was to review the implementation of the decentralizing health reforms in Kurdistan Region, Iraq.

Specific objectives

More specifically, the research had the following specific objectives:

1. Assess the planning process before implementing these reforms at different levels of the services
2. Evaluate the process and the steps of introducing the reforms
3. Determine the differences in applying these reforms in various districts in Erbil Governorates
4. Assess whether the reforms were entirely top-down or were there any opportunities for people at a lower level to feedback and influence implementation?
5. Identify the problems arose during implementation of these reforms
6. Come up with recommendations for the future development of these reforms

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METHODOLOGY

Study design
As the decentralizing health system reform in Iraqi Kurdistan region has not been studied in a comprehensive way, we used in-depth qualitative methodologies to provide a more robust mechanism to explore the fundamental problems, priorities and critical barriers to appropriate and sustainable improvement of the health system in district areas.

The study consisted of the following components:
1. Defining the needs, problems, and obstacles to decentralizing health system reform from the perspectives of medical and administrative staff in district health sectors through focus group discussions
2. Assessing the views of policy makers and managers on the decentralizing health system reform through semi-structured interviews
3. Assessment of health seeking behavior and perception of the quality of health services in a sample of population in semi-urban and rural areas through focus group discussions

Study setting/data sources
The study was carried out in Erbil, Iraqi Kurdistan region. The key components of the study took place in the District Health Sectors. Other elements included people living in these districts and key policy makers at the Directorate of Health.

Study population
Study participants included the physicians, nurses, and administrators working in district health sectors in Erbil governorate in Iraqi Kurdistan region. Besides, we elicited the perspectives on decentralizing health system reform from a wider group of policy makers and managers. Finally, we selected a sample of the general population in Erbil governorate to study health seeking behavior and perception of the quality of available services.

Sample size
A sample of 10-12 respondents from each of the seven district health sectors was selected for focus group discussions. A sample of 10-12 respondents from the population in each of the seven districts sectors was selected for focus group discussions. All the policy makers and managers in the directorate of health and the seven district health sectors were selected for interviews.

Sampling method
A purposive sampling method to identify the key informants among the health staff, policy makers, and managers as well as the population in the different districts of Erbil governorate was used.

Data collection
A topic guide to lead the focus group discussions and a semi-structured questionnaire for the interviews were developed, tested and used. The questions centered on the main problems facing the decentralization process and priority needs for improving the process.

Two researchers facilitated each focus group. A researcher acted as moderator and the other as an observer. One researcher conducted each interview. The aim of the study and the primary

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rules regarding recording of discussions and anonymity of all materials were explained to the participants at the beginning of each focus group/interview before obtaining the informed consent.

Each session was concluded when the discussions sufficiently covered the topic, and no new information was emerged.

Data analysis

All discussions/interviews were conducted in Kurdish language and were recorded in full. To assure translation accuracy, audio recordings were transcribed and translated into English. The translation was verified by an additional native Kurdish speaker fluent in English.

The translated transcripts were analyzed qualitatively using content analysis. The condensed meaning units were identified and condensed before abstracting them and labeling them with codes. Categories were obtained from the emerging coding. The categories were further discussed between the two coders for identification and formulation of themes and subthemes. A particular emphasis was placed on themes and sub-themes repeated by more than one participant/group, themes and sub-themes raised initially, strong feelings, or themes and sub-themes of long discussions.

Coordination, monitoring and quality control

The topic guide for focus groups and the semi-structured questionnaire for interviews were tested first before using them. Two researchers reviewed the transcripts independently, compared notes and reconciled the differences.

Ethical considerations:

The research was approved by the Research Ethics Committee, and a written informed consent was obtained from each participant.

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RESULTS

Knowledge about decentralizing health reform
Most respondents from policy makers and health managers had a clear understanding of what decentralizing health reform means. They emphasized the importance of adopting this reform to enhance the efficiency of the health system. The respondents stressed the necessity of having clear instructions and guidelines for decentralization to avoid any chaos, insurgency or diversion from the actual rules and responsibilities. Examples of quotations related to the participants' knowledge about decentralizing health reform included:

> "Decentralization means transferring authority to those working under your level according to specific instructions and guidelines regarding job description of each person."
>
> "Decentralization is critical and essential because the authority of people working in different health institutions like health centers, hospitals, and other health sectors will increase and this will affect the implementation of their plan to change and improving health services in a positive way."
>
> "Decentralization is a useful reform. If everything is in once place, efficiency will be low, and control will be difficult. People in remote areas know better about their needs than those in the Erbil city."
>
> "I am always with centralization on a condition of having a clear system to follow and not to divert from the rules, e.g. both have the some guidelines and apply them."

