Iraq Health Update

There have been a number of significant developments in Iraq since Medact published *Enduring Effects of War: Health in Iraq 2004* at the end of November [1]. Publication coincided with the problematic Paris Club deal on Iraqi debts. On 30 January 2005 an interim government was elected to serve until the end of the year and in May, the *Iraq Living Conditions Survey 2004* [2] was published. This was a survey of 21,668 households conducted by Iraq's Central Organisation for Statistics and Information Technology, the UNDP and Norway's Fafo Institute for Applied International Studies in April and May 2004. The document contained unprecedented data on health, security, infrastructure and living conditions in all the governorates of Iraq. Here we present some of that data and provide a brief overview of recent events in Iraq. We also contacted a number of the sources we used last time and a few new ones for first hand accounts.

This is a fuller version of the Update published in the summer issue of *Communiqué* which includes references.

The Violence Continues

'The security situation [has] reduc[ed] the hospital['s] capacity to serve the population…[D]octors fear to be attacked by the occupying forces and…many times cannot attend … due to road blocks or curfews, the fear does prevent people from going to the hospitals and people tend to spare the hospital visit [for] very serious of conditions…[A]mong the most affected people are the women (especially pregnant women), children and elderly.' Jabar al-Khirbit, Medical Student, Ramadi, 26 May 2005 [3..]

The violence has not abated in Iraq. Asked by Sir David Frost, on June 14, whether the security situation was better now than immediately after the war, Donald Rumsfeld said 'statistically, no.' [4]

The *Iraq Living Conditions Survey (ILCS*) suggests that in comparison with previous wars in the region, this war has lead to proportionately more deaths amongst women, children and the elderly. A recent Iraqi Ministry of Health report found that, between January and April this year, 160 doctors had been kidnapped or killed. [5]

Insecurity affects not only individuals but the reconstruction of the entire health system. Although it is hard to find accurate figures, security expenses are thought to consume a significant proportion of the budget of each private sector contract. One source estimates that 43% of US reconstruction money has been spent on security. [6] In its bilateral programme, the UK Department for International Development (DfID) has spent £17 million providing security for projects worth £32 million (35%). [7] In contrast, Iraqi organisations working in partnership with western NGOs spend 5% or less on security. [8] Very few western NGOs remain operating directly in Iraq.

Counting the Casualties

'Since 5 April 2004 the Iraqi Ministry of Health has sought to collect casualty data. Explaining the procedure, the Iraqi Minister of Health stated on 29 October: "Every hospital reports daily the number of civilians (which may include insurgents) who have been killed or injured in terrorist incidents or as a result of military action. All casualties are likely to be taken to hospital in these circumstances except for some insurgents (who may fear arrest) and those with minor injuries. The figures show that between 5 April 2004 and 5 October 2004, 3,853 civilians were killed and 15,517 were injured. I am satisfied that this information is the most reliable available." We share this view.'
Jack Straw, 17 November 2004

At the time of the last Medact report, the debate about Iraqi civilian casualties was raging following the publication of the Roberts et al paper in the *Lancet.* [10] The *ILCS* contained its own estimate of mortality directly caused by the war – between 18,000 and 29,000. Whilst this is half what Roberts et al had estimated it was double the number suggested by the Iraqi Ministry of Health figures which the British Government advocated using. There are many reasons for this. For example, it is hardly surprising that if people do not attend the hospital

unless seriously ill, they do not take their dead to be registered. These criticisms were made at the time. [12,13] There are other problems with the *ILCS* figure. Unlike the Roberts paper, it excludes criminal murder. This is not only hard to define but may be a product of the poor security situation. By the time this article went to press, Iraq Body Count (www.iraqbodycount.org) had published a Dossier on Civilian Casualties with detailed information about the 67,365 civilians who have been reported killed or wounded in the media between 19 March 2003 and 19 March 2005. Medact is part of the Count the Casualties Campaign (www.countthecasualties.org.uk) which calls on the government to fund a full, independent enquiry into excess mortality, both direct and indirect, since the invasion in 2003.

