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RIGHT TO HEALTH IN IRAQ

Fragile structures and growing challenges

Muntather Hassan

Iraqi al-Amal Association

This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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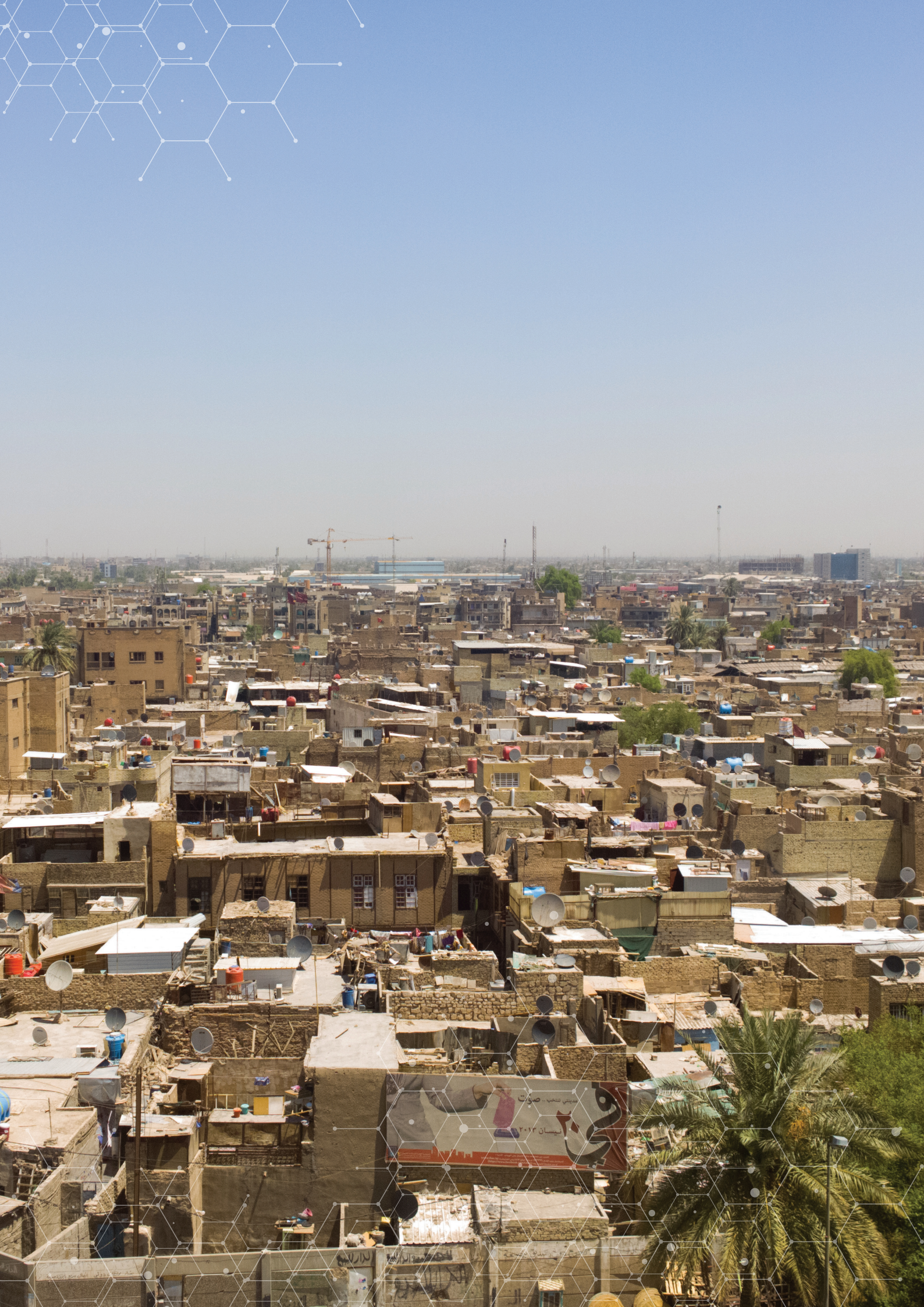