Decentralizing health reform in Kurdistan
The respondents agreed that implementing decentralizing health reform in Kurdistan region that was started in the late 1990s was a good initiative. However, it was implemented differently in the three governorates due to having two different political zones at that time. Decentralization has been applied to some extents in Erbil governorate by the establishment of district health sectors. However, it is still not fully implemented as it does not include the transfer of all the elements of decentralization particularly the financial issues.

The respondent emphasized that the decentralizing health reform had started as an individual initiative without having a central policy for that. The reform emerged mainly from having a big load and pressure on Erbil Directorate of Health. It started step by step by the delegation of some responsibilities at the beginning and followed by more and more responsibilities and authority. Only one respondent mentioned that the initiative was to relieve the load on the staff in remote areas who had to come to Erbil for each and everything.

The respondents agreed that these reforms are appropriate for the health system in Kurdistan. However, most of them suggested that success would depend on proper planning and preparation at different levels, availability of adequate human and financial resources, and providing buildings and other equipment for the district health sectors. Examples of quotations related to the participants' perspectives about decentralizing health reform in Kurdistan region included:

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> “I think the decentralizing health reform in Kurdistan region was a good step. It started around 1996 in all the three governorates of Kurdistan region (Erbil, Sulaimania, and Duhok), but the implementation was different in these three governorates because there were two political zone administrations at that time. This was a big problem for the international organizations like WHO regarding dealing with these reforms in these different governorates.”

> “I think we have decentralization of health system to some extent not fully because we have to transfer all elements including financial issues.”

> “As I know, this was an individual initiative without having a general policy from the Ministry of Health. The Directorate of Health felt high pressure and gradually transferred responsibilities to the district health sectors.”

> “In 1997, I noticed somebody was coming from Haj Omaran (on the border with Iran) to Erbil for a signature and at that time transport was tough. Some people were getting money to process papers in Erbil Directorate of Health.”

Planning and preparation for decentralizing health reform

There was general agreement among most respondents about the lack of proper planning and preparation before implementing the decentralization reform. The respondents indicated that there were some meetings and discussions at the level of the Ministry of Health, Erbil Directorate of Health, and the managers of health facilities in the districts. These discussions have primarily focused on the best ways to implementing these decentralizing health reforms. However, there were no any preparations on the ground. For example, no enough staff members were appointed or buildings allocated for the new district heath sector offices to initiate the work. In some particular departments, there was a complete lack of any training for the staff members regarding their new work or role.

There were no explicit instructions on the functions and responsibilities of these district health sectors and the actual authority that they have. Only limited number of staff members at the Directorate of Health were aware of the role of these district health sectors.

Some respondents mentioned that some training courses were organized in the different administrative disciplines with the assistance of international organizations including WHO. The respondents emphasized these were short training courses that were introduced after implementing the reforms and focused primarily on administrative issues. Examples of quotations related to planning and preparation for decentralizing health reform included:

> "There was some preparation in different governorates regarding the implementation of these reforms, but that was not adequate. WHO run some training courses regarding how to deal and manage these reforms but there were problems in nominating correct persons for these training workshops, and some of the participants were interested in traveling rather than learning."

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> “There was some preparation at different levels, but it was not adequate.”

> "There were no training courses on this issue other than monthly meetings with the minister that were held each time in a district and all directors in the ministry were attending. These meetings were very useful."

Introduction of the reform

The respondents emphasized that the decentralizing health reforms were introduced gradually. Such gradual introduction of the reforms was not planned initially, and these steps were not clear at the beginning of the reform. Implementing different levels of reform depended mainly on the needs and circumstances of the various district health sectors. As one respondent mentioned:

The authority to appoint or transfer staff members to different health facilities within the same district was the first area of authority transferred to the new district health sectors. Then, the authority for other administrative issues related to personnel such as local rewards and disciplinary powers was transferred. Later, the authority of distributing drugs and medical supplies to the health facilities was transferred to these district health sectors, which was followed by management of preventive and primary care activities.

Financial management was the last area to be assigned to these district health sectors, which was done gradually and slowly. However, the financial authority is still not completely transferred to the district health sectors.