The Health of the Population

A number of interesting and alarming health statistics can be pulled out from the *ILCS* including…

- 9% of under-fives had had an episode of diahorrea in the previous two weeks but only 37% of these children had received oral rehydration salts
- Infant mortality data indicted 32 deaths during the first year of life per 1,000 births. *ILCS* acknowledge that this may be an underestimate and say that since the start of the conflict there has been a 'progressive worsening of the situation for children'.
- There were an estimated 193 maternal deaths per 100,000 births. It is not possible to infer a trend in maternal mortality.
- Among children aged 6 to 59 months, 12% suffer from general malnutrition, 8% suffer from acute malnutrition, and 23% suffer from chronic malnutrition. Some regions are significantly worse than others.
- The estimated number of persons living with a chronic health problem directly caused by war is 223,000 with a 95% confidence interval of 205,000 to 242,000.

Growing Evidence of Corruption

'If you take US $10 million from the US government and sub the job out to Iraqi businesses for US $250,000, is that business, or is it corruption?'
Ed Kubba, American-Iraqi Chamber of Commerce [14]

At the time of the last Medact report on Iraq there were rumours and accusations that there had been gross corruption and a lack of transparency within the Coalition Provisional Authority (CPA). [15] These have since been confirmed. Stuart Bowen, Special Inspector General for Iraq Reconstruction, reported to Congress [16] at the end of January that inadequate CPA controls meant that there was no assurance that $8.8bn from the Development Fund for Iraq (DFI) had been used, as mandated by Security Council resolution 1483, 'to meet the humanitarian needs of the Iraqi people, for the economic reconstruction and repair of Iraq's infrastructure, for the continued disarmament of Iraq, for the costs of Iraqi civilian administration, and for other purposes benefiting the people of Iraq'. [17] The DFI is Iraqi money, mostly revenue from oil sales, and $8.8bn is equivalent to almost 10 years of Ministry of Health spending at current (2004) levels.

There is also evidence of substantial overcharging under the CPA with the same work being subcontracted five or six times but still proving profitable. [[18] The US Department of Defence and the CPA initially had half the number of people overseeing the reconstruction than was needed according to the Association of Inspectors General. [19] They eventually outsourced oversight to private companies. International supervision was even worse. [19] The heavy involvement of the military may also explain these problems. The Office of Reconstruction and Humanitarian Assistance (ORHA) was under the US Department of Defense. Over the years, organisations such as DfID and the US Office of Foreign Disaster Assistance have effectively handled relief and reconstruction. ORHA were inexperienced. [20] Furthermore, military involvement blurs the line between the military and the reconstruction efforts, narrowing the humanitarian space and making life more dangerous for the humanitarian agencies. [20]]

Problems with audit and transparency continued after the handover of power on June 28[21] and after the elections in January. They are well recognised by the new regime. [22] Major

western NGOs are finding the lack of transparency is a greater problem than security when operating in Iraq. [8] They have seen significant amounts of money spent with few appreciable results, except in the Kurdish north. [8] Whilst ministries are keen to take control of projects, NGOs often find their Iraqi partners highly resistant to this. [8] Fearful of corruption and rent seeking they prefer to run their projects in parallel to government services. This can present a significant sustainability problem. The recent IMF deal has implications for transparency which are discussed below.

Work not Done, Money not Spent

US $32 billion was pledged for reconstruction in Iraq at the Madrid conference in 2003. Estimates of expenditure vary but some sources suggest that only half a billion has been approved for projects so far. [23] Spending is slow because there is limited capacity within Iraq to oversee projects. The lack of a humanitarian space has resulted in the withdrawal of most multinational agencies and NGOs. The majority of the £268 million dispersed so far by DfID for Iraq has gone to multinational bodies such as the International Reconstruction Fund Facility for Iraq (IRFFI), which is administered by the World Bank and the UN. [24] The UN's international staff are in Amman and those working on Iraq for the World Bank are mostly in Washington. [7] With very few internationals in Iraq the rate of spending is held back by the limited capacity of Iraqi ministries and NGOs to oversee projects. [7]