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INTRODUCTION

Iraq's long history of wars, violent conflicts, economic crises, and social divisions had a direct and indirect impact on its population's health, including lost lives, disabilities, and loss of livelihoods. After eight years of war against Iran in the 1980s and the second Gulf War in 1991, Iraq faced harsh international sanctions that destroyed the health and healthcare infrastructure. After the fall of Saddam Hussein's regime and the US occupation in 2003, neoliberal government policies failed to improve the right to health in the country. The public healthcare infrastructure barely changed due to the ongoing political instability that restricted the system's ability to provide services to the population. Furthermore, the long history of violent conflict has left most Iraqis with varying mental health problems and unhealed trauma. However, the healthcare system, health policies, and government and private sector approaches rarely address such issues.

In addition, Iraq faces serious environmental challenges, including pollution, climate change effects, extreme heat, and drought. In the spring of 2022, thousands were admitted to hospitals due to unprecedentedly intense sandstorms that temporarily brought the country to a standstill. Moreover, eight small rivers and three lakes completely dried up due to generally low water levels and high temperatures, threatening food security and agricultural livelihoods. Vulnerable groups continue to suffer from multiplying effects due to their inability to access appropriate health services and the components of healthy living.

This report consists of three main sections. It begins with a brief historical overview of the context of the right to health in Iraq from the establishment of the modern state to the present day. It then examines and analyzes right-to-health indicators and discusses the leading challenges to the right to health. Finally, it concludes with recommendations for various actors, including civil society, the government, and the international community.

METHODOLOGY

This report is based on a desk review of available literature, including government documents such as laws and performance reports, and reports by United Nations (UN) institutions like the World Health Organization (WHO) and the World Bank. Other sources included academic research, press reports, and reports by local and international civil society organizations (CSOs). The conclusions were supported by anecdotal observations from the author's practical experience as a dentist in the Iraqi public sector, where he spent nearly six years. This methodology was chosen after failing to obtain important information from primary sources through key informant interviews with stakeholders in leading positions in the Iraqi health sector. Five directors of departments concerned with public health from three Iraqi Ministry of Health Directorates were interviewed. The research focuses on all governorates except for the Kurdistan region, which uses another health system and has different social and political contexts.

The report builds on a rights-based approach. It adopts the principle of the right to health to understand the situation and challenges in Iraq. However, this right is not limited to obtaining appropriate health services. It includes all the elements of individuals' and groups' well-being. Thus, the report uses systems theory to analyze the main issues regarding the right to health within its social, political, and economic context. It looks at aspects such as food, medicine, education, work, transportation, infrastructure, and public order as systemically linked, going beyond direct cause and effect. Finally, the report benefited from a consultative session in Baghdad with academics, civil society workers, Iraqi health sector workers, and several reviews by the ANND team.

HISTORICAL OVERVIEW

This section reviews Iraq's historical, political, social, and economic context, analyzing its relationship and impact on the right to health, including health services, in three historical stages. It begins with the establishment of the modern Iraqi state during the British occupation, the monarchy, and the establishment of the republic. Then it moves to the Baath Party era and its great wars. The last stage discusses the post-war period from 2003 to the present day.

TRANSITIONING INTO THE MODERN WORLD (1920-1968)

Iraq has undergone significant transformations since the first Iraqi government establishment in 1920 under British occupation. The state's shape and systems witnessed many transformations from the parliamentary monarchy to the dictatorial republic, then to the democratic republic. However, the structures of modern state institutions were laid down under British occupation and during the monarchy after four centuries of being part of the Ottoman Empire. For example, the Iraqi army was first established in 1921. Modern schools were introduced, facing popular resistance and the scorn of religious institutions at the beginning. The health system was put in place simultaneously after establishing the first Ministry of Health in Iraq's history and its first government. However, due to the financial crisis during the Iraqi state establishment, it was incorporated into the Ministry of Interior until 1939. That year, it became part of the Ministry of Social Affairs as the General Directorate of Health, consisting of two departments: the Directorate of Public Health and the Department of Brigades Health. The Ministry of Health was re-established in 1952 under Law No. 28 (2014 حسين; 2021 حميد).