The authority over technical and engineering matters is still with the Erbil Directorate of Health no technical departments have been established in the district health sectors primarily due to lack of technical staff at the district level. Examples of the quotations related to the introduction of decentralizing health reforms included:

> "The introduction of these reforms was gradual in a step by step and till now we do not have complete decentralization."

> "At the beginning, there was some administrative authority such as transferring staff members or tools and equipment within the health facilities of the same district or limited leave. However, such authority"

> "The financial authority was limited at the beginning. We had to take all the invoices to the Erbil Directorate of Health to have a financial settlement. Then, we were given some advance money to be spent. Later on, we had the authority to sign small contracts."

Focus on the needs of disadvantaged population

The respondents agreed that the planning and preparation activities did not specifically focused on the needs of the disadvantaged population such as people in the remote rural areas, women, children, old, people with disabilities, poor and IDPs/refugees. The reforms were mainly meant to reduce the administrative routine and improve the efficiency of the health system. The respondents emphasized that they expected that the disadvantaged people will get benefits from

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these reforms directly or indirectly through improvement of the quality of health services and improve the efficiency of the health system.

The respondents emphasized that these reforms were useful for the disadvantaged people as better services could be provided with the district sectors. This is particularly the case concerning the health care services to children, people with chronic diseases, labor services, and surgical operations. However, people in some districts complained of the lack of specific and specialized services at the district level and they have to go to Erbil to seek specialized care. Examples of the quotations related to the effects of these reforms on the disadvantaged people included:

> "The reforms were useful for the disadvantaged people particularly the children because the vaccination program improved after these reforms as storage and transferring vaccines was a significant problem before the reforms."

> "The chronic diseases program is improved. Before there reforms, people from far areas had to come to Erbil Directorate of Health to receive their share of drugs. Now, all of them can receive their drugs in their places."

> "The reforms were useful for the disadvantaged people to some extent because most of the people living in these rural areas are poor, and they have got benefits from these reforms."

> "The reforms had positive effects on disadvantaged people because with decentralization more health services are provided to the rural and remote area and this has improved the quality of health services in these areas and, as a result, the morbidity and mortality rates among children and old people have decreased."

> "The idea was having reforms useful for the people living in the remote areas as they do not reach the city center quickly. Many services have been made available at the districts level within these reforms such as constructing general hospitals, maternity hospitals or wards, establishing consultancy center and establishing specialized centers like TB center."

> "We still need to go to Erbil for many health issues. For example, I need to take my child to the rehabilitation center in Erbil as there is no such service in our district. This is also true for emergency care, labor, and surgical operations."

Quality of the health services

The respondents agreed that the decentralizing health reforms had led some improvement in the quality of health care services. However, such improvement was not the ideal one. Rapid processing of logistics, supply, and personnel management helped in improving the quality of health services. With the establishment of district health sectors, medical equipment and vehicles including ambulances were allocated to the sectors. Besides, more buildings were constructed. Examples of the quotations related to the effect of decentralizing health reforms on the quality of health services included;

> "Implementation of these reforms resulted in improvement of the quality of health services to some extent with the rapid implementation of practical activities."

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> “The reform focused mainly on administrative facilitation and reducing unnecessary travel all the way to simple administrative issues.”

> “Implementation of these reforms led to improving the quality of health services because local people know their needs better.”

> "The reforms had a positive effect, for example, hundreds of surgical operations are carried out in the districts in addition to having chronic diseases program and the presence of specialist doctors."

> "This decentralizing reform has many administrative benefits, but nothing regarding health services, for example, there is a shortage of drugs, lack of equipment, lack of emergency unit and specialist doctors prefer working in the city.”

Implementation of the reform in the different districts

All the respondents agreed that the principles of decentralization of health reforms were the same in all the districts of Erbil Governorate including the same training courses. However, there were some differences in implementation of these reforms among different districts. There was difference according to the available infrastructure and existing human resources. For example, the implementation was bet in Soran district as they already had enough infrastructure and adequate human resources. However, the implementation was worst in Choman district as they lack such facilities.

Some of the respondents mentioned that the application of these reforms in all districts did not occur at the same time, and also the timing of different steps was different. Implementation first started in one district (Soran district), then after a period followed in the other districts gradually according to the availability of local infrastructure.