Limited audit means that, even where money has been spent, the work is not always completed as planned. One of the major contracts in the health sector was awarded by USAID to ABT Associates. USAID audited ABT and found that only 40% of the work achieved its intended output. [25] Incomplete work included a household survey, a primary healthcare quality improvement programme and a facilities database. There were serious delays in the delivery of 600 kits containing essential equipment such as stethoscopes and blood pressure cuffs to primary health centres (PHCs). However, since the contract had expired by the time the audit was published, the report concludes that "there is little that can be done with regards to the activities and unachieved outputs." [25]

Major Infrastructure Problems

Water	Using UN definitions only 54% of households have access to a safe and stable water supply. 'Safe' means a household connection, public standpipe, borehole, protected dug well, protected spring or rainwater collection. Thus piped water in Baghdad is 'safe' although we know it is not potable.
Electricity	Apart from rural areas in the north, the vast majority of households are connected to the grid; 29% of households have a secondary source; 78% of households have daily cut-offs or voltage problems.
Sanitation	36% of households have 'unimproved' toilet facilities (i.e. service or bucket latrines where excreta are manually removed, public latrines, latrines with an open pit.)

ILCS Data on Iraqi Infrastructure

In October and November 2004, the NGO Medicine for Peace (MFP) surveyed 12 hospitals and a specialised outpatient centre in Baghdad. [26] Their data demonstrates the impact that unreliable infrastructure has had upon healthcare facilities.

To deal with the unreliable electricity supply, all the hospitals that were surveyed had installed electrical power generators and had adequate stores of fuel on hand. [26] It was estimated that these generators could provide 60-70% of a single hospital's electrical needs as compared to public electricity. [26] A recent report by Dhar Jamail documented a death on the operating table at Yarmouk Teaching Hospital, Baghdad, due to a power outage. [27]

The public water in Baghdad is not safe to drink. Hospitals must develop and implement purification systems or obtain potable water elsewhere. [26] Filter systems were looted from a number of hospitals during the chaos after the invasion. [26] At the present time, the supply of potable water is inadequate and water is reported to be unsafe to drink in four facilities. [26]

Sixty percent of toilets in hospitals do not work. [26] A number of hospital floors do not have a single functioning toilet. [26] Sewage had backed up onto the basement floor of one hospital. [26] The study also noted serious problems in disposing of medical waste and that five hospitals reported insufficient refrigeration facilities to reliably store labile pharmaceuticals and biologics. [26]

Dhar Jamal's report 'Iraqi hospitals ailing under occupation' pulls few punches. The survey of 13 hospitals, including Falluja General Hospital, is full of graphic first hand testimony from Iraqi health workers. You can read it at www.brusselstribunal.org/DharReportSummary.htm.

Health Systems in Transition

The Ministry of Health produced a document in December detailing their plans for the system. [28] It expresses the laudable desire to set up a school of public heath, to develop the specialty of primary health which they describe as "almost non existent" and to provide access to healthcare "irrespective of…socio-economic status". Civil society must monitor delivery closely.

This report goes on to examine ways of funding the health service in the future and considers introducing user charges. It acknowledges the need for an "effective exemptions policy" if this is not to reduce poor people's access to healthcare. Medact agrees that it is crucial to ensure equity in service provision and that user charges, both formal and informal, would be a barrier to access for the poor. Qasim Alawe, official spokesperson for the Ministry of Health, told us salaries in Iraq were too low to sustain an insurance based system. [29]

Whilst drugs are available for free in the public health system there are shortages [30] and considerable problems with supply. One Iraqi physician that we spoke with talked of "urgent" requests for drugs taking more than six months to arrive. [31] There are other shortages. Half of the Baghdad hospitals surveyed by MFP did not have disinfectant solution in stock.