When the Ottomans left Iraq, it was not yet a state but a group of scattered tribes and cities torn apart by large waves of plague and cholera in the seventeenth century. Also, poverty and the lack of a culture of hygiene and health were widespread (الوردي 1992). The British mainly introduced health concepts and institutions as a colonial product (Al-Dewachi 2017). The Royal Medical College was established in 1927 in Baghdad to educate and prepare Iraqi physicians in English, mainly by professors from England. Today it is

called the College of Medicine at the University of Baghdad. It is called the mother college, and from which came the University of Baghdad, the mother university. Some foreign professors continued to teach until the first Gulf War in 1980 at the University of Baghdad. Then, the departure of foreign professors indicated that the Iraqi health and education systems had become unsuitable. Waves of immigration of Iraqi doctors and professors soon followed, resulting in the deterioration of health and educational services (Al-Dewachi 2017).

The medical profession became associated with social prestige beyond the importance of medicine, including a better economic situation, foreign language advantage, travel, and proximity to positions of power. Despite the changing social and economic dynamics, medicine remains Iraq's most important social profession and specialty. This social attitude undermines the importance of other essential roles in health and other sectors. Thus, the right to health became reduced to health services, a problem that continues today.

The Monarchical era from 1920 to 1958 began Iraq's transition toward modernity. State institutions began to emerge, and transport, irrigation, sanitation, and other systems were developed, especially in major cities. Meanwhile, the countryside, which formed most of Iraq at that time, remained under the control of an exploitative feudal system. As a result, the peasantry suffered under dire economic and social conditions and low quality of life. Unequal development and the rise of various political and ideological aspirations contributed to the coup of July 15, 1958.

The new state shifted to a welfare state model that abolished the feudal system through the Agrarian Reform Law No. 30 of 1958. The law set an upper limit for owning agricultural land. The state took control of the rest, redistributed it to the peasants, and compensated the owners. However, the peasants, especially indentured workers, could not manage their lands. They lacked the necessary management skills that went beyond agriculture.

On the other hand, the economic situation of middle-class farmers improved. They started moving to the cities (Marr 2012), where the rural and clan culture they brought began to spread. This culture included low health awareness and unhealthy practices in hygiene, treatment, and lifestyle. It also added pressure on the already weak health infrastructure. Furthermore, the migration was disorganized, as most

immigrants were scattered around. Women who used to work in agriculture within their families, while it did not grant them economic independence, became unemployed after migrating to the cities and were confined to their homes.

THE GREAT WARS (1963-2003)

The nationalist movement rose to power by the February 1963 coup to enforce the concept of the state as custodian of all citizens. The state became more involved in providing education and health services. Banks and some companies were nationalized in 1964, and the state took responsibility for importing and distributing basic needs (Marr 2012). Simultaneously, oil companies were nationalized in 1972, which increased the state's ability to spend directly on services and militarization. The 1970s witnessed a boom in development, health, and education indicators. For example, the maternal mortality rate was 87 per 100,000 live births in 1979 compared to 294 in 1999 and 73 in 2022. "During the 1970s and 1980s, the Iraqi health care system was lauded as one of the best in the Arab region, providing free health care in hospitals and primary health care clinics" (Abdurahim & Bousmah 2019).