There was also a difference in the way the different district health sector managers used their delegated authority. The new areas of authority were deployed entirely by some districts and poorly in some other district depending on factors such as political intervention, personal relationships, and the capability of these managers. Examples of quotations related to the difference in implementation of the reforms in the different district of Erbil governorate included:

> “There was some difference in implementation depending on the geographical area, available infrastructure and the personality and ability of the manager in each district.”

> “There was some difference. Some managers have more power than others depending on many factors including ability and personality of the manager and political connections.”

> "The district sectors received the same training, and the reforms had the same policy. However, more attention was given to the districts with a larger number of population and a higher number of staff members."

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Formulation of the reform

These health reforms were introduced in the late 1990s as a result of discussions between different departments of Erbil Directorate of Health and the managers of the health facilities in Erbil governorate to find solutions to decrease the load on the Directorate of Health. After these discussions, a plan of reform was prepared and approved to the Ministry of Health.

The respondents mentioned that these discussions were limited to the level of Erbil Directorate of Health and did not extend downwards to involve lower-level staff to any significant extent, at least in the beginning. The respondents agreed that the communities did not have any role in these reforms and they were not invited to participate in the designing and planning the reforms. However, all of the respondents agreed that after implementation of these reforms, there were opportunities for lower level staff to discuss and give feedback about different aspects of these changes. There was a monthly meeting of the district health sector and the Directorate of Health to discuss problems and possible solutions and to improve health services in the districts. In addition to these monthly meetings, the staff of the district health sectors could contact the Directorate of health on any issue related to their jobs or to getting advice. Examples of the quotations related to the formulation of the reform included:

> “I do not think there was any role for the community in these reforms.”
>
> “We were receiving different requests from the people such as building a health center in a village and these requests were studies and considered. However, they were not involved in discussion and decisions in general.”
>
> "We were only working with the administration, but were considering people's request on our list of needs such as building a health center or appointing doctors to specific areas."
>
> “I don’t think there was any role for the community in these reforms, but it is important to involve them in the implementation of these reforms.”

Challenges facing the reform

A range of different challenges were mentioned by the respondents including:

1. Shortage of trained and experienced staff

Shortage and rapid turnover of trained and experienced personnel in various disciplines were common problems reported by most respondents. This deficit involved staff in different disciplines including medical, nursing, administrative, and technical staff. The respondents stated that the lack of staff in these areas was due to many reasons. There is a lack of staff members that are originally from these districts because of the history of forced population movement. Besides, staff members from Erbil city and the Directorate of Health are not interested in working in these areas because there are no any incentives for them to work in these remote areas. There is also a lack of continuing professional education courses for the staff in these districts which impedes career development and makes long-term employment less attractive. In some districts there is a shortage of female doctors, lack of emergency departments and labor wards, shortage of specialist physicians, etc.

> "The main problem is the rapid turnover of the staff."

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"There is a shortage of doctors as they prefer to work in Erbil city as they work in the private sector and with drug companies."

"The biggest problem is the lack of skilled staff members since we need to have experienced staff in all departments including personnel, finance, etc. Many times we are compelled to appoint staff without degree or skills, and this has negatively affected the process."

2. Financial problems

At the start of the implementation of these reforms, there was a financial problem because there was no particular allocated budget for each district. When financial authority was transferred to the district health sectors, these problems have become less visible. The respondents complained of the effect of the general economic situation of the region in the health sector in addition to the issue of corruption which is frequent in the region. An example of the quotations related to financial problems included:

"It is critical to have a complete finance unit in the district health sector to carry out the work smoothly. In the areas where there no finance unit, there are real problems."

3. Problems with transportation and communication

Transportation and communication difficulties arose mainly because all the districts are far from the Erbil city. At the beginning of the reform, the telephone was commonly used to solve problems and get advice on different aspects of work. However, there are still some administrative processes that need the staff members to go to Erbil even if there are relevant administrative units in the district health sectors.

The problem of communication is most acute for those working in statistics because they collect the statistics from all health facilities in the district at the end of each month and need to send that to the Directorate of Health within specified deadlines. This problem was more evident at the start of the implementation of the role of these new district health sectors was not clear, and this affected the performance of these health offices.

4. Lack of monitoring and supervision

The respondents mentioned that there were inadequate monitoring and supervision from the Erbil Directorate of health. This problem affected implementing of some programs and activities of these district health sectors because of a lack of experienced staff to supervise different programs and activities of these District Health sectors.

5. Shortage of equipment and materials

Most of the respondents mentioned that they have problems related to the scarcity of medical devices, cars, and ambulances. An example of the quotations related to shortage of equipment included:

"We need to go to Erbil for having an x-ray as the x-ray machine in the district is down and is not repaired for months."

