INTRICACIES AND IMPLICATIONS OF IRAQ’S HEALTH PREDICAMENT

A Thesis
submitted to the Faculty of the
Graduate School of Arts and Sciences
of Georgetown University
in partial fulfillment of the requirements for the
degree of
Master of Arts
in Arab Studies

By

Abbie C. Taylor, M.A.

Washington, DC
April 18, 2012
INTRICACIES AND IMPLICATIONS OF IRAQ’S HEALTH PREDICAMENT

Abbie C. Taylor, M.A.

Thesis Advisors: Rochelle A. Davis, Ph.D. and Joseph Sassoon, Ph.D.

ABSTRACT

This thesis reveals how eleven years at war and thirteen years of economic sanctions followed by invasion and occupation led to the degeneration of Iraq’s health infrastructure and the health of a nation. It further argues that waves of internal and external displacement, omnipresent corruption, hollow state institutions, and the individual and collective trauma following years of exposure to extreme violence remain unaddressed. These trends have prolonged inertia and stifled attempts to rejuvenate Iraq’s health system - a keystone in the foundation for a country’s recovery and in its healing from the visible and invisible wounds of the past.
When making the connection between 'Iraq' and 'health', an academic search engine unearths numerous studies on the physical and mental scars endured by veterans of the Iraq wars - American, British and European veterans, that is. Conversely, literature on the state of Iraq's health is scarce, and in the shadow of conflict and lingering security concerns, a number of disconnects and silences prevail.

I started to make my own connections between Iraq and health after much time spent working with Iraqi refugees in Glasgow, Damascus, Washington DC and Amman. Like many students of the Iraqi dialect, the first word I learned was zuin, or 'good'. The second, was ma'ku. As in, ma'ku 'amal, or, 'there is no hope'. Over the past four years, I have heard the latter phrase more times than I can count, prompting me to question such pessimism and to contemplate notions of recovery in relation to health. As someone who has never been to Iraq, I have often struggled in my interactions with the subject, trying hard to envision an Iraq, but often imagining many fragments. I have grappled with the dichotomies of 'before' and 'after', 'inside' and 'outside'. Such binary oppositions have been reified by what I see as an alarming, yet understandable disconnect among Iraqis in exile when talking of their country and repeating the words, ma'ku 'amal when referring to its future. I hope that by narrating and navigating such a web of intricacies, incorporating and connecting the voices and experiences from those inside and outside Iraq, this issue – at the heart of every Iraqi – will prove to be one that forges further connections and provokes collective thinking among people for the sake of national healing. It is the beginning of what I hope will be more work on health as the basis for national reconciliation in Iraq; an idea I first discussed with an Iraqi doctor, scholar and former health official at a bus stop in Virginia, and one that I look forward to working on with him in the future.

I am indebted to several individuals of whom I had the pleasure of meeting in Jordan. I only hope that I am able to thank you again in person one day - hopefully in one of those fish restaurants someone told me about on the banks of the Tigris. I must also thank Dr. Joseph Sassoon for his unwavering patience, time, insight and wisdom. Finally, I am extremely grateful to Dr. Rochelle Davis for her relentless efforts, mentorship and teaching. Over the past two years at Georgetown University, she has opened my eyes to a wealth of knowledge, scholarship, people, experiences and opportunities.

My deepest thanks and sincere appreciation goes to everyone who has provided support and guidance along the way.

Abbie C. Taylor
# Table of Contents

Introduction .................................................................................................................................................. 1

Chapter I .................................................................................................................................................. 13  
   Mapping the Cycles of Degeneration within the Health Sector in Iraq
Chapter II ............................................................................................................................................... 39  
   Health Experiences and Perceptions of Iraqi Refugees in Jordan
Chapter III ............................................................................................................................................... 71  
   Uncertain Recovery in Iraq’s Health Sector
Conclusion ................................................................................................................................................ 96

Bibliography .......................................................................................................................................... 104
INTRODUCTION

In 1932, as Iraq gained official independence, the number of Iraqi doctors was more than three times that of 1920. That same year, the first cohort of Iraqi doctors graduated from the Royal College of Medicine in Baghdad, founded in 1927. Iraq’s health care system was established in 1918 and was one of the more successful legacies of British colonialism, modelled on the free, centralised and hospital-oriented British National Health Service. According to the Iraq Administration Report of 1932, “In the hospitals of Baghdad, Basra, and Mosul first class medical and surgical treatment with skilled nursing are given to the public.”

Almost a century later, any deficiencies in the nascent system as noted by the British Civic Administration in 1932 - a dearth of hospital beds and ‘occasional visits of Cholera’ - pale in significance. Today, Iraq grapples with the catastrophic fallout from over three decades of conflict, a plethora of violence and insecurity. In 2010, the authors of a report to the Congressional Committees admitted: “Iraq continues to lack adequate access to essential services – that is, food, water, sanitation, electricity, health services, and education. Moreover, insufficient government capacity and commitment cross over each of the problem areas and serve as a deterrent to returns and reintegration.”

---

2 Ibid., p. 69.
3 Ibid., p. 66.
4 Ibid., p. 70.
health consequences of Iraq's turbulent history, according to Levy and Sidel, constitute seven categories: direct impacts on health, diverse effects on health services, damage to infrastructure that supports health, refugees and internally displaced persons, impact of human rights and international order, diversion of resources and its impacts on physical, sociocultural and economic environments.\textsuperscript{6} Public health is directly shaped by war and conflict, of that there is no doubt. Yet, exploring these connections, tracing these processes and their multitude of dimensions from beginning to end remains neglected in the scholarship and policymaking arenas.\textsuperscript{7} Health is but a microcosm of what Iraq must overcome today, with the knowledge that an unhealthy nation will cease to function. In the same way that the deterioration in health and health care mirrors a country's demise, it can also reflect the sound basis of a recovery.

This thesis reveals how eleven years at war and thirteen years of economic sanctions followed by invasion and occupation led to the degeneration of Iraq's health infrastructure and the health of a nation. It further argues that waves of internal and external displacement, omnipresent corruption, hollow state institutions, and the individual and collective trauma following years of exposure to extreme violence remain unaddressed. These trends have prolonged inertia and stifled attempts to rejuvenate Iraq's health system - a keystone in the


foundation for a country’s recovery and in its healing from the visible and invisible wounds of the past.

**Structure**

In his ethnographic account of experiences and politics of AIDS in South Africa, entitled ‘When Bodies Remember’, the medical anthropologist, Didier Fassin, proposes to name the ‘condition’ - what he describes as ‘life embedded in the economic and social reality’ - and the ‘experience’ of ‘life lived both individually and collectively’. People, after all, are a creation of the past.\(^8\) Remembering the importance of such personal experience rooted in history, I will endeavour to unveil the personal experiences and perceptions of Iraqis, framing them within a historical context that is coloured with social, economic and political intricacies. So as to best map the cycles of degeneration and stagnation over the thirty-year period, the three chapters will correspond to the chronology of events as they unfolded, concluding with an assessment of the present day and recommendations for the future.

The first chapter of the Iraqi health sector’s troubled history begins with the wake of the First Gulf War and the imposition of economic sanctions, and concluding with the end of the US Occupation. During this period, a process of ‘de-development’ created a large-scale humanitarian crisis, with disastrous implications for the repair of Iraq’s health infrastructure.

---

The second chapter follows the hundreds of thousands of Iraqis who fled as a result of widespread insecurity, carrying with them their health problems across the border to Amman, Jordan after 2003. In Jordan, there was little regard for the past or the future from the parties involved. Rather, Iraqis viewed themselves and were viewed by neighbouring host countries and the international community as a short-term refugee ‘crisis’ embedded in the present. This section looks at Iraqis’ experiences and perceptions of access to health services in their host country, arguing that failure to situate the humanitarian aspect within a future trajectory aggravates the health of Iraqis.

Back in Iraq, the third chapter focuses on the contemporary period from 2005 until the present, a phase characterised by under-development. It brings to the surface those underlying concerns that have been left unaddressed for decades and fosters interaction between these social, economic, historical and political intricacies and their implications for Iraq's health predicament.

The thesis will conclude with tempered optimism, alluding to recent signs of promise, and offering recommendations for the future of a healthy Iraq.

**Methodology**

Adhering to the principle of triangulation, the data gathered originates from a number of individuals, materials and settings so as to reduce the risk of conclusions that reflect the shortcomings of one specific method.⁹

---

The contemporary nature of the topic attests to the number of primary sources used and speaks volumes to the need for further scholarship, particularly in the most recent period following the US Occupation. Memoirs from those heavily involved in Iraq during the sanctions period and the occupation (including Martti Ahtisaari, David Phillips and Hans von Sponeck) proved useful, as were numerous reports from those political and humanitarian actors working in Iraq and Jordan. The use of film and journalistic sources from the English and Arabic media was a vital means of illumination, particularly as I was unable to visit Iraq for my research. Wary that Iraq has often fallen victim to sensationalist writings, I used discretion when citing such sources. Articles from the British and the North American Lancet were also insightful and often featured personal accounts and interviews conducted by Iraqi or foreign medical professionals with their Iraqi peers during fact-finding tours in various hospitals and clinics across Iraq.

The survey of the literature was given another dimension through access to 90 anonymous interviews with Iraqi refugees living in Amman, as part of a greater research project with the Institute for the Study of International Migration, for which I worked as an assistant. The interviews were conducted by Iraqis themselves with the model of participatory research in mind.

Although the social and political essence of reconciliation and rebuilding of Iraq remain relatively out of focus, aspects of humanitarian crisis and subsequent intervention attract attention. In such crises, whether natural or human in origin,
there is an element of naturalisation (or depoliticisation) of war. Indeed, the ‘humanitarianisation of intervention’ implies the neutralisation of conflict situations. Today, it is conceived as if the only issue were to aid victims in need, as if the local context presented no historical peculiarities, as if military operations did not originate in the realist interests of the states conducting them.\textsuperscript{10} The aim of this research was to delve deeper into such obscurities, and to surpass them. Humanitarian endeavours are inevitably the ‘law of the strongest’\textsuperscript{11}, but such laws need not always be replicated through research. In their examination of the ethics of refugee research and development of a participatory action model, Hugman et al recognise the imbalance of power between researchers and refugee subjects and the risks of intimidation, marginalisation, misunderstanding, and false expectation of both parties involved.\textsuperscript{12} Such a participatory method in which Iraqis themselves are conducting interviews also allows for a more comfortable and natural discussion. Moreover, shared experience erodes barriers and alleviates concerns of preconceptions on the part of an ‘outside’ interviewer.

Between December 2010 and January 2011, 15 Iraqis participated in a training workshop conducted by a Georgetown professor. Interviewers then used the method of snowball sampling to locate and conduct six interviews with individuals, often speaking on behalf of their family unit, within their communities. Such a small sample size does not permit definitive conclusions to


\textsuperscript{11} \textit{Ibid.}, p. 13.

be drawn. However, so as to address sampling biases, interviewers were selected from various areas of Amman and asked to diversify as much as possible in terms of demographics. Interviewers had a template of subjects to cover, including: reasons for leaving Iraq, livelihood, living conditions, health, education, social life and the future. Questions were deliberately broad in order to elicit as much as possible from the interviewees. Interview fatigue has become common among Iraqis living in Jordan, after countless interviews with UNHCR, the Department of Homeland Security, numerous relief and development organisations, journalists and researchers. Although mitigated by a familiar researcher, the effects are often apparent in the painstaking detail and mechanisation of story-telling. Nevertheless, the value of such interviews lies in the qualitative data and the *telling* of the oral histories themselves. Rich in description, interviewees make sense of their lives affected by conflict, and in doing so reveal their perceptions and experiences accessing health care in Iraq and Jordan.

After translating, coding and analysing the interviews, I travelled to Amman for three months during the summer of 2011 so as to conduct a further 16 interviews with stakeholders, and to witness first-hand the experiences of Iraqis in accessing health care through participant observation. Once there, I was able to establish good relations with members of the Iraqi community living in East Amman as a student of Arabic and a volunteer at a local community-based organisation providing recreational activities for Iraqi refugees. During this time, I visited the homes of families I met, attended a church meeting with Iraqi members of the congregation and accompanied two Iraqi patients to seven
medical clinics across the city so as to better understand the power dynamics and processes at play. Whilst in Amman, I also worked as an intern in the Displacement Monitoring Department of the International Organisation for Migration’s Iraq Mission. Among other things, this allowed me to access qualitative and quantitative data from all eighteen governorates inside Iraq, which I used to author a report on female-headed households in Iraq.

In January 2012, I returned for two weeks with another Georgetown professor to focus on health and health care access among Iraqis. During this time, we conducted a further 15 interviews with stakeholders, ranging from Jordanian government officials, international governmental organisations, nongovernmental organisations and local community-based organisations. In addition, there were seven informal health discussion groups, each containing 8 participants. They were convened with Iraqis at two different locations - a community centre in East and a church medical clinic in West Amman - over a two-day period. Iraqi and Jordanian staff in the two locations used their network to contact participants, all of whom had used health services in Amman to varying degrees.\(^{13}\) Those Iraqis contacted in the sample then alerted friends and neighbours through word of mouth. In East Amman, participants were split into groups relating to the nature of their health problems.\(^ {14}\) There, I was assisted by a member of the Iraqi community who acted as an interpreter. In West Amman, I

\(^{13}\) In accordance with the regulations of Georgetown’s Institutional Review Board (IRB), the condition of anonymity was made clear to participants. Any names used in this thesis are pseudonyms.

\(^{14}\) The four groups were divided as follows: tertiary diseases, secondary diseases, the elderly and miscellaneous.
led the discussions with Iraqi patients of the clinic entirely in Arabic, without the use of an interpreter.

Another facet of the research involved the perspectives of Iraqi healthcare providers. As part of his extensive research on Iraqi health concerns, Gilbert Burnham and his research team interviewed 401 doctors in Jordan. With this in mind, I set out to interview a small sample of Iraqi doctors during the second research trip to Jordan. Their existence in Amman was confirmed by many, but in reality, finding willing participants proved extremely difficult. This was apparent in my experience with one Iraqi doctor who was working as a senior cardiologist at a large hospital on the outskirts of Amman. Although an outspoken individual, he was unwilling to impart his knowledge about health care in Iraq with anyone affiliated with an American university. This was due to his disagreement over the United States’ involvement in Iraq, highlighting the political permeations of the subject. Fortunately, he directed me to an interview he gave with an Iraqi journalist in Arabic, and segments I translated feature in the third chapter. I conducted two further anonymous interviews in Washington D.C. with former government officials and doctors whose insights proved extremely valuable complements to the literature reviewed on the most recent period after 2005.

**Perceived Limitations**

My inability to conduct field research in Iraq has already been noted. Although mitigated by extensive interviews with Iraqis (the majority of whom had left Iraq in the period from 2006 – 2010), an extensive review of the literature and time
spent analyzing quantitative and quantitative data from IOM Field Monitors working in all eighteen governorates, there may be details that only time spent researching in Iraq could have captured. One such nuance is the distinction between Iraqi Kurdistan in northern Iraq, and central and southern Iraq. Destruction and subsequent development of health infrastructure in these areas is by no means uniform. The effects of Saddam’s neglect and destruction reaped on parts of southern Iraq are still evident in the acute shortage of health care facilities, compared with that of the central region. Conversely, the general state of health care in those northern governorates under the auspices of the Kurdish Regional Government (KRG), is better than the rest of the country, with some labelling Iraqi Kurdistan a ‘beacon of hope’ for the rest of the country’s development of the health sector. All things considered, the KRG’s per capita spending on health care remains about a tenth of the figure in Jordan, revealing the low priority given to health care. Moreover, there continues to be neglect of gender-based violence and related mental health problems in the region.

Along a similar vein, I must mention my inability to conduct research in Syria, which hosts one of the largest urban refugee populations in the world, including an estimated one million Iraqi refugees. Measurements and calculations of numbers are problematic, as noted by Sassoon. It is likely that this number is lower than the figure given by the Syrian government, somewhere

---

16 Ibid.
18 Ibid.
in the region of 450,000, according to UNHCR in 2007.\textsuperscript{20} The current unrest and widespread violence afflicting the country prevented me from carrying out fieldwork in Syria. However, after spending nine months in Damascus in 2007 and 2010, I developed a strong network of contacts and collected some anecdotes pertaining to the situation for Iraqis in Syria. I also had encounters with a small number of Iraqis in Amman, who had moved there from Damascus and Aleppo via Iraq, for fear of deterioration in security within the major cities.

Over the past year, the Displacement Monitoring Department of IOM Iraq has been asked frequently to give estimates of the number of Iraqis returning from Syria. However, the trend has been one of a trickle rather than an outpouring. The majority of Iraqis live Damascus, where the situation has remained largely one of uneasy calm. The need for Iraqis in Syria to enter Jordan from the Iraqi border is another reason for the low numbers. The opacity surrounding Syria and the need to protect those residing within the country makes it extremely difficult to comprehend the state of health and health care. However, the physical and mental health of those Iraqis currently residing in Syria will only deteriorate as the economic, social and political situation worsens. This aspect of Iraq’s health predicament must be considered by humanitarian and political actors, as well as other researchers.

Finally, although a mere interpretation, it is hoped that this thesis, with its focus, presentation and analysis of data, will raise awareness of an issue many suspect or know is present, but few are willing and able to diagnose let alone treat -

\textsuperscript{20} Ibid., p. 65.
particularly if it means delving into historical memory, the politics of responsibility and painful truths of entirely manmade destruction.
CHAPTER I

Mapping the Cycles of Degeneration within the Health Sector in Iraq

(1990 – 2004)

My Homeland, may you have a happy morning,

Gather the masses [of Iraqi people] around your wound,

One day I would like to see you laughing,

Oh when shall sadness set you free, my Homeland.

Sunnī, Shī‘a, Arabs, Kurds,

Embrace them under the flap of your wings,

You are their father, you are their mother,

Steadfast, no matter how much your winds blow.

al-Saher, Kadhum, ‘Watani’ (2004) Video Link:
http://www.youtube.com/watch?v=5VNoHdFPY51

21
You are the brother of Jesus and the father of Zahra’,

Their unity is their only weapon.

Love, peace, thought and prosperity.

May the Lord of heaven bless your success.