Despite the positive impact of the state's immediate ability to spend on development, its long-term effects were negative (Al-Jebory 2017). The abundance of oil resources, dictatorial rule, and militarization after the July 17, 1968 coup, in addition to a patriarchal culture, led to the outbreak of the first Gulf War in 1980. In eight years of war, around 125,000 Iraqis were killed, 255,000 were wounded, and 50 to 80 thousand soldiers were captives. Furthermore, the Anfal operations in the Kurdistan Region of Iraq led to an estimated 50 to 100 thousand fatalities.

The direct war victims amounted to about 2.7% of the total population of Iraq at the time. The populations of entire cities along the war lines were displaced to central Iraq. They produced demographic changes that persist until today and added pressure on the health infrastructure already suffering from the war. The situation led to a significant shake-up in the social and economic system from which Iraq has not recovered. After its exit from the war, Iraq's debts amounted to about 50 billion United States Dollars (USD). Most of the industry had been transformed to serve the military. Iraq had lost about 45% of the workforce by then. Inflation was close to 28% (Marr 2012).

On the other hand, gender roles witnessed a transformation.

Women took over most public sector jobs due to the men's involvement in the war and its resulting reduced wages. Women-led families appeared, and became a phenomenon. However, as migration continued from the countryside to the city, clan values with patriarchal standards became more dominant. It exposed women, in particular, to social discrimination that encouraged violence against them directly and indirectly. More girls were deprived of education and sent to early marriage due to the coupling of the patriarchal culture and poor economic situation.

The ground was set for the Second Gulf War in 1990 as a cover-up for the state's failures and economic deterioration. The First Gulf War brought growing debt, continuous spending on weapons of mass destruction, and militarization in general. Then, the Second Gulf War led to an economic and social setback, with the loss of 10 to 30 thousand Iraqis and the capture of 86 to 90 thousand soldiers. However, after the failure of the popular uprising against the regime in 1991, government repression became harsher and more organized, especially in central and southern Iraq. It instilled a general culture of fear of power and silence in the face of its transgressions, no matter how severe they were. It also produced a culture of lack of transparency and administrative corruption that is still firmly present today. Thus, the health system's efficiency and ability to improve the system's situation were compromised.

Following the cease-fire imposed by Security Council Resolution 687, international sanctions reduced oil exports by 85% for six years (1991-1997). Hence, the Iraqi Dinar (IQD) collapsed from 3.20 USD per 1 IQD before the war to 2,600 IQDs per 1 USD in 1996 (Marr 2012). The infant and maternal mortality rates increased during that period, health indicators dropped dramatically, and "hospitals became places of death and disease rather than treatment" (Al-Dewachi 2017). The government took advantage of the people's suffering to call for the world's sympathy. Pictures of children suffering from deformities filled the television from the end of the 1990s until 2003.

In addition to the collapsed health system and economy, the sanctions were disastrous for the social system in Iraq. Bribery became a socially acceptable practice by most state employees to compensate for their measly salaries (around 0.8 USD a month). In schools, for example, it was common to hand over foodstuffs as a bribe to teachers as one of the conditions for the success of students with medium and weak performance.

The same situation applied to hospitals and other services. Nevertheless, the economic situation saw a slight improvement right before 2003.