The *ILCS* found that 18% of acutely ill people did not seek help because they could not afford it and 4% did not seek help because there was no appropriate facility nearby. In rural areas and in the lowest income quintile, more than 30% did not use health services because they could not afford them. This is probably due to both the inability of public facilities to treat many conditions and the existence of unofficial user charges, which we have been told are not uncommon. [32]

The *ILCS* asked people who had sought external help, which type of institution they had attended. 50.2% had attended private clinics, 24.5% had attended a public clinic and 16.0% a public hospital. NGOs run facilities represented less than 2% of services provided and 0.0% had used coalition facilities. This strongly suggests a weak public system. Whilst private clinics dominate the health sector, the informal sector is playing a significant role in social care. "Hundreds" of organisations have emerged to care for widows and orphans. [31] Kaplan has described a "strengthening of Shi'a movements that provide social support – healthcare, shelter, aid to the poor". [33] This also indicates a weak state system.

Skilled Workers Begin to Return

The last Medact report documented serious personnel problems in the Iraqi health sector, especially with respect to nurses. From Baghdad, there is evidence of recent movement in the right direction which is probably due to wage increases. [28] MFP note that in Baghdad, since 2002, the number of hospital-based physicians has increased by 20%, the number of nurses by 70% and the total number of hospital staff showed a 62% increase. However, the salary is still low for the region, security is terrible [5] and 20-40% of medical graduates leave the country. [31] A disproportionate loss of experienced staff has been noted recently [26, 28] which may be because junior staff cannot afford to travel. [27] Furthermore, many doctors are not working and those who work typically spend half their time in the private sector. [31] Studies

should look at whether similar staffing increases have occurred in rural areas. If they haven't, extra incentives may be required to achieve equity.

Critical personnel shortages remain in a number of areas including midwifery, pharmacy and the primary healthcare. [28] Support staff also seem to be in short supply. MFP reported that 60% of Baghdad hospitals do not have the necessary personnel to clean the hospital daily. Seventy percent of the hospitals had insufficient staff and facilities to provide clean laundry to patients on a regular basis. [26]

The Crisis in Public Health

'…there really hasn't been a public health approach.'
Frederick Burkle, 3 July 2004 [34]

Although the Iraqi Ministry of Health wants to establish a school of public health and to develop the speciality [28] there has been no progress since the invasion. We spoke to a source at the World Bank, who told us that there is almost no public health expertise in Iraq at present, none of the agencies are funding training and there are no plans to do so. [35] Whilst he acknowledged that it was 'clearly a priority' he said the security environment was not conducive to initiating training at present. Asked whether it might be feasible to arrange training in Jordan, he said the logistics are difficult and it increases cost. Furthermore, the journey to Jordan is dangerous. [35] However, USAID run a course in the management of childhood illness in Amman and the WHO organise week long seminars there. [35] Donors and the Iraqi Government should look into the feasibility of public health training in Amman as a matter of urgency.

A number of contributors have expressed concerns about disease monitoring and public health surveillance in Iraq. The World Bank source said that the system was in poor shape with no health information system and reports not reaching the ministry. [35] He said effective disease surveillance was not possible without the capacity to travel in safety. Branko Dubajic, director of the NGO Lifeline, told us that communicable disease surveillance worked on a basic level except in the 'Sunni triangle'. [36] Dr Momtaz Wasfy, who worked in Basrah in 2003 as a WHO consultant, told us he believed 'Surveillance throughout Iraq is still going on through native specialists who receive oversight from a small WHO office in Jordan. Non-communicable diseases are also recorded but proper analyses are not provided and the quality of data is questionable.' [37] Effective service planning is impossible without accurate information.