My Homeland, Iraq, my Beloved.22

The melancholy tones of Kadhum al-Saher resonate during the opening credits of Laura Poitras’ documentary film, My Country, My Country23. It is July 2004 and the same lament accompanies Dr. Riyadh on his daily journey to work in al-Adhamiya district of Baghdad. He concentrates on the road ahead, straining his neck to see past the Iraqi flag placed over the shattered windscreen. He steers left to get past an American armoured vehicle. On the other side of the road, cars slow down to navigate great pools of stagnant water due to ruptured pipes and open sewers, juxtaposed with the blazing summer sun. From the car window, the camera wanders to the shells of burnt-out buildings and the young Iraqi men who roam the streets. Dr. Riyadh arrives at his clinic, housed in a dilapidated apartment building. A handwritten banner indicates that this is a ‘free medical clinic’ run by a charity calling itself ‘Muslim Aid’. Patients flock to the clinic, telling Dr. Riyadh of the misfortunes in their daily lives as he hands them prescriptions. Every night, after reaching the end of a long line of patients, he returns home in the dark to his family and positions himself in front of the television. One night in November, the household eats the evening meal in

22 Ibid. (English Translation)
silence, interrupted by incessant gunfire, explosions and frantic cries of ‘Don’t shoot!’ in English emanating from the blaring television:

“The medical team is reporting a number of casualties on the streets. Young people, old people, women and children...We’re cut off from any communication.”

The next day, Dr. Riyadh meets with other doctors at the clinic to discuss the delivery of urgent medical supplies to the besieged city of Fallujah. One doctor tells him:

“Our doctors were bombed on the first day...Whether the entrance is legal or illegal, you can’t get inside Fallujah.”

Dr. Riyadh explains to the men: “You need their approval to bring in aid, doctors and blood supplies.” When he tells colleagues that he can get permission from the Americans to enter, he is met with dismay. “No one can enter...planes are bombing. Do you want something like this to happen to you?”

The camera pans the scenes of mass insecurity and desolation, portraying the wounded and killed civilians (some of them doctors) and the obliteration of infrastructure.

The flattening of Fallujah is but a small link in the chain of destruction endured by Iraq’s infrastructure since the 1980s. In mapping the deterioration of Iraq’s health system since the end of the war with Iran, this chapter will draw on the idea of social and economic ‘de-development’. Sara Roy defines de-

---

development as a *deliberate* process undermining the ability of an economy to grow and expand by preventing it from accessing and utilizing critical inputs needed to promote internal growth beyond a specific structural level. This interpretation of de-development, I argue, began with the onset of the First Gulf War in 1991 and intensified with the imposition of sanctions and economic embargo by the international community, lasting until the overthrow of the Ba’thist regime. After 2003, I elaborate on Roy’s definition of de-development to demonstrate that although the systematic or *deliberate* aspect of de-development was absent in Iraq at this time, the destruction caused by the Allied invasion and the ill-thought policies and practices of the US Occupation, led to deterioration of health and further de-development of health infrastructure.

After a brief impartation of the context prior to 1990, I analyse the period from the UN-imposed economic sanctions until the uncomfortable elections period portrayed in Poitras’ film. I conclude that phases of de-development have created a cycle of degradation that has led to the atrophy of the health infrastructure in Iraq, due to ill-regard for the ‘condition’ and its plethora of humanitarian and political intricacies.

**Historical Background**

In spite of the population explosion and the political upheaval of the 1950s and 1960s in which Iraq endured monarchical rule and four other political regimes,

---

an array of new policy initiatives and subsequent administrative confusion\textsuperscript{26}, the country made progress and had experienced transformative waves of economic and social ‘explosive development’\textsuperscript{27} by the early 1980s. This was largely thanks to a golden age, which saw the peak in oil prices and expansion of revenues lead to an astounding 10.4 per cent yearly growth in GDP during the period between 1974 and 1980\textsuperscript{28}. For a number of years, the health and education sectors in Iraq were among the finest in the Middle East, where patients travelled to Iraq from other countries in the region so as to receive high quality care.\textsuperscript{29} The progress made in the health system was reflected in the leaps and bounds made in the falling mortality rates among children as the infant mortality rate dropped from around 117 per 1000 live births in 1960 to 90 in 1970, 80 in 1974 and to 40 deaths per 1000 live births in 1989.\textsuperscript{30} Certainly, the above figures are impressive and an indication of the growth the country experienced in the 1970s, which was above the regional average in some instances. This socio-economic advancement was also reflected in its ‘epidemiological transition’, according to one WHO official. Experts noted that diabetes, hypertension, cardiovascular disease and other chronic and degenerative illnesses were on the increase, as

\textsuperscript{27} Medical Professional Interview (December 2011). He described development policy under Saddam Hussein, literally translated as انخفاض التنمية.
\textsuperscript{29} Jawad, Shakir; Mahmoud, Maysaa; Al Ameri, Ali; Nakano, Gregg in Army Peacekeeping and Stability Operations Institute (PKSOI), \textit{Transitions: Issues, Challenges and Solutions in International Assistance} (August 2011), p. 99.
communicable diseases associated with lack of development were on the decline.\textsuperscript{31}

As the numbers of hospital beds doubled with the nurturing of a comprehensive infrastructure in health, education and social welfare, so too did the population. The Iraqi population amounted to approximately 12 million people, according to the 1977 census. It increased to 16.3 million in 1987 and almost doubled in 20 years to 22 million in 1997. At the same time, little attention was paid to strategy and policy - something that continues to be ignored by numerous authorities until the present day - and thus the ‘seeds of deconstruction’ were sown.\textsuperscript{32} Rather than demonstrating the role of an outside aggressor in initiating the process of de-development as inferred by Sara Roy, the Iraqi case unearths intricacies of ‘de-development’. The 1980s revealed the role of the state in de-developing its own infrastructure through neglect and policies aimed at destruction; namely, the devastating effects of Saddam’s draining of the marshlands in the 1980s, as a punishment for those Shi’a Arabs who rose up against him. Moreover, the health system lacked any formal mechanism through which to record health indicators and there was little focus on public health. Saddam Hussein’s government frequently sent hundreds of professionals to the United Kingdom on scholarships, but their eligibility was dictated by personal preference rather than by demand for certain areas of expertise.\textsuperscript{33} In 1977, Iraq’s expenditure on health was a mere six per cent of expenditure on military,

\textsuperscript{31} Ibid. p. 9.
\textsuperscript{32} Ismael & Ismael, p. 127.
\textsuperscript{33} Jawad et al, p. 99.
and this ‘militarisation of the economy’\textsuperscript{34} was accelerated due to the onset of war with Iran in 1980. By 1987, the population was growing at a rate of three per cent per annum, with the prospect of further increase due to the Saddam Hussein’s fertility policies.\textsuperscript{35} In this same year, the government passed a law that encouraged families to have more children, with financial rewards and gifts for those who had four children or more.\textsuperscript{36} Despite such population growth, expenditure on health was negligible at only one per cent whereas military expenditure constituted 30 per cent of GNP.\textsuperscript{37} Incidentally, despite their increase in military spending due to civil war in Lebanon and the Israeli threat, Syria and Jordan still only spent an average of 17.6 per cent of GNP on military expenditure in comparison.\textsuperscript{38}

\textbf{Sanctions}

On the 6\textsuperscript{th} of August in 1990, four days after Saddam Hussein’s invasion of Kuwait, the United Nations Security Council imposed a near-absolute economic embargo on Iraq that was to last until May 2003. All trade and the accumulation of financial resources was prohibited, with only limited foodstuffs and medicine allowed to enter the country. During the 1980s, the rate of infant mortality was in decline, but in the 1990s infant deaths rose. Admissions of guilt and regret over the human cost of sanctions, condemnations and critical reflections have

\textsuperscript{34} Sassoon, Joseph in Baram, Amatzia; Rohde, Achim; Zeidel, Ronen (Eds.), \textit{Iraq Between Occupations: Perspectives from 1920 to the Present} (New York: Palgrave Macmillan, 2010) p. 189.


\textsuperscript{37} Ismael & Ismael, p. 128.

been abundant since the late 1990s, albeit too late. Ethical quandaries aside, differences in the cases of the Israeli blockade on Gaza and the US occupation of Iraq are clear to see – not least the sustained efforts of expulsion and dispossession practised by the Israelis. In her examination of the de-development of the Gaza Strip through the lens of political economy, Roy lists a number of policies that contribute to de-development. Of relevance to Iraq - low levels of government investment in social and economic infrastructure; prohibitions on a wide range of economic activities; a myriad of restrictions on research and trainings; prohibitions on the development of agricultural, industrial, trade and other credit facilities and financial institutions in both the private and public sectors; restrictions on the development of public and private utilities and infrastructure; and of course, restrictions on foreign trade. Indeed, the similarities of the economic embargo placed on Iraq are also striking due to the slow and painful devastation such a blunt instrument reaps upon an entire civilian population. Both the Gaza Strip and Iraq have suffered “...the deliberate and systematic deconstruction of an indigenous economy by a dominant power.” As is the case in Gaza, sanctions were designed to ensure that there was no economic base to support the independent existence of the Iraqi population. However, the crucial and somewhat sinister difference in the case of Iraq’s de-development in the 1990s, was that such a policy was sanctioned and implemented by the international regime, rather than an occupying force.

39 Roy, p. 131.
40 Ibid., p. 4.
It can be said with good cause that the combination of war and thirteen years of economic sanctions erased most of Iraq’s social and economic achievements of the previous twenty years.\textsuperscript{41} Worse still, it was the unflattering will of all three US administrations from 1990 onwards, to inflict such economic destruction on Iraq.\textsuperscript{42} Gordon notes that blame was often directed at the corrupt Iraqi government, on the grounds that Hussein was using Iraq’s funds, illicit income from smuggling, and proceeds from the Oil-for-Food Programme to buy luxury goods for himself and those he held close to him. Certainly, cronyism and networks of patronage remained a staunch characteristic of Saddam’s regime until its end. However, a grim characteristic of de-development, the ‘real damage’ to Iraq’s economy was not so much from Saddam Hussein’s neglect or corruption, but from the systematic impoverishment of an entire nation due to the indiscriminate nature of sanctions. \textsuperscript{43}

On a special United Nations mission to Baghdad to assess the humanitarian situation in 1991, the Finnish diplomat Martti Ahtisaari remarked that despite extensive prior knowledge of the unfolding crisis in Iraq, nothing could have prepared him or members of his mission for the kind of ‘devastation’ that had befallen the country:

The recent conflict has wrought near-apocalyptic results upon the economic infrastructure of what had been, until January 1991, a rather highly urbanized and mechanized society...Iraq has, for some time to come, been

---

\textsuperscript{43} \textit{Ibid.}, p. 3.
relegated to the pre-industrial age, but with all the disabilities of post-industrial dependency on an intensive use of energy and technology.\textsuperscript{44}

The targeting of electricity, water and sanitation infrastructure by the Allied Forces early on in the attacks meant that without immediate external assistance to repair the havoc wrought on public health facilities, the consequences would be unbearable. Experts returning from Baghdad described the city as looking like Venice from the air, with 'streets ankle-deep in raw sewage'.\textsuperscript{45} Yet, due to the dramatic increase in the spread of communicable diseases such as digestive illnesses resulting from a lack of sewage treatment and contamination of water treatment works, such health experts brought into the country were forced to devote time and money to crisis management in disease control and prevention, which delayed much-needed repair and longer-term focus on health infrastructure.

Aside from physical destruction, the Iraqi economy was particularly vulnerable due to its overwhelming reliance on imports and trade. In the late 1980s, food imports reached $2 to $3 billion and imported medical supplies amounted to $400 to $500 million. After sanctions commenced in August 1990, these imports equalled a mere 10 to 15 per cent of previous levels.\textsuperscript{46} Access to medical treatment diminished, medicines became scarce in supply and essential vaccines and medicines could not be disseminated efficiently due to a lack of


communication and scaled-down transport system.\textsuperscript{47} In 1989, the Ministry of Health reported spending more than $500 million on medical supplies and equipment. Following the war, this figure was estimated to have dropped by as much as 90 per cent. Health care spending fell from $86 per person in 1989, to $17 per person in 1996. It later increased to $65 per person in 2000, thanks to revenues from the United Nations’ Oil-For-Food Programme (OFFP)\textsuperscript{48}, but did not return to levels prior to 1990. The Iraqi regime was characteristically stoic and pragmatic in its response to the squeezing of resources and in 1991, it imposed a strict rationing system on both food and medicines. This led to some doctors under-prescribing medications. Those with chronic diseases suffered in particular as medicines for diabetes, cancer, cardiovascular disease and severe pain relief had all but disappeared by the early 1990s.\textsuperscript{49} Saddam Hussein’s regime also tried to generate revenue at the expense of the increasingly impoverished civilian population by abandoning the country’s once reputable universal free health care and creating a tiered fee-paying system. By 2002, the fees charged to patients accounted for 80 per cent of a total health spending of about $50 million.\textsuperscript{50} This came at a time when a middle-ranking civil servant earned approximately $1.50 per month and a chicken cost approximately $1.20.\textsuperscript{51,52} Similarly, inequality among doctor’s salaries became widespread as

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{47} Ahtisaari et al., p. 9.
\item \textsuperscript{48} Report of an independent Working Group established by the Independent Inquiry Committee, “Impact of the Oil-For-Food Programme on the Iraqi People”, p. 45.
\item \textsuperscript{49} Ibid., p. 45.
\item \textsuperscript{50} Alwan, Ala’din, “Health in Iraq: The Current Situation, Our Vision for the Future and Areas of Work”, p. 11.
\item \textsuperscript{51} Sluglett, Peter in Lamani, Mokhtar; Momani, Bessma (eds.), \textit{From Desolation to Reconstruction: Iraq’s Troubled Journey}, (Ontario: Wilfrid Laurier University Press, 2010), p. 21.
\item \textsuperscript{52} Sluglett estimated the figures at 5000IQD and 4000IQD respectively. However, I converted the figures to USD based on the average exchange rate of 2002 so as to give the reader a better indication of the economic situation. (http://www.oanda.com/currency/historical-rates-)
\end{itemize}
\end{footnotesize}
corruption pervaded every aspect of daily life. A select few doctors in successful surgical units could expect to earn hundreds of thousands of US dollars per month, while other doctors working in units that had fallen out of favour with the regime and generated low income (an example being mental health) might earn as little as $20 per month. Nurses and ancillary staff fared even worse, earning wages of $2 to $3 per month. According to Ali Allawi:

Corruption actually increased in hospitals as doctors and other health workers sought to augment their ridiculously low state salaries with extra income from patient charges. There were other extortions, such as allowing patients in need for emergency services to wait until a bribe had been paid, or denying them hospital beds or food unless a payment had been extracted.

The rampant destruction and de-development of Iraq’s health is most apparent from the heavily-quoted statistic of 567,000 preventable child deaths that occurred in Iraq during the period from 1990 until 1995. Before 1996, 148 ambulances served Baghdad; after 1996, only 4 ambulances worked in the capital city. The Director of Public Affairs at UNICEF described his shock at the ‘homogenous spread of calamity’ in Iraq and remarked: “The Iraqis are as fat as the Americans.... Before the war, the average Iraqi had 124 per cent of his required daily calorie intake.” Indeed, in a matter of weeks, Iraqis were transformed from a population of ‘haves’ to ‘havenots’. Moreover, after living under a system in which goods were gaily doled out and distributed centrally in

---

54 Allawi, p. 129.
56 Garfield, p. 286.
the fashion of other rentier states in the Gulf today, Iraqis did not have the same coping capability or experience to survive as in parts of Africa or south Asia.

During a hearing before Congress as early as 1992, there appears to have been the creeping realisation that such de-development of infrastructure in Iraq was absurd, never mind morally questionable. A professor from Tufts University stood before the International Task Force committee and said:

It makes no sense, in my judgement, to leave the Iraqi people increasingly dependent on international charity any more than it makes sense to inflict enormous hardship on innocent people for the misdeeds of their leaders.\footnote{Osgood Field, John in \textit{Ibid.}, p. 34.}

A representative from the Catholic Relief Services even added a word of caution when the idea of the UN’s OFFP was first muted:

Suggestions about unfreezing Iraqi assets for the purchase of food under UN control are encouraging, but we should not be diverted into thinking that the UN can be an effective substitute for the commercial and government mechanisms of commodity distribution.\footnote{Pezzullo, Lawrence in \textit{Ibid.}, p. 30.}

Despite the words of caution, in 1996 the United Nations passed Resolution 986 due to its concerns for the severity of the health situation in Iraq. After a delay of several months, medical equipment and supplies began to trickle into the country in 1998. The OFFP alleviated the worst effects of the sanctions regime on the Iraqi population, shifting the development paradigm from de-development to one of underdevelopment, stagnation and dependency of a once-capable population on the international community. Under the auspices of the initiative, calorific intake increased (albeit to a much lower level than before

\footnote{Osgood Field, John in \textit{Ibid.}, p. 34.}
\footnote{Pezzullo, Lawrence in \textit{Ibid.}, p. 30.}
1990), malnutrition among children was halved and clinics were rebuilt.\textsuperscript{60}

Production of medical goods also increased slowly until it reached a reported 50 per cent of capacity by 2002. Meanwhile, the OFFP was plagued by inefficiency, ill-planning, corruption and a lack of coordination. It is estimated that the Iraqi regime earned over $1.5 billion in illicit income or ‘kickbacks’.\textsuperscript{61}

\begin{center}
\includegraphics[width=\textwidth]{chart.png}
\end{center}


On an operational level, many of the chemicals needed for finishing products in the pharmaceutical industry were unavailable. Paul Volcker’s Independent Inquiry Committee notes that filters, machinery and other equipment to manufacture the drugs was ordered at the beginning of 2000 but had still not arrived by 2002. This shortage of equipment resulted in poor quality products and wastage.\textsuperscript{62} A lack of communication with the Iraqi government also led to

\textsuperscript{62}Ibid., p. 46.
the erratic supply of medicines, delayed deliveries, shipment of inferior or 
damaged goods, missing items, delayed installation and a dearth of expertise:

Of course, the high proportion of corruption that existed in health care 
and the lack of international interest in it was the biggest problem, along with 
the lack of hygiene and the lack of specialists present, especially during the time 
of the economic blockade.

Thus, one can regard the sanctions period as one of aggressive de-development 
that decelerated but by no means stopped after the imposition of the OFFP in 
1996, as the standard of health infrastructure failed to come close to levels seen 
before 1990. Worse still, citizens were caught up in the paradox of their country 
having the potential financial resources to pay for their own relief effort, and yet 
being forced to remain in a state of debilitation and stagnation without prospects 
for development as they remained at the mercy of the highly politicised 
international aid regime for distribution of Iraqi funds. In the words of one 
former electrical engineer from the governorate of Missan:

There used to be no problem with the health care in Iraq because it was 
free. Medicine was provided and the medical staffing was excellent. 
However...even before the fall of Saddam, we lacked modern medical techniques 
and sophistication...The matter increased especially after the overthrow, when 
we lost our infrastructure, including medical services.

In his frank memoirs, Hans von Sponeck describes the ‘uncomfortable feeling’ he 
had as UN Humanitarian Coordinator of Iraq for this very reason. When 
implementing the fifth phase of the OFFP for the period between November 
1998 and May 1999, the health budget was allocated at $240 million, which 
amounted to $10.70 for six months per person for an estimated 22.5 million

---

63 Ibid., p. 45.
64 Anonymous Interview 30.4 (December 2010)
65 Anonymous Interview 210.1 (December 2010)
people. He describes the ‘inadequacy’ of such an amount, and recounts a visit he made to a hospital in the governorate of Kerbala:

The picture was always the same: crowded conditions, fearful faces, malnourished children and harassed looking medical staff. These hospitals reminded one more of the disorderly and unkempt train stations than places of treatment.