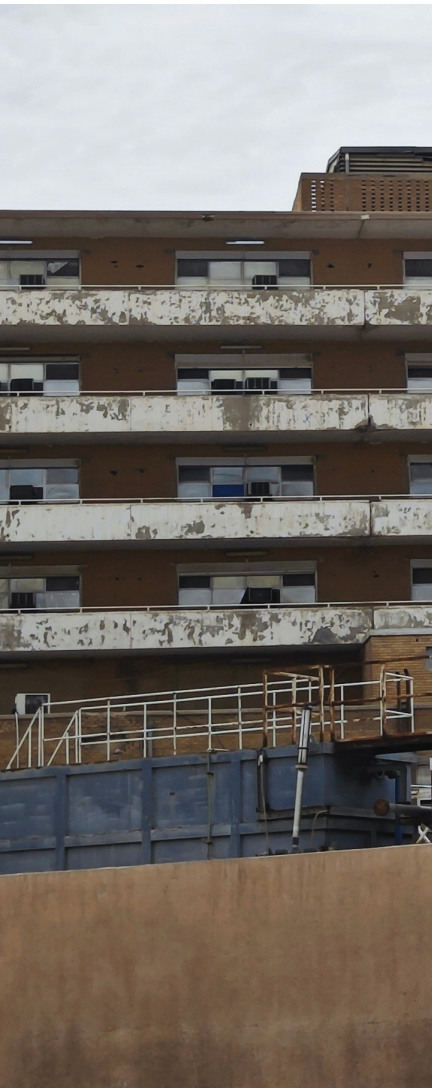
In 1995, Saddam Hussein's regime launched a faith campaign to Islamize the state and daily life and encourage radical Islamic ideologies, coinciding with the government's rapprochement with the clans. It ended the liberal character of the state that prevailed until the end of the 1980s. With this change, religious extremism increased, and with it, patriarchal extremism. It led to an increase in girls' early marriage rates to relieve their economic burden. Domestic violence and violence against women increased. Death during childbirth became prevalent due to poor health services and decaying infrastructure.

DEMOCRACY AND SOCIAL UNREST (2003-2022)

After the US occupation of Iraq in 2003, the economy opened up after a long economic blockade. Goods and food entered without regulation or quality control. Salaries jumped from about 0.80 USD per month to around 250 USD. Although consumption rates increased, the tired and poor local industry collapsed, and agriculture was severely harmed. The switch from a completely closed economy to a completely open market (neoliberalism) and a lack of standards transformed Iraq into a consumerist society dependent on imports.

On the social level, the status of the public sector employees rose quickly. People competed for important government jobs, and many were absorbed into the security sector, especially those without university degrees. The white paper of the Crisis Cell for Financial and Fiscal Reform (2020) indicated that the salary expenditures of employees and retirees increased by 400% from 2004 to 2020. Although the number of employees tripled, productivity increased by a mere 12% between 2006 and 2018. On the other hand, most revenues (about 95%) came from oil exports.

As the state's income improved, large sums went to the ministries to reconstruct the infrastructure and clear the way for investments. However, they also opened the door wide for administrative corruption at the higher levels. While bribery in daily transactions generally decreased, fake projects and theft of public money increased significantly, placing Iraq at the bottom of corruption and transparency indicators.



The situation contributed to the failure to improve the health sector in proportion to the population increase. The hospital beds rate decreased from 1.7 per thousand people in 1980 to 1.2 per thousand in 2019. Meanwhile, hospitals dropped from around 305 in 1989 to 295 in 2020 (The World Bank 2022a). Most hospitals were old establishments from the 1970s and 1980s. Some had exceeded their designated lifespan. On the other hand, several new hospitals were temporary, especially those established in response to the COVID-19 crisis. This decrease in the number of hospitals and beds rate was accompanied by a decrease in quality in general, except for a few newly established public hospitals and some private ones.

An indicator of Iraqis' lack of confidence in their health system and its ability to meet their health needs is the spread of medical tourism, especially to Iran, Lebanon, Turkey, India, Syria, and Jordan. For example, Iraq signed two agreements with Lebanon in 2019 and 2021 to provide treatment services to Iraqis and medical expertise to Iraqi health institutions in return for supplying Lebanon with oil. The health services Iraqis travel for vary between hard-to-cure diseases such as cancer and services unavailable in Iraq, such as some complex surgical interventions, all the way to cosmetic services. Moreover, many of these patients "chose to sell their possessions, borrow money, or rely on the help of charitable organizations to seek critical medical and surgical procedures abroad" (Al-Dewachi 2013).