Mental Health

'The mental health service is the worst service in the healthcare system in Iraq.'
Jabar Khirbit, Medical Student, Ramadi, 26 May 2005 [3]

'Mental health services in Tikrit are minimal to non-existent.'
John Quinn, paramedic, near Tikrit, 29 May 2005 [38]

It is well established that poverty and chronic conflict are bad for mental health. [39] Dr Adnan Fawzi, Assistant Manager at the *National Program Against Narcotics and Misuse of Drugs used for Mental Care* stated that mental illness and drug use had increased since the war. [40] The Iraqi mental health service is poorly prepared to deal with this. Figures presented by the Iraqi Ministry of Health at a recent conference in Amman suggested that just 1% of consultant grade doctors in Iraq are psychiatrists. The figure in the UK is 13%. [41] The WHO stresses that in developing countries the psychiatric services should be integrated with primary health services [42] but this will be problematic in Iraq since both the mental health services and primary healthcare networks are weak. Community based mental health services are almost non existent and people do not consult until their condition becomes chronic. [31]

Debts, Reparations and the IMF

'As for writing off the debts of Iraq, there are conditions to reducing the support of the government for basic services. Iraq has 10 billions of debts, and I think we cannot avoid this.' Laith Kubba, the Prime Minister's spokesman, 2 June 2005 [43]

On 21 November 2004, the Paris Club of creditors agreed a deal on Iraqi debts. They agreed to write off 30% of the debt immediately, 30% when a restructuring deal was agreed with the IMF with the last 20% to arrive on completion of this deal. The restructuring deal is expected in September. [44] Whilst many welcomed the deal as generous, Saad Salih Jabr, chairman of the Iraqi National Assembly's Economic Committee, called it "yet another crime committed against the Iraqi people." [45] One problem is that Iraq's debts are so vast that even 80% relief will not alleviate the problem. Even if the non Paris Club creditors agree to 80% reductions Iraq would still be shackled with over $25bn of debt, on top of more than $31bn in war reparations and the repayments for any new debts to the IMF and others. [45] Secondly, this debt relief is very bluntly conditional on Iraq obeying the IMF. The IMF has often forced countries into rapid privatisation. Transparency International state that if this were to happen in today's Iraq it would be "almost certain to result in widespread corruption". [19] Finally, the timing of this agreement, just weeks before the elections, seriously limiting the ability of any new government to dictate Iraqi economic policy, raises questions about the true level of Iraqi sovereignty.

Another powerful critique is the moral one. Surely creditors are more responsible for this unpaid debt than are the people who suffered under Saddam? Many of the loans were used to arm the dictatorship or for luxuries. A resolution of the Iraqi National Assembly in January uses the doctrine of odious debt. Debts stemming from loans that did not benefit the Iraqi people would be repudiated. There would be a fair arbitration tribunal where creditors could prove that their claims came from loans which benefited Iraq. [45] This certainly merits investigation. A moral argument can also be used to argue for a cancellation of the reparations Iraq is currently paying countries such as Kuwait, and companies such as Texaco and Toys'R'Us for damages, including loss of earnings incurred during the first Gulf War. [46] The Iraqi people suffered greatly during that war and should not be held responsible for it.

Action

Write to your MP and ask her or him to…

- Enquire whether the government still believes that tallies in hospitals are the "most reliable available" means of collecting data on mortality in Iraq now that the *Iraq Living Conditions Survey 2004* suggests violent deaths were double the number that hospital tallies had documented. Demand a full and independent survey of excess mortality since the 2003 invasion of Iraq.
- Ask who is responsible for the $8.8bn unaccounted for by the CPA and who is responsible for bringing prosecutions. Ask how so much Iraqi money could have gone missing.
- Demand that the UK government advocate an immediate moratorium on war reparations and claims under the UNCC, followed by a UN Security Council Resolution cancelling all outstanding payments.
- Demand the UK explores Iraqi requests for the elimination of all odious debt incurred by Saddam Hussein's regime as determined by an arbitration tribunal in which Iraq has full due process rights.
- Ask how much of the money Britain allocated for the reconstruction of Iraq has been spent and ask to see audits of the effectiveness of these programmes.

Let us know what they say.

This Health Update should be seen as a work in progress. We would be very grateful for feedback, information, contacts and other input so that we can continue to track developments relating to health and its determinants in Iraq.

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