When evaluating the humanitarian impact of the OFFP on the Iraqi people, Paul Volcker includes a number of alternative uses of OFFP resources. These include: increasing the amount of resources, buying from local Iraqi suppliers, buying products of better quality at lower prices and devoting more revenues to infrastructure and development. At worst, the mistakes of the OFFP heightened levels of corruption and allowed for continued deterioration of Iraqi infrastructure. At best, they stabilised a dire situation. In another example of history repeating itself, efforts were focused on crisis management and visible results, similar to those of the British Development Board in the mid-twentieth century. Moreover, the OFFP’s lack of allocations for training, skill development, and management in the centre and south of the country meant that it did not allow for even limited development of human resource capacity within the health sector. Volcker’s concern over “…funds being used to buy goods of inferior quality (grains fit only for animal feed, pharmaceuticals of doubtful efficacy or of expired date...) or to pay excessively high prices (because certain

---

67 Ibid., p. 45.
69 Owen & Pamuk, p. 163.
suppliers, especially those owned by or tied to the government, were favoured with contracts)...”\(^7\) appeared in the story of one family, who left Iraq for Jordan in 1998:

We headed for Jordan, seeking treatment for my young son because he was suffering from inflammation of the intestines and acute poisoning from the milk I was giving him during the embargo. Many children died in that period because of the milk that was offered.\(^8\)

As the beginning of the end unfolded by the close of the 1980s, the 1991 Allied Operation Desert Storm destroyed more of Iraq’s economic infrastructure than did the entire war with Iran\(^9\). Moreover, sanctions left Saddam Hussein’s political infrastructure relatively intact if not buttressed by the blockade. Networks of patronage and nepotism were intensified and an atmosphere of dependency on Saddam Hussein’s brutal enterprise was consolidated as people flocked to the regime and its quickly-developed rationing and distribution system, out of sheer desperation and survival. Such a food rationing system worked because the regime understood and responded to a threat of food insecurity instigated by what it wanted people to perceive as ‘outsiders’.\(^\) This combination set in motion a process of socioeconomic polarisation\(^\) and the onset of Iraq’s brain drain of the educated middle class, among them many medical professionals.

---

\(^7\) Report of an independent Working Group established by the Independent Inquiry Committee, “Impact of the Oil-For-Food Programme on the Iraqi People”, p. 81.
\(^8\) Anonymous Interview 240.2 (December 2010)
Occupation

In an uncomfortable echo of 12 years prior, but with less damage – at least physically – the Allied forces invaded Iraq in 2003 and toppled Saddam Hussein’s regime. In terms of medical infrastructure, the 2003 invasion saw 12 per cent of the hospitals and a number of primary care clinics and other health care facilities damaged.\(^76\) However, the fall-out from the sanctions period was clear to one Iraqi doctor on a fact-finding tour for the UK Royal College of Paediatricians in 2003. The doctor, practicing medicine in the UK, expressed her dismay at the retardation of Iraq’s health care:

I saw a lot of congenital heart disease which should have been treated years ago. One child aged about four years had hydrocephalus [water on the brain] and had not been operated on after her birth.\(^77\) Consequently her head was huge. Drugs that have been superseded here [UK] are still being used. For example, asthmatics are still being treated with outdated medicines. As a doctor, I felt helpless, and as an Iraqi I feel angry.\(^78\)

With sanctions obliterating two-thirds of the country’s GDP and debts of almost $130 billion\(^79\), the UN OFFP evolved into the Development Fund for Iraq and was handed over to the US-led Coalition Provisional Authority (CPA) in November 2003. The few billion squandered\(^80\) due to the manipulation and mismanagement of the OFFP suddenly was but a minor transgression compared to the $9 billion unaccounted for in less than a year after the CPA gained

---


\(^77\) I witnessed a similar life-threatening case on a home visit in East Amman. The family had left Iraq in search of treatment in September 2011. (January 2012).


\(^79\) Sassoon, Joseph in Baram, Rohde, Zeidel (Eds.), p. 195.

\(^80\) It is hard to verify the numbers, but different estimates range from $300 million to $7.5 billion, according to Sassoon, Joseph, The Iraqi Refugees: The New Crisis in the Middle East (London, New York: I.B. Tauris, 2009), p. 135.
Ruination of the health sector accelerated and gross mismanagement became a hallmark of the CPA regime. The poorly-functioning Iraqi state that struggled to function during the sanctions period seemed mildly efficient in light of the virtual breakdown of even the most basic services during the US-led invasion and occupation of the country, all of this directly impacting Iraq's health and health sector.

In the chaos and state of lawlessness that ensued during the months after the invasion, hospitals and laboratories were among the prime targets in the mass looting that took place across the country, with two major public health laboratories in Baghdad and Basra damaged and looted. In his memoirs, former Senior Advisor to the US State Department David Phillips recalls the ‘unmitigated disaster’ following the first days of so-called ‘liberation’ as looters pillaged everything in sight: “Looters dismantled the electricity grid, creating power shortages that shut down refrigeration, lighting, and water systems. Frenzied mobs attacked hospitals, stealing medicines and even patients’ beds.”

Under the CPA’s watch, what was at first random looting became systematic and expanded in its remit to the targeting, kidnapping and killing of civilians. Initially, those perpetrators of the crimes were met with little or no resistance from the Occupying Forces, who were ill-prepared for such a phenomenon. This,

---

in turn, added to the chaos and sense of widespread insecurity affecting the health of all Iraqis. Widespread looting of hospitals and health care centres at the hands of militias was replicated at the institutional level, as astronomical levels of corruption also impeded the recovery of the health sector – most visible in the controversy over the medical imports company, Kimadia, a state-owned monopoly from the Saddam era. “Pharmaceuticals were routinely hoarded by company officials and then diverted to the black market or illegally exported.”

The budget for the Ministry of Health had rocketed from a mere $16 million in the last year of Saddam’s rule to nearly a $1 billion in 2004. However, “…this had to accommodate massive losses to the health system’s infrastructure and the theft or destruction of medicines and medical equipment.” In a USAID analysis of Kimadia’s warehouses, it was reported:

There is a feeling from the Management staff that the system is very corrupt both above and below their authority. Several years ago, there was a plan to build new warehouses in Baghdad, however it took five years to simply survey the site and thus the plan was never completed as certain persons had a personal interest in prolonging the process.

Written as early as 2003, a Lancet Editorial entitled ‘Act now to secure Iraq’s health’ described the US government’s plans for health in a post-Saddam Iraq as ‘ill-conceived’ and having ‘actively delayed efforts to restore public services.’ It went on to attribute the delays to “…the insistence by the US Department of Defence that it control pre-war planning and coordination of relief.” Indeed, the Pentagon’s exclusive possession of the postwar reconstruction effort

---

94 Allawi, p. 378.
95 Ibid., p. 379.
ostracised Iraqis, foreign health experts, other US Agencies (namely, the Department of State and USAID), international governmental and nongovernmental organisations with years of experience and expertise in planning for humanitarian crises and in the transition from disaster relief to long-term development. With many still questioning the legality and morality of the Iraq war, humanitarian actors did not want to be associated with the occupying power. Others had no choice and were left in the dark due to numerous protocols erecting a wall of secrecy and air of superiority. Phillips claims that military systems have no training or experience in dealing with the transition from relief to rehabilitation and then to reconstruction. Moreover, humanitarian assistance is not just about mitigating short-term needs with the giver doling supplies to victims. Rather, vulnerable populations need to feel they are able to restore some degree of normality and security in their daily lives through the repair of existing infrastructure and provision of basic services, such as the food rationing system that had become so crucial to the survival of Iraqi civilians during the sanctions, the latter of which only ended in 2003 with regime change.

Military personnel were similarly ill-equipped and unwilling to instill a sense of empowerment and reconciliation among the Iraqi population through collaborative partnerships and dialogue. At the local level there was little or no inclusive policy-making or coordination with community groups such as

---

98 Phillips, p. 231.
99 A good example of an unsuccessful attempt at dialogue is a meeting between Dr. Riyadh and US soldiers that features in the documentary film, My Country, My Country.
religious charities and mosques. Instead, military leadership stifled meaningful debate from the top-down and precluded Iraqi participation among the grassroots. Meanwhile, the gravest health needs turned out not to be supplies to treat acute emergencies that had been stockpiled before the war, but rather medicines for common chronic illnesses of the largely urban population, such as cardiovascular drugs, and the critical diagnostic and therapeutic equipment needed to refurbish and replenish the ransacked laboratories and hospitals. The disruption of such essential services as electricity, water, police, public transport, and communication systems also made it impossible for patients to travel to obtain health care and for health workers to do their jobs.

Fassin cautions for the need to be clear that the work of humanitarian organisations is by no means similar to the action of military forces. “It is therefore important that analysis does not add to the confusion of categories that reigns on the ground by blurring issues and by placing all actors and all logics on the same level.” One cannot fail to note that in spite of the differences between humanitarian actors the military, although in emergencies the two sides typically come together on the same scene, in what Fassin calls a ‘reciprocal and asymmetrical dependency’. The military increasingly rely on humanitarians to legitimize their interventions and the latter need the former to ensure their safety in carrying out relief operations. In the case of Iraq, such a relationship was distorted as association of humanitarian organisations with the military put

---

102 Fassin, Didier in Fassin; Pandolfi, p. 14.
103 Ibid., p. 15
them at increased risk and the military continued to ignore the need for any input from relief organisations.

The most enduring and widely-known example of the CPA’s misdiagnosis, to the detriment of Iraq’s health sector and the wider functioning capacity of the country, was the purging of the middle class. In what has become known as the process of ‘De-Ba’thification’, thousands of highly competent and educated professionals were ousted from their positions, due to alleged ties with the Ba’th Party. In a country for years at the mercy of a centralised dictatorship, even those wishing to teach in public schools or planning to pursue graduate study were tied to the Ba’thist regime. De-Ba’thification left behind a dearth of qualified professionals in the middle and senior levels of the bureaucracy, in turn creating a vacuum of inefficiency, inexperience and inertia. At the most senior levels of the Ministry of Health within the interim government, the lack of qualification, clear and consistent leadership was demonstrated in the appointment of Khudair Abbas as Minister of Health, who had been brought out of exile after twenty years living outside the country. Typical of the suspicious attitude among Iraqi health experts towards the CPA’s overnight decentralization and re-jigging of the Ministry of Health, one doctor commented: “…the people in control of health now are just like the previous regime in that Iraq’s health professionals are excluded from decision-making and are afraid to speak out and criticise those in power.”

The CPA further miscalculated through its blind emphasis on privatisation - another indication of its ill-regard for the intricacies of the Iraqi context, which they chose to view as somewhat of a blank canvas. In the eyes of Paul Bremer and his team, there was no existing health infrastructure worth preserving and thus, no need to understand the previous system.\textsuperscript{105} Rather, the CPA advocated that reconstruction be accomplished mostly by the private sector, funded by oil revenues and supported by a cooperative Iraqi population. Sassoon notes that this faith in a ‘vibrant private sector’ was to come after forty years of state monopoly and centralisation.\textsuperscript{106} Certainly, projects with rapid results and obvious ‘deliverables’ (such as the building of new clinics and medical schools) tended to prove popular with the political parties to the conflict but were regarded with skepticism by others, who did not consider such projects to address the more urgent issues of staff and medicine shortages and the repair of existing health infrastructure. Larger contracts were awarded to the private sector rather than to WHO, UNICEF and nongovernmental humanitarian organizations, even though such projects absorbed resources inefficiently. Ultimately, those who understood the need for a system-wide approach could not be heard over the clamour politicians and military officials calling for visible results to coincide with their own agendas.\textsuperscript{107} Such a transformation and will to transplant readymade and foreign ideals in making a ‘New Iraq’ without considering the vision of Iraqis\textsuperscript{108} was doomed to failure and contributed to the further neglect and degradation of the ailing public health sector.

\textsuperscript{105} Paterson, M. in Medact, “Rehabilitation Under Fire: Health Care in Iraq 2003-7”, p. 5.
\textsuperscript{106} Sassoon, Joseph in Baram; Rohde; Zeidel (Eds.), p. 191.
\textsuperscript{107} Phillips, p. 147.
\textsuperscript{108} Sultan Barakat in Sassoon, The Iraqi Refugees, p. 134.
Conclusion

The devastation reaped by the sieges of Fallujah in April and November 2004 serves as a parallel of the broader systemic causes for the steady decline of public health infrastructure from the 1990s until the US handover to the newly-elected government of Iraq in 2005. In the wake of the attacks in 2004, poor planning, lack of foresight and little thought for the humanitarian impact on civilians meant that no human corridor was provided. During the sieges, ambulances came under fire, humanitarian convoys were denied access, hospitals were unable to obtain desperately needed medical supplies to treat the wounded, and civilians were left to starve. Doctors at Fallujah General Hospital told Al Jazeera that almost 2000 Iraqis died in the two attacks and spoke of medical personnel being fired upon by US forces while trying to evacuate the wounded. Approximately 60 per cent of those victims were women, children, and elderly. 85

During a meeting with US troops at al-Adhamiya District Council after the second attack in November 2004, Dr. Riyadh expressed his dismay at the ‘misunderstanding’ on the part of the American forces about their treatment of the Iraqi people.

They have no food, no blankets, and no roof. This is shame. The war had been over since last May, but it seems to be continuous.

The worsening social, political and economic insecurity felt by the Iraqis in their daily lives was indicative of the continued degradation of Iraq's infrastructure over a number of years. Just as in November 2004, the Occupiers had not learned from the mistakes of their first attack on Fallujah seven months prior. Moreover, the disregard for health and subsequent de-development was reminiscent of Saddam Hussein's obsession with war and security concerns in the 1980s. The period between 1990 and 2004 showed little learning from or consideration of the intricacies of the past and present, and their long-term impact on the future. In 2005, in the aftermath of years of de-development, Iraq was transformed into a shadow of its former self with a large proportion of the population forced to migrate to neighbouring countries of Jordan and Syria due to the new phenomenon of widespread sectarian violence that soared after the bombing of the al-Askari mosque in February 2006. The remaining segment of the population in Iraq continued to suffer from kidnappings, threats and violence, the housing deficit, high unemployment and food scarcity, as well as being denied access to their basic right to health care, as stipulated in the Iraqi constitution.
CHAPTER II

Health Experiences and Perceptions of Iraqi Refugees in Jordan

(2003 – Present)

“Exile, immigration, and the crossing of boundaries are experiences that can provide us with new narrative forms...with other ways of telling.”133

Since the 1980s, the state of exile has become a reality for millions of Iraqis, with a history of protracted displacement woven deep into the social fabric of contemporary Iraq. The previous chapter mapped the social and economic reality inherent in the de-development of the health sector inside Iraq, portraying the individual and collective experiences lived by Iraqis. Illustrating the context and following the experiences of those living as refugees outside the country, a case study of Iraqis in Jordan illuminates the debilitating consequences of those years spent in exile. The discernment of narratives and observations of protracted displacement in the urban setting of Amman unearths yet more intricacies embroiled in the recovery of Iraq’s health predicament. Once again, it becomes evident that failure to converge ‘the humanitarian’ and ‘the political’, placing the former within a wider and multi-faceted context, risks further stagnation. In Jordan, this is evident in the persisting division perceived by many, between the short-term relief and longer-term development paradigms. Precluding any vision for the future, this risks under-development and further delaying the recovery of the health of a nation.

Given the urban setting in which Iraqis are dispersed in all their diversities and the political sensitivities surrounding the status of forced migrants in Jordan, it

first is necessary to clarify what is meant by the term, ‘refugee’. Rather than a label for an essentialised ‘type’ of person or situation, which connotes constricting visions of refugees as depoliticised and homogenous ‘humanitarian problems’ synonymous with poverty and disaster; ‘refugee’ should be understood only as a broad “…descriptive rubric that includes within it a world of different socio-economic statuses, personal histories…”134. An individual, although they might not view it themselves, is a ‘product of history’135; of their own personal histories interlaced with others around them, uniquely shaped and shaping in their interactions and resistances as they navigate the structures of lives lived. Thus, this chapter examines the various health experiences and perceptions of Iraqi refugees in Amman, with particular focus on the process of mainstreaming Iraqis into the Jordanian public healthcare system. Issues of accountability and responsibility are brought to the surface, highlighting the historical, political, social and economic intricacies embedded within the broader condition that appears increasingly characterised by waiting. Ultimately, this ‘hiatus of humanitarianism’ played out due to failure to address the genealogy of displacement leads to the worsening of the physical and mental health of those in Iraqis in exile.

Background to the Displaced in Jordan

Long considered a safe haven sheltering those from unrest in neighbouring countries, Jordan has received Iraqis since the 1980s. What began as a trickle of refugees increased to a steady flow after the US-led invasion. By December

2003, there were an estimated 250,000 to 300,000 Iraqis living in Jordan, but only 5,000 to 7,000 registered as asylum seekers or refugees with UNHCR.\textsuperscript{136} Whilst Jordan was never inundated with a sudden outpouring of Iraqis, the refugee ‘crisis’ perceived by many reached a head in 2006, with the surge in sectarian violence forcing thousands of Iraqis to travel to Amman and Damascus. There, they sought the rights of security, shelter, and the provision of basic services no longer available to them in Iraq.

It has proved extremely difficult to provide exact numbers of Iraqi refugees in both Jordan and Syria, due to the myriad of estimates from various surveys, the political game of numbers played by the host governments, and the dispersal of Iraqis into a kind of urban obscurity. In 2007, a Fafo survey concluded that there were as many as 450,000 to 500,000 living in Jordan.\textsuperscript{137} This figure has since been regarded as an over-estimation, but a necessary compromise with the Jordanian authorities, which remained so patient in opening their doors. At the beginning of 2012, official UNHCR figures estimated that there were close to 419,900 living in Jordan, but only 32,000 registered\textsuperscript{138}; the vast majority of whom live in Greater Amman. Unofficially, discussions with government representatives and those working closely with Iraqi refugees believe the numbers to be far lower, at approximately 100,000. With no natural resources of its own and a population growing at a rate of over two per cent per annum\textsuperscript{139},

\textsuperscript{136} Chatelard, Geraldine, "From one War to Another: Iraqi Emigration to Jordan" in ISIM Newsletter (No. 13, December 2003), p. 26.
\textsuperscript{138} UNHCR Jordan 'Country Operations Profile' (February 2012), \url{http://www.unhcr.org/pages/49e486566.html}, Accessed on 02/06/2012.
\textsuperscript{139} \url{http://www.indexmundi.com/jordan/population.html}, Accessed on 02/06/2012.
Jordan’s infrastructure has been overstretched by the addition of Iraqis. Having already absorbed more than two million registered Palestinian refugees and bestowed the rights of citizenship upon the vast majority, it has also grown weary of the term ‘refugee’ and is thus not a signatory to the 1951 Geneva Convention. Rather, the government considers Iraqis ‘guests’ - the idea being that ‘when you are a guest you are expected to leave’. Although ‘local integration’ is one of three universal durable solutions put forward by UNHCR and subsequently assumed by many actors working with refugees, long-term integration within Jordan is not considered a viable option by the host country government, and nor is it accepted by the majority of Iraqi refugees living in Jordan.