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6. Political instability and interference

Interference by the Erbil Directorate of Health and bypassing the authority of the district health sectors was commonly mentioned by the respondent.

During the period of implementing these reforms, there was continuous political instability in the region. Interference by political parties in different areas of the appointment and transfer of staff, and the powers passed on to the district health sectors was a problem which affected the implementation of these reforms.

CONCLUSIONS

The decision of implementing decentralization health reforms in Iraqi Kurdistan region was taken centrally by the Ministry of Health at the beginning. However, there was a continuous discussion with health personnel in the district health sectors during the implementation to overcome emergent problems and to keep implementation on track. The communities and the disadvantaged people did not have any actual role in this decision making. There was no adequate planning and preparation, and the goals and targets of these reforms were far from clear at the beginning. Implementation took place through the gradual transfer of authority in different areas from the Directorate of Health to the district health sectors, but the specific series of steps to be taken was not clear from the beginning. The introduction of further changes was usually a reaction to emergent problems occurs in these districts depending on ad hoc basis rather than proactive planning. The reform primarily targeted the administrative and logistics aspects rather than the types and quality of health services. However, the quality of health services indirectly benefited from this reform. Although the reform did not directly address the needs of the disadvantaged population, they got some indirect benefit as a result of the changes made to the system. Although the reforms took a similar form in the different districts, there were differences in the detail of implementation in the various districts.

Many problems have arisen during implementation of the reform including lack and rapid turnover of trained and experienced staff, lack of adequate infrastructure, inadequate financial resources, lack of clarity about the roles of different institutions and lack of supervision and monitoring.

Practical implications

The study results should provide a guideline upon which policy and decision-makers can be informed about the quality of health services and can help them to direct action to improve the decentralizing health system reform. The study should also contribute in sparking off wider debates in Kurdistan and Iraq on the necessary health reforms and how this reform can be improved.

Recommendations

Suggestions to improve the experience of the decentralizing health reform in Erbil governorate included:

1. Increasing the number of experienced and trained staff in the district health sectors by sending more experienced staff from the Directorate of Health and also the preparation of additional local staff. Staff from the Directorate of Health can be encouraged to work in these districts by increasing their

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salary, provide them with incentives, and provide them with houses for their families to stay permanently in these areas. There is a need for opening nursing schools in the different districts of the people from the district areas and to encourage people from the remote areas to pursue study in various specialties to prepare them taking a leading role in the decentralizing health reform.

2. Provision of further training and continuing professional development for the staff working in the different units in the district health sectors. They can also be sent to the Directorate of Health for an internship to attain the skills and experience.

3. Establish different units in these district health sectors corresponding to all departments of the Directorate of Health such as the finance unit that does not exist in all the sectors and the engineering and technical unit as most districts still rely on the Directorate of Health for these issues. This means that the district health sectors would have an administrative structure similar to that of the Directorate of Health but in a lower profile.

4. Actively involve the communities and the disadvantaged people in the planning and implementation of the activities.

5. Redirect the reform to improve the quality of health services and directly address the needs of the disadvantaged people. This should prevent unnecessary travel of people to Erbil for the essential health services.

6. Giving full authority to the managers of the district health sectors and providing these districts with efficient and trained managers. It is also essential to appoint managers with ability and experience, rather than political contacts and personal relationships.

7. Limit the frequent interference in the roles and authority of the district health sector managers and provide them with the freedom to manage.

8. Strengthen the coordination and cooperation with the Directorate of Health and with other governmental departments in the area particularly the mayor of the district.

9. Apply information technology systems for better communication between these districts and the Directorate of Health, and for better recording of information and managing the statistics in the district health sectors.

10. Strengthen the monitoring and supervision from the Directorate of Health about critical issues affecting the districts, especially financial matters.

11. Provision of medical equipment and other facilities like adequate infrastructure and buildings, vehicles and ambulances.

Future research

This study suggests some directions for future research about the decentralization of the health system in Iraqi Kurdistan region. It would be useful to review the experience of the other governorates to explore the difference in the implementation and the outcome.

There is also need to conduct further research to assess the impact of these reforms on health service delivery. It is also essential to evaluate the various components of decentralizing health

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reform in the region, such as human resource management, financial management, logistics and procurement, primary care activities, maternity care and preventive programs.

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