**Health Profile**

As early as 2003, humanitarian actors began crafting their emergency relief response in anticipation of a possible outpouring of Iraqis amassing on the border with Jordan. Some years later in discussions with international governmental and nongovernmental organisations, they readily admit that they miscalculated the Iraqi people’s response:

> Many of the traditionally accepted guidelines for best practices and minimum standards for assisting refugees in emergency response conditions have only limited relevance in the urban setting. In the health sector, these limitations were compounded by the fact that the health profile of the Iraqi refugees is considerably different than most refugee populations.¹⁴²

---

¹⁴¹ Anonymous Stakeholder Interview 19 (January 2012)
¹⁴² Skopec, Chris; Valeeva, Natalia; Baca, Mary Jo, “Anticipating the Unexpected: Urban Refugee Programming in Jordan” in *Middle East Institute* (November 1, 2010), p. 1.
Moreover, expertise of such actors in preventing the breakout of infectious disease and the provision of basic healthcare services in the impoverished camp setting has been little use in their work with Iraq’s displaced living in Amman.143

In comparison with Palestinians, Somalis and now Syrians, the image of Iraqis as ‘the rich refugee’ developed in the 1990s as wealthy businessmen and former government officials settled in the affluent suburbs of West Amman. Writing in 2007, a well-known British journalist deemed these neighbourhoods ‘a glittering showcase’ of Iraqi wealth, with villas, new apartment blocks with balconies and Filipina maids working inside.144 As he left the area in a taxi, he observed the Jordanian driver cursing as ‘a new SUV with Iraqi plates’ drove past. Crossing over to East Amman, the same journalist visited a middle-aged Iraqi woman in a ‘dank room’ located in a working-class neighbourhood. In his description: “…a widow from al-Adhamiya, weeps over her bad heart and her three handicapped daughters, with one rickety wheelchair between them and no money for physiotherapy.”145 This journalistic snapshot conveys the risks inherent in constructing generalisations. A quest to delineate the ‘refugee experience’ prompts those to “…seize upon political or historical processes and then to inscribe aspects of those processes in the bodies and psyches of the people who are undergoing them.”146 In reality, so-called ‘refugee populations’ are heterogeneous in every respect, yet the ‘per capita method’ of aid distribution

145 Ibid.
acts as a ‘leveler’ that tends to emphasise both their ‘homogeneity and their inferior position’. In the case of Iraqis living in Amman, the geographical divide between rich Iraqi and poor Iraqi is visible for all to see. However, in this urban setting in which the displaced slip easily into ‘much larger constellations of socio-political and cultural processes and practices’, the divide between poor Jordanian and poor Iraqi, or rich Iraqi and rich Jordanian is far less obvious.

One of the commonalities that can be discerned among Jordanians and Iraqis, is in the health needs of those living in Amman. The majority of cases presented in hospitals are those afflicting an aging population of Iraqis who suffer from non-communicable diseases, such as high blood pressure, cardiovascular disease and diabetes. Jordan, like Iraq, is well-advanced in its ‘epidemiological transition’. In Amman, Iraqi’s health vulnerability is exacerbated due to their lifestyle and circumstances in exile, in which they remain confined the home unable to work. During a discussion one evening in a smoke-filled room of a local community centre frequented by Iraqis, in which eight men and women discussed their plethora of health woes, Abu Karam, a man in his sixties gave his reading of the health situation for Iraqis in Jordan.

It is simple. There are three groups of us - those with special needs and disabilities, those with chronic illnesses like high blood pressure, hypertension and diabetes; and then those who become ill suddenly.

---

148 Ibid., p. 496.
150 Leaning, Jennifer; Spiegel, Paul; Crisp, Jeff, “Public health equity in refugee situations” in Conflict and Health (Vol. 5, No. 6, 2011), p. 2.
151 Anonymous Discussion Group 2 (January 2012)
Such an assessment is reiterated in reports from expert health bodies. In 2006, a survey conducted by the Iraqi government and the World Health Organisation found that cardiovascular diseases represent the main causes of hospital admission and account for around 40 per cent of all causes of death in the country. Six years prior, a local household survey undertaken in nine Iraqi governorates in 2000 showed that around 30 per cent of the adult population above 40 years of age have hypertension and 15 per cent have diabetes. In terms of disabilities, the International Committee for the Red Cross (ICRC) estimates that 150,000 Iraqis have been left disabled as a direct consequence of war and violence. More generally, the Iraqi Association of Disability Organizations reckons that around ten per cent of the population suffers from some kind of handicap, implying that almost 2.75 million Iraqis have special needs.

NGO Sector

Since their arrival, negotiating the NGO and private sectors has become a part of everyday life for the thousands of Iraqis living in Amman. Indeed, when asked where they go their health needs in Amman, Iraqis allude to waiting a long time for an appointment at ‘Caritas’, the free medicines that used to be available at the ‘Red Crescent’ or failing to receive the right medication at the ‘Aid Centre’. The

---

unfailing mention of such organisations in interviews and discussions with Iraqis, although often in the form of complaints, is reminiscent of the love-hate dichotomy that Julie Peteet refers to in her discussion of the relationship between Palestinians and UNRWA in Lebanon. Like UNRWA, these NGOs in Amman have come to possess ‘identity-affirming capacities’. They are an integral aspect of refugee life and a reminder of the international community’s commitment and involvement. However, where tacit acknowledgement of the historical and political context permits the constant renewal of UNRWA’s ‘temporary’ mandate, Iraqi refugees remain at the mercy of humanitarian aid-giving, waiting with bewilderment as funding dissipates and their health deteriorates.

In 2008, a study reported that 55 per cent of Iraqis go to private facilities for their health needs, 35 per cent to NGO facilities and 1 per cent to informal providers. Over the past five years, Caritas Internationalis, the Jordanian Red Crescent and the Jordanian Health Aid Society have operated various ‘one-stop shop’ clinics in parts of Amman, with Iraqi refugees becoming their main clientele. Most clinics are located in areas more densely populated with Iraqis, providing them with primary consultations for a nominal fee, as well as free or subsidised medication. For secondary medical concerns, Caritas, an implementing partner of UNHCR, usually refers patients to its two private partner hospitals, the Italian Hospital or Luzmila Hospital, or on occasion to the

---

156 Ibid. p. 65
largest public hospital in Amman, al-Bashir Hospital. In these cases, there is agreement that Caritas will split the cost of treatment with the patient. More expensive tertiary cases have been referred to UNHCR’s Exceptional Care Committee for further consideration and cost evaluation. The absence of a clear policy of guidelines\textsuperscript{158}, long waiting lists and diminishing funds means that those awaiting a verdict from the health jury are exposed to more uncertainty, depending on others to decide on their futures.

The opacity and ambiguity inherent in the health system is further exemplified by the arduous process of referrals, which constitute a source of anxiety and frustration for Iraqis. It proves to be financially, mentally and physically exhausting as patients are sent to various healthcare providers across the city. Discussions on health with Iraqis for the purposes of this research frequently descended into the recounting of numerous ‘sagas’ of referrals or ‘toing and froing’ between service providers.\textsuperscript{159}

Moneer, a young construction worker, remained silent and somewhat aloof throughout one discussion group of Iraqis with a variety of health problems, nodding occasionally in agreement with more vocal participants around the table.\textsuperscript{160} When asked about his experience of health care in Jordan, he began to recount the waiting he had endured over the previous two-month period. One morning, he fell down suddenly and lost feeling in his upper body. After going to Caritas, he was told to wait two months for an appointment. Concerned, he

\textsuperscript{159} Discussions took place in May-August 2011 and January 2012.
\textsuperscript{160} Anonymous Discussion Group 7 (January 2012)
decided to visit a private pharmacy for a consultation of sorts, and more importantly, a dispensing of medication - an increasingly popular option among Iraqis. After the numbing sensation continued for three more days, he visited the Emergency Room of the Italian Hospital late one night, where he showed the doctor his UNHCR papers. Although Jordanian law requires that those in need of emergency care must be treated immediately and the cost accounted for later, cases not considered a life-threatening emergency are unable to receive treatment if they visit the ER outside the limited operating hours of the NGO clinics. Indeed, in what has become the norm in a system marred by inconsistencies, he was told by the doctor that ‘nothing could be done’ without an ‘official referral’ from Caritas. After visiting a public primary healthcare centre the following day, he was referred to al-Bashir hospital for an appointment with a neurologist. Unable to wait the two months for diagnosis with the gloomy prospect of more referrals and desperate to return to work, he eventually visited a private doctor and paid 20 Jordanian Dinars for a consultation fee. When told he would need to pay between 150- 200 Jordanian Dinars for an MRI scan, he resorted to more waiting in a life he implied is increasingly dictated by waiting.

At the height of what was considered a finite humanitarian problem, there was a consensus among UNHCR and its implementing partners that a parallel system of care for Iraqis seemed the most logical option so as to avoid adding to the burdens of Jordan’s public health system. Yet, as the situation has transformed into one of protracted displacement and funding from donors has depleted, a downward trend in the quality of services has been acutely felt by Iraqi patients.
In discussions and interviews, many Iraqis spoke favourably of the Jordanian Red Crescent clinics, which provided free medication and treatment for chronic diseases, but also spoke of their dismay when in 2010, the clinics closed as funds ‘dried up’\(^\text{161}\), despite much protest from Iraqi beneficiaries. A similar downward spiral in the quality of health care from the likes of Caritas was mentioned repeatedly. Whilst still operational, services have been reduced and accessing services has been difficult since 2010.\(^\text{162}\) Specialists are unavailable; consultation fees are increasing as financial assistance decreases, free medical supplies for chronic diseases are limited to once every three months forcing patients to look elsewhere for vital medications such as insulin, and wait times for appointments can take as long as three or four months, in the case of one man who complained of a pain in his kidney resulting from a gunshot wound in Iraq.\(^\text{163}\) In the words of another man waiting for an appointment:

> Private doctors are very, very expensive and they [refugees] cannot meet the high cost. After obtaining an appointment at Caritas, you have to wait a month, and the sick cannot wait. They suffer a lot.\(^\text{164}\)

A father of two sick children spoke of his family’s anxiety as a result of reduced services – a sentiment conveyed by many families. Roughly around the beginning of 2010, the treatment from Caritas slowed down. The children’s monthly medicine costs amount to approximately 700 Jordanian Dinars, but the monthly assistance from the United Nations does not begin to cover it. This has affected the psychological state of his children, whose fear of death increased.\(^\text{165}\)

\(^{161}\) Anonymous Stakeholder Interview (December 2010)
\(^{162}\) Anonymous Interview No. 280.4 (December 2010)
\(^{163}\) The researcher witnessed this interaction between clinic staff and an Iraqi man during participant observation at an NGO health clinic in Amman.
\(^{164}\) Anonymous Interview No. 250.4 (December 2010)
\(^{165}\) Anonymous Interview No. 30.3 (December 2010)
Feelings of despair and frustration are also shared among the NGO service providers themselves. “Once we had a lot of money, around 1500JD per patient per disease. Now we have 500JD per patient, but these funds are finished before the year is out.” He added: “Before, we were encouraging them [Iraqis] to go public, and now we are pushing them.”

In conversations with Iraqis about the perceived change in health services, they frequently mentioned the drying up of services ‘at the end of the project year’, as NGOs ran out of money to pay for medicines and minor operations. The vulnerability and dependency of these individuals, who have grown accustomed to the provider-beneficiary relationship at the crux of humanitarian aid-giving, is clearly visible. Such short yearly funding cycles geared towards emergency relief in times of crisis, are ill-suited to and preclude sustainable approaches to coping with the health needs of those in protracted displacement. Malkki asserts the need for convergence rather than compartmentalising relief and development paradigms and argues: “Economic development and assistance to refugees are inseparable issues…” with the preface that the ‘refugee’ is a symptom or ‘indicator’ and not the cause of world system dynamics. With this in mind, health experiences of Iraqi refugees in Jordan are both underlying symptoms and persistent reminders of the need to treat the causes embedded in the greater historical context.

---

166 Anonymous Stakeholder Interview 21 (January 2012)
In the urban setting, where there is a risk of Iraqis remaining ‘invisible’ to service providers, there is a need for involvement from local organisations, often perceived as more legitimate and better placed to reach hidden or vulnerable populations. However, their operational role is severely restricted due to their inability to devote time and resources to the complex process of applying for funding each year. In the words of one representative for a smaller NGO, “If local capacity is to be built, more time is needed.” In 2011 International Medical Corps and the Jordanian Health Aid Society began combining their strengths to focus on building diversified and sustainable health services. As an indigenous NGO, JHAS has valuable working knowledge and relationships with the Jordanian Ministry of Health. In turn, IMC has provided technical support and training to JHAS. Strengthening the capacity of national NGOs and local community-based organisations through collaboration with international NGOs presents opportunities to foster capacity in a situation of protracted displacement, for the sake of longer-term social development in the host country and for the remaining refugees who have been pushed out of the resettlement realm and who find themselves increasingly reliant on the patience and hospitality of their hosts.

Mainstreaming

As years have passed and Iraqis remain in what they and others perceive to be their transit country; issues of ethics and economics surrounding their health

168 Anonymous Stakeholder Interview 17 (January 2012)
169 Anonymous Stakeholder Interview 31 (January 2012)
170 Anonymous Stakeholder Interview 27 (January 2012)
needs have surfaced. Historically, the public health objective of UNHCR has been to help refugees access similar services to those in their countries of origin, or services comparable with those available to host communities that are often undergoing similar hardships. Yet enabling displaced Iraqis to access a similar level of services to those previously found in Iraq or to those currently found in their host countries will require what Mowafi and Spiegel call a ‘developed world model’ of refugee health care that poses ethical challenges.\textsuperscript{172} In the context of dealing with Iraqis in Jordan, whose healthcare needs are often chronic and costly, “...under what circumstances is it acceptable to tolerate large differences in resource allocation between one refugee population, say in Chad, and another, say in Jordan?”\textsuperscript{173} With protracted displacement of Iraqis showing no end in sight, familiar problems of donor fads and fatigue, and such similarities in the health concerns of Jordanians and Iraqis already noted, it is both irrational and inequitable to provide separate services for Iraqis. The parallel system that was emerging for Iraqis thanks to the well-established NGO sector has also been of concern to the Jordanian authorities, which were extremely wary of allowing for any semblance of a 'state within a state' that could encourage resentment and unrest among the local population.\textsuperscript{174} There has been a creeping realisation that Iraqis can no longer be situated within the short-term relief bubble, prompting the Jordanian government to grant access to public health services for Iraqis on the same basis as an uninsured Jordanian towards the end of 2007, with support pledged from donors. “Agreed priorities were primary health, both preventive and curative, reproductive and child health, emergency care and essential drugs

\textsuperscript{172} Mowafi; Spiegel, “The Iraqi Refugee Crisis: Familiar Problems and New Challenges” p. 1714.
\textsuperscript{173} Leaning; Spiegel; Crisp, “Public health equity in refugee situations”, p. 2.
\textsuperscript{174} Devi, “Meeting the health needs of Iraqi refugees in Jordan” p. 1816.
and medical supplies, including those with chronic diseases."\textsuperscript{175} Thus, Iraqis became entitled to free primary and preventive health care and subsidised secondary health care. As the Jordanian government struggles to pay for the tertiary care of its own citizens\textsuperscript{176}, for the purposes of such sophisticated levels of care, Iraqis continue to be treated as a foreign national (without insurance).\textsuperscript{177}

Whereas in the past Iraq boasted a centralised system of universally free health care; the Jordanian health system, whilst sophisticated, is a myriad of complexities and expenses that must be negotiated by the patient - whether Jordanian or Iraqi. Unlike Iraq, health insurance is viewed as a necessity in Jordan. Of the local population, approximately 70 per cent have health insurance, 40 per cent of whom benefit from civil (or government) health insurance, with military personnel and their families (27 per cent of the population) receiving insurance from the Royal Medical Services. A small percentage of the population is covered by private insurance provided by their place of work, or affiliation with professional associations. According to the Ministry of Health, there is between five and ten per cent duplication in health insurance. Moreover the figure of 70 per cent does not include those Palestinians who receive free primary health care services from UNRWA, which is estimated at almost nine per cent. Nor does it include any children under seven, as by law, there is free treatment for their childhood medical conditions.\textsuperscript{178}

\textsuperscript{175} \textit{Ibid.} p. 1816.
\textsuperscript{176} The Ministry of Health estimates that 20 per cent of its budget is spent on those in need of expensive tertiary care. Anyone with a social security number in Jordan can appeal to the Royal Court for an exemption of payment for tertiary healthcare needs.
\textsuperscript{177} Anonymous Stakeholder Interview 16 (January 2012)
\textsuperscript{178} \textit{Ibid.}
Rooting the attitudes of Iraqis in their personal histories and health experiences, one can better understand the dissatisfaction evident in the statements of these Iraqis when describing health care in Jordan:

The health care isn’t good because there isn’t a health system or culture of health care here.\textsuperscript{179}

There is hardly anything in the way of health insurance and the quality of medical care in public hospitals is fairly poor. Private care is far more expensive here in Jordan than it was in Iraq. Also, the medicines are far more expensive here than in Iraq.\textsuperscript{180}

After leaving Iraq [in February 2004], we didn’t find good health care as we did in Iraq because here they don’t just treat anyone. Only if there is an agreement with an organisation or a health centre or hospital.\textsuperscript{181}

The significance of such statements lies not in their factual accuracy, which is questionable based on what is known about the deterioration in the standards of health care and availability of medicines in Iraq as delineated in the first chapter. However, it is rather in the personal reflection on the past and its relationship with the present. Such perceptions and prejudices on the part of both Iraqis clearly constitute an obstacle to the integration of the former into the public healthcare system. When asked why they did not use public health centres more during discussion groups in January 2012, Iraqis cited overcrowding, long wait times and poor quality care as reasons for choosing the private or NGO service providers. When pressed to answer whether they had ever \textit{tried} a public primary health care centre, approximately half of the participants in each group shook their heads and said they had not used one. Similarly, the visits of one international NGO to Iraqi households in 2011 led them to conclude that less

\textsuperscript{179} Anonymous Interview 70.1 (December 2010)
\textsuperscript{180} Anonymous Interview 90.1 (December 2010)
\textsuperscript{181} Anonymous Interview 100.3 (December 2010)
than 20 per cent of Iraqis had ever used public services. Reasons given were often based on assumptions that there were long waiting-times, rude doctors and the location of health centres. Another common reason cited was perceptions of misdiagnosis on the part of Jordanian doctors and ineffective medication. Coming from a country in which cheap and branded medication was readily available before the 1990s, there is mistrust among Iraqis of generic Jordanian-made medication, despite its stringent checks and quality assurance.

As part of the mainstreaming of Iraqis into the public healthcare system, an information booklet entitled, ‘A Guide to Healthcare Services offered by the Ministry of Health to Iraqi Refugees in the Hashemite Kingdom of Jordan’, was published by the Ministry of Health, the World Health Organisation, UNHCR, UNFPA and IRD. The blue booklet, funded by the Australian government, was designed to be both lucid and comprehensive so as to prevent the spreading myths and to encourage integration, with twelve sections covering everything from emergency services to dentistry. Over the past four years, it has been widely disseminated to Iraqis by UNHCR and its implementing partners. It is visible in the waiting rooms of most NGO clinics, but its efficacy in conveying the message to Iraqis remains unclear. Few Iraqis admit to having referred to the guide in times of need, and one representative from an international NGO working with Iraqis acknowledged that: “These information booklets are not the best option. They are boring to read and there are some people who are

---

182 Anonymous Stakeholder Interview 19 (January 2012)
183 ‘Guide to Healthcare Services provided by the Ministry of Health for Iraqi Refugees in the Hashemite Kingdom of Jordan’
illiterate and cannot read them.” \textsuperscript{184} Rather, according to NGO workers, the most appropriate form of communication is by phone-call or word of mouth. Iraqis in Jordan tend to reside in the same areas where there are NGO services available and the rent is more affordable. Thus, many hear of services from friends, classmates, neighbours and those they meet at UNHCR.

Building on this idea, intensive outreach campaigns by the Ministry of Health in collaboration with an international NGO have served to heighten awareness among the Iraqi community in Amman. In the words of an IRD representative promoting referrals for Iraqis to public healthcare providers: “Iraqis have different expectations and need help to be introduced to a new system.” With this in mind, Iraqi volunteers are introduced to staff at the primary healthcare centres and they are trained in the procedures. They help Iraqis register for the white card at the centre, and assist them in making appointments. \textsuperscript{185} In the period between August 2010 and September 2011, IRD referred 10,000 new Iraqi patients to six newly-renovated public primary healthcare centres. \textsuperscript{186} With such a high number of referrals, the Ministry of Health agreed to expand the project to eight more centres, with the first quarter of the new programme year 2011-2012 counting 4,500 referrals. \textsuperscript{187}

Understanding and quashing prejudices on the part of Jordanian staff has also been crucial to facilitating integration of Iraqis into the public health system. Discrepancies in the attitudes and understanding of staff has only increased

\textsuperscript{184} Anonymous Stakeholder Interview 18 (January 2012)
\textsuperscript{185} Anonymous Stakeholder Interview 21 (January 2012)
\textsuperscript{186} Ibid.
\textsuperscript{187} Ibid.
mistrust among Iraqis, and reinforced negative preconceptions of the treatment offered at public health centres. In late 2011 and early 2012, the Ministry of Health held a series of workshops in communication skills for staff and medical professionals at primary healthcare centres. It was found that Jordanian medical providers also had their own assumptions about Iraqis, regarding them as difficult, aggressive and with little regard for rules. Explanations over the rights and entitlements of Iraqis in Jordan, as well as training in how to ‘deal’ with Iraqis who might be suffering from trauma and mental health problems, was also intrinsic to the workshops.\(^\text{188}\) However, understanding and international donor-funded training can only breed a certain amount of compassion. There is the constant danger of patience wearing thin on the part of the Jordanians and the Jordanian government, the latter of which is under no obligation to play host. Acknowledgement of the past, responsibility for the present and a long-term vision for the future continue to present the uncomfortable but ever-present truths that lie at the heart of Iraq’s health predicament within and outside the country, as is yet more apparent in the next section.

**Mapping the Gaps**

There are a lot of obstacles in terms of health care because the organisations helping refugees are now very limited in the cost of treatment. When their accounts close, everyone will have to stop treatments and pay out of their private money. And we know well that illnesses will not be stopped by costs and also will not be stopped with time. The financial situation is the biggest obstacle to us health-wise.\(^\text{189}\)

Convincing Iraqis to use the public primary healthcare services constitutes only part of the task facing the Ministry of Health, INGO and NGO service providers in

\(^{188}\) Anonymous Stakeholder Interviews 17 & 20 (January 2012)

\(^{189}\) Anonymous Interview 100.2 (December 2010)
Jordan. Results from surveys conducted by trained Iraqi volunteers at primary healthcare centres report 86 per cent satisfaction among users and waiting times of no more than 30 minutes. However, teething problems remain as the Jordanian primary health care system grapples with thousands of new referrals, many of them with costly medical complaints. Still, the fundamental issue of ‘the humanitarian’ as outside the realm of the political casts an ominous shadow of uncertainty over Iraqi health in Jordan, as Iraqis are at the mercy of the host government, humanitarian organisations, donor intentions and funding cycles.

Medicines are among the greatest expenditure among Iraqis, as some bypass consultations at health centres in favour of a drug consultation and dispensation at a private pharmacy. Others who receive prescriptions from doctors are told that the public health centre pharmacies do not stock the drugs, and that they must seek it elsewhere. The cost barrier is reflected in statistics from 2008, revealing that only four per cent reported some level of agreement with the statement ‘I can afford the care’ I need, and 74 per cent strongly disagreed; further evidence that cost of health was a significant burden on Iraqi households was that half of households reported 25 per cent or more of monthly expenditures on health, with 14 per cent reporting 50 per cent or more of all household expenditures were health related.” Another survey found that the typical Iraqi household in Jordan with four to five persons spent an average of

---

190 The survey of 10,000 participants was conducted by IRD during September 2010-August 2011.
$50-$70 per month on health care expenses.\textsuperscript{192} Due to a dearth in funding and donor disinterest as the date of US withdrawal of troops from Iraq in 2011 approached, UNHCR has been forced to reduce the number of families and individuals receiving monthly financial assistance. As the law prohibits Iraqis from working, financial assistance is the only source of income for many Iraqi families in a country whose cost of living was ten times that of their own in 2003.\textsuperscript{193} Contrary to the image of Iraqis as ‘the rich refugee’, “…international and local aid workers depict a growing economic and social distress among many displaced Iraqis: refugees draw upon increasingly limited savings, remittances, informal labour, and humanitarian aid to meet basic needs. Traditional family and kin networks have been fractured by dislocation and the loss of community…”\textsuperscript{194}

In a discussion group with elderly Iraqis, the acute need for affordable medicines is evident. Um Hani, a middle-aged woman who suffered from diabetes, received prescriptions from the doctor, but could not afford the medicines. “I visited Caritas twice, but they did not do anything for me.” Her medication costs 50 Jordanian Dinars each month, and each month she must wait to receive 110 Jordanian Dinars in financial assistance from the UN before visiting the doctor. She ended the conversation: “I am lucky I live with my son. He pays the rent and puts food on the table. My situation is very bad.”

\textsuperscript{192} Skopec; Valeeva; Baca, “Anticipating the Unexpected: Urban Refugee Programming in Jordan”, p. 5.
\textsuperscript{194} Libal; Harding, "Humanitarian Alliances: Local and International NGO Partnerships and the Iraqi Refugee Crisis”, p. 167.
In the same group of eight participants, five people suffered from diabetes. Abu Ali, a man in his early seventies spoke of being unable to afford his insulin due to his financial situation. Living alone, he receives 75 Jordanian Dinars each month in financial assistance. The monthly supply of insulin amounts to 18 Jordanian Dinars every month. At a private pharmacy, he buys a packet of ten syringes for 1.5 Jordanian Dinars. So as to save money, he injects himself at home using alcohol as a disinfectant. In both interviews and group discussions with Iraqis, there is a sense of increasingly hopelessness and despair over where they can obtain medicinal supplies for secondary health concerns.

There is yet more anxiety from those individuals and families afflicted with tertiary diseases such as Thalassemia, severe medical problems caused by medical birth defects and cancers. Thalassemia is a genetic blood disorder, particular to those living in the Mediterranean region. Those afflicted with this disease need chronic care. Among the Iraqis encountered for this research, many had family members suffering this disease. At the peak of the ‘crisis’, UNHCR was able to fund treatment for Thalassemia cases, but come 2009, this was no longer possible. Um Abdullah has two children with Thalassemia. As part of their treatment, both children need two units of blood given to them every month, at a cost of 50 Jordanian Dinars per unit. This amounts to 200 Jordanian Dinars per month, and the family receives not more than 220 Jordanian Dinars per month in financial assistance from UNHCR. In addition to monthly blood transfusions, the children need to take daily tablets. The family

---

195 Anonymous Discussion Group 6 (January 2012)
196 Anonymous Discussion Group 1 (January 2012)
income means they cannot afford to pay for this so she resorts to begging in hospitals. She admitted that sometimes her children have only three tablets per month. When asked how she will find the next tablets for her children, she replied ‘God will give me them’. Others interviewed also spoke of begging for medications, or in other cases, going into debt for the sake of paying for expensive medical treatment. In one interview, an elderly woman spoke of borrowing money so that her husband could receive treatment for his cancer at the public al-Bashir hospital. After he passed away, she was forced to take out more loans to pay for her own gall bladder surgery. To this day, the widow is in debt, living with her daughter in a poor neighbourhood of Zarqa. During the same discussion group of eight Iraqi men and women who had family members suffering tertiary illnesses, one parent’s desperation was visible in her tears when describing her son’s medical needs:

I need four boxes of colostomy bags each month for my son, but each box costs 40 Jordanian Dinars. A bag is not like tablets. It’s not like you can just run out and try to make do. My son doesn’t have nerves developed and so he can’t control his bowel movements.197

Similar distress was conveyed to an Iraqi interviewer by a woman whose son’s speech and hearing was damaged in car bomb attack.

She cannot pay the costs of the operation, because it cost $20,000. Of course, she did not any receive assistance until now, whether from humanitarian organizations or from the United Nations. The services have been reduced now to only issues like...influenza, or some small operations that require treatment. She has gone to Caritas many times about these matters. Of course, on the question of psychological health, she is very broken on account of the fact that she is a woman who cannot provide what her children require.198

197 Anonymous Discussion Group 2 (January 2012)
198 Anonymous Interview 30.5 (December 2010)
Having brought to light a few of the multitude of distressing situations endured by Iraqis in their daily lives, one can begin to comprehend the huge dilemma for all kinds of healthcare providers, severely restricted in their ability to reach all those who so desperately require treatment. Emergency triage principles in times of crisis are well-established. “One must strive to maximise the health of the greatest number of people for whom one is responsible.”\textsuperscript{199} However, in settled refugee contexts, guidelines are far more difficult to follow and boundaries are blurred. “Operational ambiguities (e.g. not knowing what has already been expended for health care, what excess the budget might permit, what process to follow for higher level permission, will future funds be available for expensive chronic cases) make a difficult ethical decision even more difficult.”\textsuperscript{200} Leaning et al conclude that, in making exceptions, the advice and guidance from stakeholders, including members from different refugee and host communities and possibly donors, would be most valuable in framing and legitimating options. Fairness issues would demand the highest level of transparency, so that everyone involved at all phases would know what was possible to permit as an exception and what was not.”\textsuperscript{201} Ideally, this approach provides what solutions can be brought to an impossible reality that can only be truly solved by mitigating funding deficiencies. Over the past year, a similar initiative has been implemented by the World Health Organization, which established a fund for Iraqis with chronic health problems. In addition, WHO also provided the Jordanian Ministry of Health with two procurements of drugs to the value of $1.7m for Iraqis with chronic and mental health problems.

\textsuperscript{199} Leaning; Spiegel; Crisp, “Public health equity in refugee situations”, p. 2.
\textsuperscript{200} \textit{Ibid.}, p. 2
\textsuperscript{201} \textit{Ibid.}, p. 6
According to one health official, more resources and information must still be made available for Iraqis in terms of what their options are surrounding tertiary care.\(^{202}\) It is impossible to predict the intentions of donors and whether this money will continue in its supply for as long as Iraqis are in Jordan and dependent on aid to meet their health needs. However, acknowledgement and desire to meet gaps in services is a positive step, as is the channelling of funds through the Jordanian government, to promote integration and development of Jordan’s capacity to meet chronic and mental health needs of its own population and the refugees whom it hosts.

Mental Health and Trauma

When I arrived in Jordan, my mental state was bad. I had lost my best friend and I was far from my family....My life was made difficult by the war and got much worse after the war. In Jordan my situation has changed. Everything is strange and I live in a basement apartment. I don’t have a lot of things and I haven’t found work and I don’t have friends. I suffer from mental problems.\(^{203}\)

The painstaking detail and chronology in which individuals talk of their leaving Iraq, mentioning routine abductions and targeted killings of family members, is indicative of the high levels of personalised violence endured. Their ability to describe in detail the perpetrators of such violence complicates the healing process, preventing their return home and acting as a barrier towards reconciliation on the national level.

In what is a good example of potential overlap, or better still, the erosion of the relief-development divide, the arrival of Iraqis in Jordan with mental health and

\(^{202}\) Anonymous Stakeholder Interview 28 (January 2012)

\(^{203}\) Anonymous Interview 50.3 (December 2010)
trauma exposed a weakness in the virtually non-existent Jordanian approach to mental health. A study on psychosocial health among Iraqis in Jordan conducted in 2009, advocated integrated approaches that included both broad and targeted interventions, and that cultivated mental health service capacity in a coordinated approach among the non-profit and government sectors, “… to ensure they are appropriate and complementary to current national strategies and that they build mental health capacity within the infrastructure of the Jordanian health system.” Previously, mental health care in Jordan was firmly rooted in the idea of a tertiary hospital, not so distant from the model of an asylum. However, the Ministry of Health has been responsive to calls from the World Health Organisation (WHO) and international NGOs in shifting towards open-space clinics and providing specialised training for medical professionals in how to care for patients suffering from trauma and mental health problems. The road to the development of an appropriate system of mental health is long, however. In approximately 850 cases per year, the Center for Victims of Torture estimates that 25 to 30 per cent are children or adolescents. Indeed, many Iraqis with children in Jordanian state schools complained of a lack of support in schools for their children, several of whom suffer from bullying due to problems of involuntary urination, anxiety attacks and other psychological effects of events witnessed in Iraq. UNICEF has worked to convince the Ministry of Education that psychosocial support for children falls within its remit. However, whilst the government has been receptive to the idea of training teachers, the stigma surrounding mental health issues persists in

204 Anonymous Stakeholder Interview 28 (January 2012)
Jordanian society and in the majority of schools, there continues to be only one school counsellor for a school of 500 students or more.\textsuperscript{206}

According to one NGO worker and mental health expert, over the course of time, the majority of those Iraqis suffering severe trauma have received treatment, and the stigma surrounding mental illness within the Iraqi community has dissipated somewhat. Whilst the work and efficacy of such an NGO specialising in mental health and trauma issues cannot be doubted, one suspects a far larger number of ‘silent’ sufferers un-referred and untreated lies outside the reach of this relatively small organisation. Certainly, there was found to be a grave need for psychological services among Iraqis who had resided in Jordan for longer periods of time\textsuperscript{207}. This is apparent in an excerpt taken an interview with one Iraqi musician who fled from Saddam Hussein’s regime after refusing to sing at a private party held in his honour:

I have been in Jordan for a long time, far from my country. There is a lack of resettlement and a lack of stability. My current situation is having a negative effect on my mental state.\textsuperscript{208}

Bader et al posit that fluctuation in mental health needs over time is associated with beliefs that residence in Jordan is temporary, making Iraqis less likely to immediately adapt to their new surroundings and creating long-term psychosocial problems.\textsuperscript{209} This belief among refugees themselves that their situation is temporary poses an obstacle to integration in Jordan. This feeling of

\begin{itemize}
  \item \textsuperscript{206} Anonymous Stakeholder Interview 29 (January 2012)
  \item \textsuperscript{207} Bader et al., “Psychosocial Health in Displaced Iraqi Care-Seekers in Non-Governmental Organization Clinics in Amman”, p. 317.
  \item \textsuperscript{208} Anonymous Interview 60.1 (December 2010)
  \item \textsuperscript{209} Bader et al., “Psychosocial Health in Displaced Iraqi Care-Seekers in Non-Governmental Organization Clinics in Amman”, p. 317.
\end{itemize}
‘otherness’ is reified through their prevention from working under Jordanian law. Rather than rediscovering self-worth and financial independence in exile and engaging with people on a daily basis, it was clear from interviews and discussions with Iraqis that much of their time is spent confined to the home. There, they sit paralysed in their wait for phone calls from IOM Amman about resettlement and in many cases, fixate on medical problems, worrying over where they will go when they get sick, or who will pay for their treatment. It is not the intention to trivialise medical concerns of Iraqis. Rather, the lack of activity in daily life forces many to dwell on medical concerns and exacerbates mental health problems. Such illness is “…deeply embedded in the social world, and consequently it is inseparable from the structures and processes that constitute that world.”210 In this daily routine characterised by inertia, created in part by humanitarian actors and the systems governing refugees, individuals are inscribed211 and socialised into believing that they are this homogenous and problematic ‘refugee’. Indeed, the ‘internalisation’ of the problem within ‘the refugee’, and the conviction that uprootedness signals a ‘moral breakdown’ or ‘a loss of moral and, later, emotional bearings’212, is to the detriment of the mental health of individuals.

‘Psychosocial’ has become the buzzword for many NGOs working with Iraqis in Amman, although it is a term that proves vague and elusive in its definition.

211 Grosz, Elizabeth, Volatile Bodies: toward a corporeal feminism (Bloomington: Indiana University Press, 1994), p. x,
After noticing that many people attending were there for the main purpose of meeting other people, NGOs began to focus more on opportunities for Iraqis to socialise outside the house. They established women's craft cooperatives, cookery classes, hair and beauty sessions, as well as some English and computing classes. These activities, whilst a means of overcoming isolation, were found to be lacking in utility and different to the desires of Iraqis, who wished to learn more practical vocational skills. Moreover, in the kinds of classes offered there is a gender bias in favour of women. Interestingly, the depression and isolation was most visible among young Iraqi males who, unable to work or study and fearing trouble, confine themselves to the home. The role of provider has vanished for men, which increases the feeling of vulnerability and despair as they are confined to the private sphere of the home. Whereas women continue in their roles as wives and mothers, 'albeit in worsened conditions', men face difficulties in adapting to their new routine, characterised by inaction.213 Such stress and anxiety was initially thought to have led to an increase in domestic violence. Speaking in 2012, NGO health experts in Amman noted a decline in this phenomenon. On the surface, such a claim indicates the success of outreach programmes and psychosocial activities aimed at extricating women from the home. Alternatively, adaptation and increased resilience of women could have led to a lack of reporting. Nevertheless, women in more than one discussion group talked of meeting each other at craft cooperatives, shopping excursions, children's activities and family planning clinics; men had very little to say about their daily activities outside the house.214

214 Anonymous Discussion Group 6 (January 2012)
The gendered divide was also observed in a discussion with elderly Iraqis. When asked to describe what they did everyday, elderly men in one discussion group struggled to answer. Women talked animatedly of the friends they had made since arriving in Amman, but men spoke of watching television and reading books because they felt alone and unable to leave the house in a city that is alien to them. When designing classes, it is imperative that both the utility and psychosocial elements are considered, with more focus on entrepreneurship, English language and computing classes suited to men, as well as women. Collaboration with local community-based organisations who might hold weekly social events for local residents of the area, is also crucial in allowing for increased interaction and integration between Jordanians and Iraqis, regardless of the duration of their stay in Amman.²¹⁵

It is necessary ‘to make people again out of refugees’, who envisage themselves and who are envisaged as a special category of people because of their personal histories. After all, ‘being’ a refugee is a misfortune and not an occupation.²¹⁶ When discussing individuals outside the realm of the eighteenth century family unit, Donzelot notes that, from the standpoint of the state, “…individuals who were rejected by the law of alliances became a source of danger through their vagabondage and indigence; they were also a loss in that they constituted unemployed forces.”²¹⁷ Indeed, Iraqis are often viewed with similar suspicion and as more likely to succumb to means of subversion, despite many having lived in the country for many years. They should be viewed less of a threat and a

²¹⁵ Anonymous Stakeholder Interview 29 (January 2012)
²¹⁶ Alami, Musa in Peteet, Julie, Landscape of Hope and Despair, p. 66.
short-term ‘problem’. However, the burning question remains - whose problem? Encouraging Iraqis to integrate and to invest themselves into life within the host country is the favoured solution by the humanitarian actors involved. However, even if Iraqis were persuaded to settled in Jordan by means of employment, the Jordanian government cannot be expected to bear the brunt of a manmade disaster it did not create, and whose long-term solution does not lie solely in humanitarianism.

**Convergence of the Humanitarian and the Political**

The individual and collective experience of Iraqis in Jordan is best described as a life in limbo, exposing them to physical and mental health vulnerabilities. A woman arrived at the essence of the argument for the need to view refugees outside the context of short-term humanitarianism when she claimed that the Iraqi government “…should be paying for her children’s medical treatment with ‘the oil’. During the discussion group, she went on to say: “…even Israel treats the Palestinians better than this…” through the provision of a centre for Thalassemia sufferers in Jerusalem.

One day I went to the Israeli Embassy here in Amman to ask them for help treating my children. I got as far as the gate before deciding to turn back.\(^{218}\)

The word *an-naft* or ‘oil’ came up repeatedly among Iraqis over who should pay for their medical care. Some believed that the money given to them by UNHCR was taken from ‘the oil’. Others believed that, as Iraqi citizens, they were entitled

---

\(^{218}\) Anonymous Discussion Group 1 (January 2012)
to such oil revenues for their treatment. There is a building in Amman known as
the Iraqi Health Attaché. Yet, when asking Iraqis or anyone working with Iraqis
about the purpose of this building, one is met with blank stares. In the words of
one man: “It doesn’t do anything.” Rather, the official role of the office is to
facilitate special treatment for some Iraqis living in Iraq who cannot get
treatment inside the country.\textsuperscript{219} It seems an obvious solution, particularly when
many are turned down for surgeries by UNHCR’s Exceptional Care Committee do
to a lack of funds, to expand the Iraqi Health Attaché’s remit to care for those
Iraqis living in Jordan, many of whom have travelled to Amman in search of
expensive surgeries and medications. However, in attempts to find out more
about the initiative, one is met with a deafening silence; further highlighting that
connections are yet to be made between events of the past, present and future.
As a result, this sense of responsibility has yet to be acknowledged by the
Government of Iraq and such a humanitarian response rooted in solving a ‘short-
term problem’ risks dehistoricising and prolonging the waiting game for Iraqis,
with devastating health consequences.

Ultimately, in the frustrations and ‘dead ends’ arrived at during time spent with
Iraqis in Amman, it is clear that governments and humanitarian actors must go
beyond the traditional understanding of refugees as short-term beneficiaries in
an impoverished camp setting. Rather, they should focus on the causes of their
displacement and their genuine concerns of both the present and the future,
whether able to return to their country of origin or not, for the sake of the health
recovery of a nation in exile.

\textsuperscript{219} Anonymous Stakeholder Interview 29 (January 2012)
'Seven years after sieges, Fallujah struggles' was the title of an in-depth article that appeared on Al Jazeera English in January 2012.\footnote{Jamail, Dahr, “Seven years after sieges, Fallujah struggles”, Aljazeera English (January 4th, 2012) (http://www.aljazeera.com/indepth/features/2012/01/20121202823143370.html Accessed on 03/15/2012.)}

The pictures accompanying the article suggest that time stopped after 2004. The words tell of attempts at reconstruction, but highlight chronic shortages of clean water, electricity and a dearth of essential services some years later. After 70 per cent of the buildings and homes in the city were damaged or destroyed in the attacks on Fallujah, the majority of people were displaced from their homes. Since then, most have returned, but thousands remain homeless, unemployed, and struggle to rebuild their lives amidst continued assassinations and bombings.\footnote{Ibid.}

With only limited reconstruction, Fallujah's past wounds remain unhealed, which is telling of the uncertain transition from stagnation to faltering development that began with the imposition of the Iraqi government in 2005. Less severe than the malignancy of de-development in its systematic efforts to debilitate infrastructure, underdevelopment can be understood as an
‘incomplete form of development’\textsuperscript{222}, denoting a lack of growth. Ayad Hadi, a baker in the city, confirmed this inertia to a journalist:

Everything here is bad...No water, no electricity, no good health care. We have between 75 and 80 per cent unemployment. Widows have no rights, no compensation.

He went on to describe the mood in the city as one of hopelessness:

The government is busy trying to keep power, and they've forgotten the poor people...We used to have a poor, middle class, and rich class. But, now, there are only the rich and the poor. That's why I have no hope for this country or for the future.\textsuperscript{223}

These words allude to many of Iraq's ailments that have been left untreated, on both the local and national levels. After describing the health burdens currently facing Iraqis, this chapter will focus on the long-standing issues, many of which have been left to fester for almost four decades. Namely, the weakness of the state and its institutions, lingering networks of corruption, poor governance, the enduring effects of the medical brain drain, and perhaps most neglected, the impact of large-scale trauma and historical memory of violence affecting millions of Iraqis today. Finally, it will elaborate on the conclusions made in the previous chapters.

In his study of postwar reconstruction and public health, Salman recognizes that high levels of unemployment, poor quality housing, damaged sanitation systems, neglected education and a devastated environment make it extremely difficult to achieve improvement in health.\textsuperscript{224} Similar remnants of war can be found in Iraq, with an environment yet more hostile to reconstruction due to unresolved

\textsuperscript{223} Jamail, Dahr, “Seven years after sieges, Fallujah struggles”, \textit{Aljazeera English}
conflict and persistent insecurities. In a matter of months after the new Iraqi government assumed power, a new wave of sectarian violence prompted yet higher levels of internal displacement.\textsuperscript{225} Large numbers of internally displaced persons and fragmented communities meant that many were forced to live in informal ‘squatter’ settlements on the outskirts of Baghdad.\textsuperscript{226} Others continue to reside in makeshift housing in rural areas of Anbar, Kirkuk, Muthanna and Thi’Qar governorates.\textsuperscript{227} In the majority of cases, improvised camps have been liable to demolition and have suffered from little or no access to clean water and sanitation.\textsuperscript{228} Malnutrition, skin and stomach diseases such as chronic diarrhoea, typhoid and cholera became far more common due to poor living conditions, akin to those reported in the sanctions period, such as open sewers, air pollution and contaminated water.\textsuperscript{229} This is reflected in recent health indicators of the Iraqi population. In 2010, life expectancy at birth was 58 years, compared to 65 years in 1980. Moreover, the chance of an adult dying before the age of 60 years had increased by almost 40 per cent since 2000. Child immunisation rates decreased by almost 20 per cent over ten years and infant mortality rates were 45 per 1000 births – three times as high as neighbouring Syria and twice as high as Jordan.\textsuperscript{230} This high infant mortality rate, often the most striking indicator of

\begin{footnotesize}
\begin{enumerate}
\item UN Habitat, \url{http://www.iauiraq.org/documents/1372/Urban%20Baghdad-Impact%20of%20Conflict%20on%20Daily%20Life-May%2022-Final.pdf} \hspace{1em} Accessed 07/17/2012, p. 5.
\item International Organisation for Migration (IOM) Iraq Mission, “Special Focus Report: Female Headed Households” (October 2011) \hspace{1em} \url{http://www.iomiraq.net/Documents/FHH%20Report%20EN.pdf} Accessed on 11/01/11
\item Ibid. p. 12
\item Campbell, Elizabeth, “Iraq’s Displaced: A Stable Region Requires Stable Assistance” on \url{www.refugeesinternational.org} (February 16\textsuperscript{th}, 2011) \hspace{1em} \url{http://www.refugeesinternational.org/policy/field-report/iraks-displaced-stable-region-requires-stable-assistance} Accessed on 03/20/2012.
\item Webster, Paul, “Reconstruction efforts in Iraq failing health care”, p. 864.
\end{enumerate}
\end{footnotesize}
a population’s health, is due in part, to the severely limited access to health services for children under five, particularly in rural areas.\textsuperscript{231}

Added to the increasing list of communicable and poverty-induced diseases afflicting Iraqis, the country is described as bearing a ‘double burden’ of disease\textsuperscript{232} as chronic non-communicable diseases have also continued to rise. Between 1989 and 1999, the World Health Organisation (WHO) recorded a 65 per cent increase in the number of hospital admissions for cardiovascular diseases.\textsuperscript{233} A WHO Family Health Survey published in 2006 revealed that 41.5 per 1000 persons suffer from high blood pressure, 21.8 per 1000 persons with diabetes and other chronic conditions frequently cited; including heart and joint diseases.\textsuperscript{234} It is thought that the prevalence of diabetes in particular is much more widespread than statistics indicate, with only 20-25 per cent of diagnosed diabetics treated with insulin.\textsuperscript{235} With virtually no communication or trust among hospitals and ministries and very little in the way of records or statistics, it is very difficult to ascertain numbers and thus an accurate health profile of the population. Health officials have said that without sufficient health data, decision-makers will not have the information to identify vulnerable health

\textsuperscript{231} Al –Obaidi, Abdulkareem Et Al, “Child and Adolescent Mental Health in Iraq: Current Intervention and Scope for Promotion of Child and Adolescent Mental Health Policy” in \textit{Intervention} (Vol. 8, No. 1, March 2010), p. 41.
\textsuperscript{232} Salman, p. 185.
\textsuperscript{235} Alwan, Ala’din, “Health in Iraq: The Current Situation, Our Vision for the Future and Areas of Work”, p. 35.
populations, such as displaced Iraqis and develop strategies to meet Iraq’s health needs.²³⁶

What can be described as a ‘third burden’ of illness affecting an increasing number of Iraqis is the rise in congenital birth defects, still-born babies, miscarriages and cancers thought to be linked to decades of exposure to war weapons and their environmental contaminants. According to a brief from the NGO Coordination Committee for Iraq (NCCI) in June 2011, the rate of cancer cases in Iraq has risen from 40 out of 100,000 in 1991 to 1600 out of 100,000 people by 2005.²³⁷ One paediatrician at a hospital in Anbar governorate personally recorded 699 cases of birth defects from October 2009 until December 2011, with the vast number of cases having had no previous family history of abnormalities. The same doctor described dozens of babies born with cleft palates, elongated heads, a baby born with one eye in the centre of its face, overgrown limbs, short limbs, and malformed ears, noses and spines.²³⁸ Yet more serious are those with incomplete organs, large growths and severe nervous system problems.

There are not even medical terms to describe some of these conditions because we’ve never seen them until now,” she said. “So when I describe it all I can do is describe the physical defects, but I’m unable to provide a medical


The doctor’s inability to assign medical terminology to the cases indicates the recent nature of the phenomenon. Such conditions were also apparent among Iraqi families in Jordan, many of whom had come to Amman in search of treatment unavailable in Iraq. In many cases encountered, the family relied upon resettlement to a third country such as Germany or the United States, where there is the capacity to treat such complex medical anomalies. When asked if they thought there was a correlation between war weaponry and health, two Iraqi men now residing in Jordan spoke of relatives and friends in Baghdad and Najaf who had experienced multiple miscarriages. In recent years, a fear of conception has spread among women who are afraid they will give birth to a child afflicted with poor health. During a visit to an informal settlement in Dhi’Qar, monitors from the International Organisation of Migration (IOM) encountered a widow and her three children, all of whom were mentally handicapped and in need of special care. They were living in acute poverty with no source of income other than from neighbours who gave them in-kind assistance of food and small amounts of cash from time to time. The widow mentioned difficulties socializing with the local community and the stigma associated with giving birth to handicapped children. In spite of there being more than two million people with special needs throughout Iraq, social integration and acceptance remain difficult and special health facilities are rare across the country.

---

239 Ibid.
240 Environmental Contaminants from War Remnants in Iraq, NGO Coordination Committee for Iraq (NCCI) Brief, p. 8.
241 Sarhan, Abbas, “Disabled people in Kerbala: Iraq abandons its handicapped”, niqash.org
Once again, poor health records and the absence of credible national and international studies on the subject do not allow for strong causal links to be drawn between the effects of war contaminants and the health of the Iraqi population, impeding understanding of the subject and justifying inaction.

A recurring theme throughout this examination of Iraq’s health predicament, has been that of poor governance and pervasive corruption among the past and present ruling administrations. In an interview with an Iraqi doctor and former health official within the Iraqi Ministry of Health during the US occupation, he spoke of his frustrations during meetings as little else was achieved other than ‘countless cups of tea and the smoking of cigarettes’. Development stifled by a lack of commitment is further evident in budget allocations. In 2008, the Ministry of Health budget was 7.1 per cent of the overall government budget of $49.9 billion. That same year, a health care reform conference saw officials and parliamentarians call for an increase in the health budget to ten per cent of the overall government budget. However, the government resisted. The health budget for the following year, whilst a little over $4 billion, saw no incline in its percentage of the overall government budget of $58.6 billion. Although a slight increase in the health allocation in comparison with the previous period depicted in the first chapter, there has been little tangible

242 Anonymous Medical Professional Interview 1 (December 2011)
245 Webster, “Reconstruction efforts in Iraq failing health care”, p. 864.
246 International Organisation for Migration (IOM) Iraq Health Information Sheet for Movement and Assisted Migration Program (MAM) (September 2011)
progress made by the Ministry of Health, one suspects is in large part due to poor management and governance. Indeed, in 2006-7, it was reported that the Ministry of Health was unable to spend all of its budget allocation due to bureaucratic obstacles, allegations of corruption and problems with imports.\textsuperscript{248}

This sentiment was shared by another Iraqi medical professional in his dealings with the Ministry of Higher Education and the Ministry of Health. Reforms are seldom implemented due to inexperienced professionals reluctant to bear responsibility\textsuperscript{249} - a common obstacle in the absence of a resolute government with the appropriate institutional capacity to take full ownership and provide effective leadership.\textsuperscript{250} The centralised decision-making cultivated under Saddam Hussein’s rule continues to overshadow Iraq’s government, as officials are hesitant to take the initiative over decisions for fear of reprisal. This was further aggravated by the removal of senior officials during de-Baathification, leaving a vacuum to be filled through means of nepotism by under-qualified and ill-experienced bureaucrats.

According to UNICEF’S Child Survival and Development Specialist for the Middle East, “The current government lacks health management experience”, in large part due to the high number of senior professionals forced out of positions.\textsuperscript{251}

The overnight transition from the Coalition Provisional Authority to the new Government of Iraq ‘placed in the driver's seat’ individuals unfamiliar with the newly decentralised organisational structure, precluding continuity and

\begin{flushleft}
\textsuperscript{249} Anonymous Medical Professional Interview 2 (February 2012)
\textsuperscript{250} Jawad, Shakir; Mahmoud, Maysaa; Al Ameri, Ali; Nakano, Gregg in Army Peacekeeping and Stability Operations Institute (PKSOI), \textit{Transitions: Issues, Challenges and Solutions in International Assistance} (August 2011), p. 108.
\textsuperscript{251} Webster, “Reconstruction efforts in Iraq failing health care”, p. 864.
\end{flushleft}
consistency in reconstruction projects and institutional capacity. Had competent
and 'national players' been involved in the early phases of reconstruction, they
would have had better control and more vision for policy formulation and
implementation. Rather, poor governance, evident in the dearth in leadership
and experience at senior levels of the Ministry of Health, has resulted in the
absence of a unified and comprehensive national health strategy led from the top
down that is so crucial to the upward mobility of Iraq's health system.

Repeating the CPA's mistakes of 2004, the majority of the construction projects
have not been driven by demand. Instead, initial rehabilitation efforts focused
on visible results. Conducting immunisation campaigns, distributing essential
medicines and medical supplies, and construction of hospitals and health clinics
fared well in politics, but the absence of capacity-building and lack of focus on
repair of existing infrastructure did not create a foundation for sustainable
development. According to data procured for IOM's Movement and Assisted
Migration Program, in September 2011 there were approximately 2,170 clinics
located throughout the country. Distribution of clinics amongst the governorates
is also unevenly spread, with many residents in rural areas required to travel up
to 30km to reach a primary health care clinic. This has been particularly
visible in the marshlands, where basic health care services are virtually non-

\[252\] Jawad, Shakir; Mahmoud, Maysaa; Al Ameri, Ali; Nakano, Gregg in Army Peacekeeping and
Stability Operations Institute (PKSOI), Transitions: Issues, Challenges and Solutions in
International Assistance (August 2011), p. 106

\[253\] Ibid. p. 107.

\[254\] Ibid. p. 107.
existent or in some cases shared by four governorates. Another example of politics and ill-planning over practicality is the appearance of a new heart surgery centre and a nursing school in the rural and relatively ill-populated governorate of Dhi’qar, which requires health care at the most basic level in the form of primary health care centres before anything else.

Another proverbial ‘black hole’ for the Ministry of Health has been the need to fund the huge increases in the salaries and wages of workers in the health care system. Recognising the need to boost salaries after the dramatic decline during the sanctions period, the Ministry of Health has increased salaries exponentially in recent years. One Iraqi doctor and former health official estimates that 95 per cent of the health ministry’s budget was allocated for salaries, administration and some importing pharmaceuticals, with only five per cent directed toward investment. When mentioning the increase in doctors’ salaries in another meeting with an Iraqi physician, he laughed and said it was more in the region of 900 or 9000 per cent. He later explained that such an increase is beginning to tempt Iraqi doctors living outside the country to return to practise medicine in Iraq. However, such an increase in salaries is discouraging doctors from undertaking much-needed training in health updates.

---


257 This number is anecdotal, but a similar sentiment of a ‘considerable increase’ in salaries is mentioned in Alwan, Ala’din, “Health in Iraq: The Current Situation, Our Vision for the Future and Areas of Work”, p. 57.
They do not want to waste time in medical school or training when they can be earning such large amounts money as doctors for the Ministry of Health.\textsuperscript{258}

**Health Insecurity**

Not only had war, sanctions and occupation contributed to the de-development of Iraq’s economy and infrastructure, but many observed that at least under Saddam, they had security. In the five years following the invasion, patients were unable to reach health facilities and during the worst violence, doctors were forced to limit their time in health facilities, remaining in the relative safety of their homes.”\textsuperscript{259} Indeed, one woman remarked:

> Before the war, we had all the necessities to live life. I owned a house and it had everything that we needed. First of all, there were the important things like freedom and the ability to move around day and night. We had all the health services and the best doctors but now everything is lacking in Iraq.\textsuperscript{260}

Health insecurity characterised Iraq’s health sector quite literally, as problems of violence and discrimination persisted and were manifested in ‘sectarianisation’ of government ministries\textsuperscript{261}. By the end of 2004, the Ministry of Health became a site for the Sadrists. Ministry buildings were transformed into ‘chambers of torture’\textsuperscript{262}, with one deputy minister arrested for ordering the kidnapping and torturing of opponents inside the ministry’s building.\textsuperscript{263} In the words of an Iraqi doctor: “The medical establishment collapsed entirely and transformed some medical institutions into the playgrounds of militias who ran the order of

\textsuperscript{258} Anonymous Medical Professional Interview 2 (February 2012)
\textsuperscript{260} Anonymous Interview 50.5 (December 2010)
\textsuperscript{262} Anonymous Medical Professional Interview 1 (December 2011)
\textsuperscript{263} Sassoon, *The Iraqi Refugees*, p. 143.
Priority access to healthcare was seized upon by powerful groups, with insurgents demanding treatment at gunpoint. Killings, kidappings, intimidation and abuse of staff by gangs became a widespread phenomenon, and women health workers in particular often remained at home. A man whose cousin was killed after being taken from his hospital bed said: ‘We would prefer now to die instead of going to the hospitals. The hospitals have become killing fields’.”

According to representatives from an international NGO working with officials from the Ministry of Health, such ‘sectarianisation’ of the health ministry has dissipated somewhat. However, general insecurity has continued to linger, with the bombing of a hospital in Tikrit in June 2011 and with increased bouts of violence and bombings since the withdrawal of US troops at the end of 2011. In January 2012, an explosion occurred outside Yarmouk Hospital in Baghdad, killing 28 men, women and children. Far from providing remedies and guarantees of health security, a culture of terror spread among patients, with WHO representatives observing the trepidation among many Iraqis in travelling to health facilities, with fears of sectarian violence and discrimination limiting their access to care.

---

266 Anonymous Stakeholder Interview 32 (March 2012)
As a result of the deteriorating standards in the public system, private medicine started to increase after 1991 and the informal health sectors in particular flourished in the years following the invasion and occupation. Lack of control and regulations permitted many small hospitals and diagnostic clinics to operate in the larger cities, with no system to regular professionals and prices, or to monitor the quality of care provided. Nevertheless, people unable to access health facilities utilised informal private neighbourhood clinics staffed by paraprofessionals in order to receive needed care. Makeshift clinics such as that of Dr. Riyadh’s in My Country, My Country revealed the importance of such endeavours, with the improvised waiting room of the free clinic overcrowded with patients awaiting diagnoses, and more importantly, prescriptions. Militias and ad hoc neighbourhood associations also established health clinics to treat minor health grievances, filling gaps in health and social welfare, but reifying nascent sectarian divisions. A report published in 2007 on humanitarian activities in Iraq after 2003 noted that assistance provided by local religious charities and mosques was often readily distinguished from assistance provided by other actors, with many Iraqis describing their services as ‘vital’.

Researchers noted the sinister effects of such initiatives:

Local Islamic charities and mosques were identified in many of our conversations as the preferred option of first resort for those needing assistance or protection. However, we heard several examples of “pressures” being exerted on local religious charities to conform more to the wishes and priorities of parties and militias.

---

270 Salman, p. 187
Another response to the failure of the state in its provision of adequate health care, was that families opted to nurse their sick in the safety of their homes, with some turning to witchcraft, self-healing and traditional herbal remedies in place of conventional treatment as advocated by medical professionals. 275 A similar concern associated with poor public health services has been the trend of self-prescription of potent drugs. Drug addition, once a minor problem in Iraq, has become far more prevalent in recent years276 – with a particular problem observed by IOM Field Monitors in one southern governorate.277 Unwilling and unable to seek obtain treatment for mental health issues, the most abused drug in Iraq is reportedly the sedative, Artane, known as the 'pill of courage'.278

Whilst illicit drug use and abuse proliferated, over-the-counter drugs became yet more scarce. One Iraqi doctor, who continued practising medicine in Iraq until 2009, said that by the end of his time in the country, on a monthly basis his clinic received a mere 4 out of 17 medicines on the Ministry of Health's list of medicines for chronic diseases. He went on to say that the drugs he did receive were 'silly drugs' such as aspirins and diuretics, rather than the sought-after medicines for hypertension and diabetes.279 A similar tale is recounted to one journalist by a doctor in a Baghdad hospital whose stock of medicines and basic supplies was so unreliable that doctors routinely dispatched patients' relatives

275 Anonymous Interview with Medical Professional 2 (February 2012)
276 Allawi, p. 379.
279 Anonymous Interview with Medical Professional 1 (December 2011)
to source medicines, intravenous fluids and syringes from private merchants or the black market. The doctor could not explain the shortages, concluding: "No one can tell us why...It is as if they just disappear somewhere."280

Such stories of paucity in medical supplies are common among doctors and patients in Iraq and the leak in medication in particular has caused many to look elsewhere for much-needed drugs for chronic diseases. Some medication, often expired, has been smuggled illegally from neighbouring countries and sold illegally on the streets, as described by one Iraqi refugee in Amman:

    Nowadays, the healthcare in Iraq is terrible because of the emigration of a number of good doctors and the deaths of others. The medicines now are sold on the streets and they are expired and of a poor quality. There are no regulations for them. We went back to Iraq recently, and thank God, we didn’t need treatment.281

**Brain Drain**

Arguably, doctors more than many of their patients have been plagued by problems of extreme insecurity. Perhaps the most disastrous and unique characteristic of the decline in Iraq’s health system has been the medical brain drain that has occurred since 2003. Dissolving several thousand jobs overnight and eroding any sense of economic security on both the individual and societal levels through a series of destructive policies left many with no choice but to leave the country without hope of return. Furthermore, it has left widespread hallmarks of de-development that will endure for generations.

---


281 Anonymous Interview 240.3 (December 2010)
The emigration of health specialists and medical practitioners is not a new phenomenon of the twenty-first century. The country's history of internal and external displacement must not be forgotten – particularly during the 1990s, as salaries and facilities worsened, and medical professionals felt they had no choice but to leave the country. Nevertheless, the exodus of Iraq's educated middle class – many of them doctors and nurses – as a result of de-Ba’thification and targeting by militias, has led to a severe shortage of medical staff in what remained of the hospitals and clinics. According to the International Committee of the Red Cross (ICRC), more than 2200 doctors and nurses were killed and more than 250 kidnapped from 2003 until 2008. By 2006, Iraq had incurred the loss of 30-40 per cent of its doctors. Of the 34,000 doctors registered in 1990, at least 20,000 had left the country by 2007. According to a conversation with one Iraqi doctor now living in the United States after he was kidnapped in 2004, as many as 80 per cent of senior doctors had left Iraq. Furthermore, in a study by one academic at the University of Baghdad, it was estimated that 3000 professors were laid off in 2003 as a result of de-Ba’thification laws, forcing the Ministry of Higher Education to shut down 152 departments (17 per cent of the total number of educational departments). In 2004, UNESCO reported that 84 per cent of vocational buildings were at least partially destroyed and in need of significant repair or complete.

---

282 Sassoon in Baram; Rohde; Zeidel (Eds.), p. 202.
283 Due to lack of accurate records, it is difficult to verify this number. Other estimates are only slightly lower at 30,000 – 32,000.
285 Anonymous Interview with Medical Professional 2 (February 2012)
286 Majeed, Sawsan Shaker, “The Scientific Production of Faculty Members at Iraqi Universities before and after the Occupation” (University of Baghdad, 2007), p. 6.
reconstruction. A survey of 401 Iraqi doctors living in Jordan reveals that four per cent of those interviewed fled in 2003, increasing to 16 per cent in 2004, 25 per cent in 2005 and peaking at 43 per cent in 2006. In the same year, the Deputy Health Minister, Ammar al-Saffar was taken from his home by militia during an investigation into practices of corruption within the Ministry of Health and has never reappeared. Iraqis now living as refugees in Jordan allude to the effect of the medical brain drain and describe the further deterioration of the health services after 2003:

The government hospitals were crowded but they had all of the services on offer – x-ray, scanners, specialists and medicines...Now, there are not enough doctors because of the threat campaigns and emigration and assassinations of doctors.

After the war, there wasn't any medical support and people lacked good doctors. All the doctors who had experience were killed. When I came to Jordan, I found many good Iraqi doctors who had fled from the war and killings and kidnappings.

One such doctor - an Iraqi cardiologist living in Jordan – spoke in an interview with an Iraqi journalist of how systematic targeting of specialists from professors, doctors, pilots and senior military forced a number to leave:

I started receiving threats at my place of work, both written and verbal. I tried to seek help from the government, but unfortunately its hands remained tied in treating this phenomenon. Here, I would like to make an important point that the doctors targeted were not targeted on the basis of their religious sect – Sunni, Shi’a or Christian. Forced migration after the occupation was the

---

290 Anonymous Interview 290.2 (December 2010)
291 Anonymous Interview 50.4 (December 2010)
targeting of people according to their profession. This will affect the country for years to come. It is not easy to lose scientists and doctors. It costs the Iraqi state millions of dollars...This is a real disaster for the country.  

The physician left Iraq in 2005 and came to Amman, where he faced some difficulties in working and practicing medicine due to employment laws. There, he found many others like himself and continued to receive calls several times a day from doctors newly arrived from Iraq:

I feel great frustration when I see my colleagues sitting in cafes in Amman, suffering great hardships, and I swear to you that these are surgeons and specialists. Many of them have gone to neighbouring countries or to Europe and this is a tremendous loss for Iraq. If the situation does not improve in Iraq through a strong government, one cannot expect the return of these minds. They will settle in these countries and leave the medical profession, and this is one of the greatest losses of the country.

When asked if he will eventually return, he replied to the interviewer that it was ‘difficult’ to separate fear from the heart – a sentiment undoubtedly shared by thousands of medical émigrés. In his parting message to doctors remaining in Iraq, he called upon God to protect them.

We demand the state to provide them with protection, even if it’s two guards for every doctor. They are no less important than members of parliament or government officials.

In September 2008, the Iraqi government heeded such calls to protect doctors, allowing them to carry firearms by law. This did little to quash genuine fears of abduction and murder, but rather reinforced fears among doctors that the security environment remained volatile. In 2009, there were thought to be 22,396 physicians working in the country; including 5,997 specialists, totalling 22,396 physicians working in the country; including 5,997 specialists, totalling

\[\text{(1)}\] 

\[\text{293 Ibid.}\]
\[\text{294 Ibid.}\]
\[\text{295 Ibid.}\]

an average of 6.1 physicians per 10,000 people. As such, there continue to be shortages in the areas of anaesthesia, emergency medicine, psychiatry, community, and family medicine, with around 1.5 pharmacists and 1.4 dentists per 10,000 people.\textsuperscript{297} With such a dearth of senior physicians, younger doctors have taken the strain, often tasked with decision-making and performing surgical procedures above and beyond their experience and level of qualifications.\textsuperscript{298}

Iraqis describe their health system as ‘beheaded’ because many of its brightest have already migrated, while other health practitioners, managers and teachers of the future are not being developed or supported.\textsuperscript{299} The problem of a lack of health data arises once again and there are very few resources currently available to quantify the number of doctors who fled Iraq. Moreover, there is no governmental infrastructure or singularly reliable source of demographics to report the number of students graduating each year from Iraqi medical schools.\textsuperscript{300} Another long-term challenge is the cultivation of Iraq’s younger generation of doctors. Currently, government priorities appear more focused on political aesthetics than practicalities, in their funding of projects. Sassoon notes the tragic irony behind the proliferation of medical schools in Iraq. Before 2003, Iraq possessed seven medical schools. In 2004, this figure had increased to 12, soaring to 20 by the end of 2007. Yet, the sudden rise in medical schools was the result of sectarianism and political gain more than it was for the purpose of

\begin{flushleft}
\textsuperscript{297} International Organisation for Migration (IOM) Iraq Health Information Sheet for Movement and Assisted Migration Program (MAM) (September 2011)
\textsuperscript{298} Medact, “Rehabilitation Under Fire: Health Care in Iraq 2003-7", p. 3.
\textsuperscript{299} Harding; Libal in Singer; Dodge, The War Machine, p. 73.
\end{flushleft}
educating a new generation of medical professionals. “Some of these schools did not even have a medical library, so although they might turn out the necessary quantity of doctors to replenish the brain drain, it is unlikely that the quality of their education will be of an acceptable level.”

Mental Health Awakening

International studies have shown that mental disorders are among the most disabling diseases for a nation. This is most certainly the case for Iraq, with a recent history shared by much of the population, embroiled with extreme insecurities and trauma. Due to such high levels of personalised violence alluded to in the second chapter, one doctor estimated that 99 per cent of Iraqis need treatment for trauma endured over years of persecution and sectarian violence. Thus, focus on mental health is of paramount importance when considering the issues of integration, reintegration and reconciliation on the community, governorate and national levels.

In 2004, the Ministry of Health developed a National Strategy for Mental Health and identified priorities related to the rebuilding of mental health infrastructure, human resources development, community education and research. A flurry of activity resulted from the action plan, with the establishment of new community-based psychiatric facilities, mental health training for medical professionals, a public awareness campaign and the development of partnerships with a number of national and international nongovernmental

---

301 Sassoon, *The Iraqi Refugees*, p. 146.
303 Ibid.
stakeholders. Now, almost all eighteen governorates have at least one psychiatric facility, which constitutes a positive step away from a highly-centralised, urban and hospital-based system of mental health care. However, until now, the only two state psychiatric hospitals in Iraq are located in Baghdad, one of which is more than fifty years old and contains no separate inpatient mental health services for children and adults.

Such progress is tempered with gaps in services for a population in desperate need of care. In 2010, Iraq’s psychiatry association estimated that there were 100 psychiatrists available to serve a population of over 30 million people. According to the WHO Mental Health Survey, worryingly low levels of care availability and accessibility is a major concern for the future. Moreover, the lack of treatment facilities has also contributed a tacit understanding among many Iraqis that they must adapt resiliency as a necessity for survival. In the long-term, such forced resiliency among victims of trauma in the absence of mental health support is at a high psychological cost to Iraq’s future.

Like Jordan, mental health, particularly among children and adolescents is a relatively new phenomenon in Iraq. In an interview at his office in Washington DC, one Iraqi doctor described the 'neglected' issue of mental health

---

304 Fadel, Leila, “Iraq ill-equipped to cope with an epidemic of mental illness”
306 Ibid.
307 Iraq Mental Health Survey 2006/7 Report, World Health Organisation
308 Ibid. p. 42.
problems, particularly among children, as a ‘timebomb’ waiting to explode.\textsuperscript{309}

Such a latent mental health problem is implicit in one father’s description of the violence his family endured and the impact on his children:

I left Iraq to keep my children from the violence and killing we faced from militias and some parties. In September 2003, I was arrested in Baghdad, in the Green Zone. I was living there with my children in a house. The ages of my children were 12, 9, 8 and 4. One time I was going to work and I left the children with one of my relatives. When I returned to the house, I found that there had been an ambush and my children were tied up in one of the rooms. They were crying and screaming in fear. It was the religious militias financed by Iran and under the cover of the Ministry of the Interior...officially they were the government but they were lying. I was arrested in front my children and they were left alone screaming in the house at night. This horror affected them psychologically in a big way. After being imprisoned for seven months, I was set free due to lack of evidence (or any proof) but I was mentally and physically tortured and threatened and this had a psychological effect on my children because they were by themselves in the house. There were threats against my house by those who kidnapped me and took my children. A month after I was released, the police station near my house was blown up by terrorists. All of the windows in my house were broken and the doors blocked. All of my children were at school. They witnessed all of the panic and horror and this had a great psychological effect on them.\textsuperscript{310}

Iraq’s median age lying between 20 and 21 years\textsuperscript{311}, coupled with the reluctance of so many educated professionals to return to Iraq, signals that mental health treatment among youth can no longer afford to be sidelined if the country is to ever recover from the past.

In \textit{The Empire of Trauma}, Didier Fassin explores the facets of trauma, the evolution of the term and its growing legitimacy and usage in daily life. He is careful to make the distinction between trauma in the ‘restricted sense’ as it is used by mental health clinicians, and its popular usage as ‘an open wound for

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{309} Anonymous Interview with Medical Professional 2 (February 2012)
\item \textsuperscript{310} Anonymous Interview 50.5 (December 2010)
\item \textsuperscript{311} ‘Iraq Demographics Profile 2012’, http://www.indexmundi.com/iraq/demographics_profile.html Accessed 04/12/2011.
\end{itemize}
\end{footnotesize}
collective memory’ or ‘moral trauma’. As he sees it, trauma can be understood figuratively, as the ‘immortal trace’, or literally as ‘a physical scar’. Furthermore, trauma is ‘...a screen between the event and its context on the one hand, and the subject and the meaning he or she gives to the situation on the other.’ One should not be satisfied with trauma as medical experts or society constructs it, nor as a social process of recognition, ‘choosing its victims’. Such words echo the ‘medicalisation’ and ‘psychiatrisation’ to which Michel Foucault refers. Applicable to Iraqis suffering mental health problems in both Iraq and Jordan, such ‘medicalisation’ and construction of the victim has been institutionalised through the physical separation from society of mental health sufferers in tertiary mental institutions, reinforcing the stigma associated with victims of traumatic events and those with mental health problems in their communities. Around 80 per cent of families abandon their relatives once they are committed to the public psychiatric hospital, al-Rashad, in Baghdad. With only eight doctors and 1300 patients, there is no space within the confines of such an institution for any more, and even fewer places to go for those who have been discharged and deemed ‘fit’ to rejoin society. Inscription or ‘internalisation’ of collective and historical problems onto the victim is also prevalent in the attitudes of the population, as noted by Sadik et al:

---

313 Ibid., p. 281.
314 Ibid. p. 282.
316 Fadel, Leila, “Iraq ill-equipped to cope with an epidemic of mental illness”, *The Washington Post*

93
Attitudes towards mental illness in Iraq are very mixed, with large proportions of the population holding stigmatising attitudes towards people with mental illness in relation to treatment, work, marriage and recovery. The majority put the blame on the afflicted individual, avoided contact with them and would not openly discuss their own psychological problems.\textsuperscript{318}

Notably, mental health problems tend to be far more prevalent among those perceived ‘outliers’ of Iraqi society at risk of marginalisation – those with disabilities\textsuperscript{319} and those women separated, widowed or divorced. Although the government no longer denies the problem neither in its public discourse, nor in its through training and provision of mental health staff and facilities in primary health care centres\textsuperscript{320}, the state falls short on its promises to ‘protect the sick’ from ‘ignorance, fear and poverty’ and in its provision of special programmes of care and rehabilitation regulated by law.\textsuperscript{321} In realising such promises, the social processes of education, recognition, reintegration and acceptance of mental health sufferers and victims of trauma should be nation-wide and not selective. Moreover, the language of trauma must be spoken collectively, and further steps taken to provide decentralized, versatile and accessible care, preventing paralysis of a generation in the future.

**Conclusion**

“The State shall guarantee to the individual and the family – especially children and women – social and health security, the basic requirements for living a free and decent life, and shall secure for them suitable income and appropriate

\textsuperscript{319} http://www.niqash.org/articles/?id=2849
\textsuperscript{320} Sarhan, Abbas, “Disabled people in Kerbala: Iraq abandons its handicapped”, niqash.org
housing.” The positioning (or juxtapositioning) of ‘health security’ in Article 30 of the Iraqi Constitution speaks volumes to the current state of Iraq’s health and the challenges for the future. Yet, so-called ‘health security’, or health and security (economic, social and political), for much of Iraq remains but a craved ideal. Intricacies abound, as outlined in this chapter, but the task is by no means insurmountable. Such challenges must be tackled from the highest levels of government, starting with increased efforts to tackle corruption and improvement in means of communication and governance within the Ministry of Health. The commitment displayed in a uniform discourse on physical and mental health strategy must then be translated into action at every level of society, if Iraq’s health care is able to break from its destructive cycles, and for the pledges of the Iraqi constitution to be fulfilled.

CONCLUSION

In 2011, the Iraqi Ministry of Health published its ‘vision’ for health care in Iraq:

The portrayal of such a vision in a cloud of thought is indicative of the current state of Iraq’s health predicament. The sentiments are there, but lack definition and clarity over implementation and the development of the health sector. It is with this eye of consideration that the conclusion adopts a tone of measured optimism, making general recommendations for the future grounded in existing structures and achievements.


English translation: “A health system reliant upon primary health care as an anchor to ensure that health services meet the needs of the individual and society, in line with international health standards as much as possible through competent leadership, so as to build and sustain the delivery of adequate levels of health services (primary, secondary and tertiary) with high quality specifications and work that integrates services.”
Strong leadership characterized by a coherent national health policy

In recent years, the Iraqi Ministry of Health, with support from the World Health Organisation, has come to view primary health care as ‘the anchor’ of the health sector, moving away from centralized and urban-based care, to a system bearing the hallmarks of decentralization and embodied in evenly-distributed primary healthcare centres across Iraq’s governorates from north to south. This pillar of care at the local levels is stated in the above vision of the 2012 Annual Training Plan. However, consistency, uniformity and wide circulation of this vision within the Ministry of Health is questionable. Furthermore, there is no documented national health policy, but rather a myriad of strategies, regulations and no less than 26 laws within the Iraqi constitution that cover issues pertaining to Iraq’s health sector. In its 2011 Review Report, WHO cites fragmentation, lack of policy and ‘gaps’ in the national strategic policy framework as obstacles to progress in the strengthening of primary health care systems.\textsuperscript{324} Indeed, without a clear vision, embodied in decisive leadership and a documented policy translated and transferred to all stakeholders involved in health care, good intentions risk floundering in ambiguity and stunted development.

Following heightened awareness of the desired direction for health in Iraq, such commitment to accessible health care at the local level through a documented policy of decentralisation must be translated into implementation. In his reflections on ‘Displacement and National Institutions’, Van der Auweraert advocates the creation of a ‘national displacement fund’ to empower and enable local governments to procure funding for projects required at the local level, as

well as ensuring more accountability and transparency for those outside the
circles of power in Baghdad. With tendencies of corruption, mistrust and ill-
communication in mind, tentative steps to improve access through the
empowerment of local authorities should be encouraged.

Research Development

In March 2012, research development showed signs of promise when there was
tacit acknowledgement from both the Iraqi government and the international
community of the need to investigate the rising number of health problems in
areas badly affected by war. Following a series of meetings of Iraqi and
international health officials in 2011, the Iraqi Ministry of health and the WHO
announced that a pilot assessment of congenital birth defects in six Iraqi
governorates would commence in April 2012. Such a study is limited in its
geographical scope, but demonstrates acknowledgement of a neglected and
crippling health problem. Moreover, such an initiative shores momentum for
further research endeavours within Iraq’s universities and research institutions,
restoring them to their former glory and enticing back to the country those
scientists and academics who were forced to leave.

325 Van der Auweraert, Peter, “Displacement and National Institutions: Reflections on the Iraqi
11/04/11.
Data Management

In December 2010, WHO was working with the Ministry of Health to train professionals and to update the national health information system. This is a positive move at least, with slow but steady progress made over the past year in building an electronic database of patient records so as to address the information deficit following years of poor registration and to replace the erratic and outdated mode of paper records. In 2011, WHO and the Ministry of Health also completed the first round of the National Health Accounts, which serves as a useful analytical tool to access health care financing. With a clearer picture of who is paying for what and out-of-pocket expenses (currently standing at 25 per cent), the Government of Iraq can promote regulation within the private sector, address corruption and inefficiency within the Ministry of Health, better allocate public health expenditures and ensure that there is health equity and accessibility throughout the country.

Coordination of Health Strategy with NGOs and the Private Sector

Data management can also facilitate the coordination of health strategy with non-state actors involved in health care. Currently, the boundaries are blurred between the public and private because of ‘dual practice’ by many medical professionals. Moreover, the history of poor relations between humanitarian and political actors in Iraq heightens the risk of ill-communication among actors. Lessons can be learned from post-conflict Bosnia and Herzegovina, where uncoordinated international activities left some areas inadequately covered. Similar to Iraq, the health ministry was overwhelmed by the array of programmes and projects initiated by various

international organizations and other actors. The weak functional capacity of the state did not allow for proper needs’ assessment and priority setting, and thus many international activities were planned and begun without close collaboration with local civil servants. On the part of international and national non-state actors involved in health care, there should be more communication over projects within the field. As more agencies move their headquarters from Jordan to Iraq, this is becoming easier. Moreover, the 3W report that is now published by the United Nations Coordination Team (UNCT), highlights ‘Who does What, Where’ among the various agencies and facilitates dialogue and collaboration rather than suspicion and competition.

Reinforcing Standards and Cultivating Professional Development

For those doctors who have remained or have recently returned to practice medicine in Iraq, there is an urgent need to update and retrain many in the latest medical practices. In the recent training plan published by the Ministry of Health, the Ministry of Health expressed interest in Career Professional Development (CPD), describing as “...a modern concept in the training process, meaning the training and development of all specialties involved in organization.” Through continuous refresher courses and training workshops, the Ministry of Health can propagate an air of dynamism, reinforcing its leadership and contact with medical professionals in all areas of the health sector. If the government is to encourage the return of Iraq’s doctors through an increase in salaries, there must be regulation and conditions attached so as to cultivate an atmosphere of dedication, commitment to learning and professionalism. Such professional development will set high standards in

---

medical practice, fulfilling the desire to meet international health standards in primary, secondary and tertiary care.

Mitigating the Harmful Effects of the Brain Drain

The regional demographic is often overlooked when considering Iraq – largely due to a lack of statistics – yet the country has experienced one of the highest population growth rates over the past thirty years. The rate of three per cent per annum has been on the decline since 2004, mostly likely due to the high level of external displacement. However, the population is expected to reach 38 million by the year 2030.\textsuperscript{329} The age distribution of the population in Iraq is typical of a population with high demographic growth, as according to a WHO survey in 2007, more than half of the population is under the age of 20 years.\textsuperscript{330} What should be somewhat of a demographic gift, however, is unable to fulfil its potential as “…the young generation of Iraqis, more than half of whom are under 30, are robbed of their teachers, doctors and future opportunities.”\textsuperscript{331} Others living as refugees outside Iraq, have seen their career hopes dashed as they are unable to access higher education in host countries due to cost barriers. For those aspiring young Iraqi doctors within and out-with Iraq, the health and education ministries must therefore make a concerted effort to improve career opportunities and training, offering reasonable incentives and support for returning students. This is for the sake of the younger generations, who rather

than constituting a lost generation or a disenfranchised threat\textsuperscript{332}, can restore life to Iraq's depleted professional labour force. If not, for the future of the country's health and prosperity.

**Mental Health**

In 2011, the Ministry of Health and the Ministry of Education worked with the World Health Organisation to provide training to teachers in schools. The latter have since been given guidance on how to help children subjected to previous violence and gender-based violence at home.\textsuperscript{333} In Kurdistan, the regional government signed a memorandum with the Royal College of Psychiatry, which will facilitate continuous education and training for psychiatrists and psychologists in Iraq. All of these initiatives are beginning to transform perceptions of mental health as a 'disorder' or 'deficiency' to more of concern with individual and collective well-being. However, there is a need for more education and health professionals with qualifications in mental health, particularly at the local level. Educating the population on mental health issues, opening the doors to people in need of care, recognizing symptoms of trauma and soothing memories of violence within local communities is crucial to the health and prosperity of the country. Moreover, if Iraq can augment its levels of mental health care, such services could also be a valuable means of encouragement to return, facilitating the reintegration of those Iraqis remaining in a state of uncertainty with limited access to health care in host countries such as Jordan and Syria.


Concluding Remarks: Health, Reintegration and Reconciliation

They don’t think about returning to Iraq, and she said that when she thinks about what happened in Iraq, her chest tightens and she can’t even speak. She can’t think about returning.\(^{334}\)

In unraveling the period from the onset of de-development and destruction until the present days of faltering recovery and development, this thesis has revealed that health has been both a casualty and a cause of Iraq’s predicament, entrenched deep within the hearts of those inside and outside of the country. Years of economic sanctions, war, occupation and continuing violence de-developed and destroyed public health infrastructure, and severely damaged the health of the population, forcing many to flee Iraq. Such physical and mental health problems left untreated among those Iraqis in exile and those remaining in Iraq, as well as the failure to address weaknesses in Iraq’s health infrastructure, has prolonged Iraqis’ suffering and delayed the recovery and development so crucial to the reconciliation and functioning of a healthy nation.

Ultimately, in breaking the cycles of degeneration and stagnation, there must be further recognition of the past, responsibility for the health of current generations of Iraqis within and out-with the country, and commitment and consensus towards the future. It is only then, and with further commitment to the intrinsic social, economic and political ailments facing the country, that reintegration and focus on national reconciliation can begin. Iraqis on an individual and collective level in the southern, central and northern regions of Iraq, can address specific challenges and make up for those years lost in recent history.

\(^{334}\) Anonymous Interview 310.2 (December 2010)
Books and Academic Journal Articles

- Abed, Riadh, T. “An update on mental health services in Iraq” in The Psychiatrist (No. 27, 2003)
- Al-Obaidi, Abdulkareem Et Al, “Child and Adolescent Mental Health in Iraq: Current Intervention and Scope for Promotion of Child and Adolescent Mental Health Policy” in Intervention (Vol. 8, No. 1, March 2010)
- Al Samarai, N.A,”Humanitarian implications of the wars in Iraq” in International Review of the Red Cross (Vol. 89, No. 868, 2007)
- Bader, Farah et al., “Psychosocial Health in Displaced Iraqi Care-Seekers in Non-Governmental Organization Clinics in Amman” in Prehospital and Disaster Medicine (Vol. 24, No. 4, 2009)
- Baram, Amatzia; Rohde, Achim; Zeidel, Ronen (Eds.), Iraq Between Occupations: Perspectives from 1920 to the Present (New York: Palgrave Macmillan, 2010)
- Bayat, Asef, Life as Politics: How Ordinary People Change the Middle East (Stanford, CA: Stanford University Press, 2010)
- Chatelard, Geraldine, “From one War to Another: Iraqi Emigration to Jordan” in ISIM Newsletter (No. 13, December 2003)
- Devi, Sharmila. “Meeting the health needs of Iraqi refugees in Jordan” in The Lancet (Vol. 370, December 1, 2007)
• Fassin, Didier; Pandolfi, Mariella, *Contemporary States of Emergency: the politics of military and humanitarian interventions* (New York: Zone Books, 2010)
• Fassin, Didier, *When Bodies Remember* (Berkeley: University of California Press, 2007)
• Hugman, Richard; Pittaway, Eileen; Bartolomei, Linda, “When ‘Do No Harm’ Is Not Enough: The Ethics of Research with Refugees and Other Vulnerable Groups” in *British Journal of Social Work* (No. 41, 2011)
• Ismael, Tareq Y; Ismael, Jacqueline S, “Whither Iraq: Beyond Saddam, sanctions and occupation” in *Third World Quarterly* (Vol. 26, No.4-5)
• Jawad, Shakir; Mahmoud, Maysaa; Al Ameri, Ali; Nakano, Gregg in Army Peacekeeping and Stability Operations Institute (PKSOI), *Transitions: Issues, Challenges and Solutions in International Assistance* (August 2011)
• Lamani, Mokhtar; Momani, Bessma (eds.), *From Desolation to Reconstruction: Iraq’s Troubled Journey*, (Ontario: Wilfrid Laurier University Press, 2010)
• Leaning, Jennifer; Spiegel, Paul; Crisp, Jeff, “Public health equity in refugee situations” in *Conflict and Health* (Vol. 5, No. 6, 2011)


• Majeed, Sawsan Shaker, “The Scientific Production of Faculty Members at Iraqi Universities before and after the Occupation” (University of Baghdad, 2007)


• Richards, Alan & Waterbury, John, A Political Economy of the Middle East (Boulder, CO: Westview Press, 2008)


• Sadik, Sabah Et Al, “Public Perception of Mental Health in Iraq” in International Journal of mental Health Systems (Vol. 4, No. 26, 2010)


• Skopec, Chris; Valeeva, Natalia; Baca, Mary Jo, “Anticipating the Unexpected: Urban Refugee Programming in Jordan” in Middle East Institute (November 1, 2010)
• Taipale et al, in War or Health: A Reader (London; New York: Zed Books, 2002)

Journalistic Sources
• Al-Mulhim, Mahmood, “Ministry of Health plans new hospitals for Dhi’Qar”, Mawtani (May 16th, 2011)
• Editorial, ‘Act now to secure Iraq’s health’ in The Lancet, (Vol. 362, No. 9392, October 18th, 2003)
• Reilly, Corinne, “Iraq’s once-envied health care system lost to war” on mcclatchydc.com (May 17th, 2009) 
• Rubin, Alissa, J., “Squeezed by oil price’s fall, Iraq budget is passed”, The New York Times, 
  http://www.nytimes.com/2009/03/05/world/africa/05iht-iraq.4.20628652.html Accessed on 04/03/2012.
• Sarhan, Abbas, “Disabled people in Kerbala: Iraq abandons its handicapped”, niqash.org (June 6th, 2011) 
• Webster, Paul, “Reconstruction efforts in Iraq failing health care” in The Lancet (Vol. 373, No. 966, February 2009)

Reports and Surveys

• Campbell, Elizabeth, “Iraq’s Displaced: A Stable Region Requires Stable Assistance”, www.refugeesinternational.org (February 16th, 2011) 
• Environmental Contaminants from War Remnants in Iraq, NGO Coordination Committee for Iraq (NCCI) Brief, (June 2011), 
• Fafo, “Iraqis in Jordan: Their Number and Characteristics” (2007) 
  https://wikis.uit.tufts.edu/confluence/download/attachments/1455363
• “Humanitarian dilemma in Iraq: hearing before the International Task
Force of the Select Committee on Hunger”, House of Representatives, One
Hundred Second Congress, first session: hearing held in Washington, DC,
• International Committee of the Red Cross (ICRC) Operational Update,
“Iraq: giving disabled people a chance to resume a normal life” (October
20th, 2011)
http://www.icrc.org/eng/resources/documents/update/2011/iraq-
update-2011-10-20.htm Accessed on 04/03/2012.
• International Committee of the Red Cross (ICRC), “Iraq: No Let-Up in the
Humanitarian Crisis” (March 2008),
http://www.icrc.org/eng/assets/files/other/icrc-iraq-report-0308-
• International Organisation for Migration Iraq Health Information Sheet
for Movement and Assisted Migration Program (September 2011)
• International Organisation for Migration (IOM) Iraq Mission, “Five Years
of Post-Samarra Displacement: Bi-Annual Report” (February 2011)
• International Organisation for Migration (IOM) Iraq Mission, “Field
Monitor Monthly Narrative Report for Dhi’qar Governorate” (June 2011).
• International Organisation for Migration (IOM) Iraq Mission, “Special
Focus Report: Female Headed Households” (October 2011)
http://www.iomiraq.net/Documents/FHH%20Report%20EN.pdf
Accessed on 11/01/11.
• Iraq Mental Health Survey 2006/7 Report, World Health Organisation
Accessed 03/10/2012.
• Iraqi Ministry of Health & World Health Organisation, “Chronic Non-
Communicable Diseases Risk Factors Survey in Iraq” (2006)
on 04/03/2012.
• Medact, “Rehabilitation Under Fire: Health Care in Iraq 2003-7” (London:
Medact, 2008)
• Report to Congressional Committees: “Displaced Iraqis: Integrated
International Strategy Needed to Reintegrate Iraq’s Internally Displaced
and Returning Refugees”, United States Government Accountability Office
• Report to Congressional Committees: “Stabilizing and Rebuilding Iraq:
Iraqi Revenues, Expenditure and Surplus”, United States Government
Accountability Office (GAO) (August 2008)
• Report of an Independent Working Group established by the Independent
Inquiry Committee, “Impact of the Oil-For-Food Programme on the Iraqi
People”, (September 7th, 2005), http://www.iic-


Additional Resources Cited
• Interview with Dr. Omar al-Kubeisi (translated from Arabic), ahewar.org (July 31st, 2006), http://www.ahewar.org/debat/show.art.asp?aid=71446 Accessed 01/18/2012.