However, the economic situation and health indicators improved between 2003 and 2013. Most of the improvement happened after ending the displacement crisis due to the sectarian war in 2008. The defeat of al-Qaeda in 2008 and the US forces' withdrawal in 2010 were also significant milestones. The so-called "explosive" 2012 budget crossed the barrier of 120 billion USD, allocating a large proportion to investments in services and security, including building new hospitals. However, many of these hospitals have not yet seen the light of day due to administrative corruption.

The emergence of the Islamic State in Iraq and the Levant (ISIS) in 2013 posed an existential threat to the Iraqi state in its current form. By 2014, it had captured Nineveh, Anbar, Salah al-Din, and parts of Kirkuk, Diyala, Baghdad, and Babel. Consequently, The Iraqi Popular Mobilization Forces (PMF) and the Global Coalition to Defeat ISIS emerged, and the war lasted until the end of 2017. Iraq was left with an insurmountable debt and budget deficit. The economic crisis reached its peak in 2016 when oil prices fell. Health and environmental services

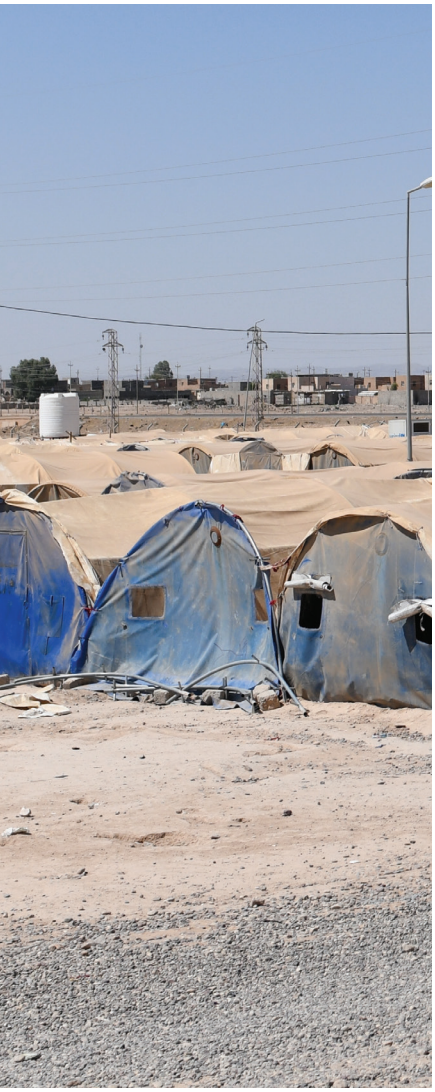
were no longer a priority for the government. The war also displaced more than five million persons internally. Between 186 and 209 thousand Iraqis are estimated to have died through direct violence from 2003 until today. They include about 38 thousand persons during the war against ISIL (Iraq Body Count 2022). However, there are no reliable statistics on injuries or disabilities during this period.

During this time, internal displacement significantly impacted the health system, as displaced populations lost their livelihoods and access to essential services. Poor living conditions in camps and other places of displacement, especially those that are not organized, threatened internally displaced persons' (IDPs) physical and psychological health. The long-term effects of displacement include the deteriorating socioeconomic situation, loss of education and other essential services, and increased post-traumatic stress disorder (PTSD) and similar conditions.

The high volume of internal displacement also puts tremendous pressure on public services in host communities already suffering from poor infrastructure. Host communities began rejecting IDPs because of competition for services and job opportunities. Moreover, patriarchal gender norms played an essential role in this rejection. Most IDP men were subjected to security restrictions and prevented from entering cities, especially in the period following ISIS's takeover of Nineveh, Anbar, Salah al-Din, and other regions in 2014. The prohibition of IDPs from entering the cities prevented them from working or accessing health services. As a result, access to essential needs became dependent on humanitarian aid.

The same period saw fluctuating interventions by the Iraqi state. Politicians presented themselves to their constituents through care programs such as compensation for the families of martyrs and those affected by military operations or by providing free services. Government jobs were distributed in a manner closer to social security than actual employment. At the same time, the state tried to keep up with international priorities in developing the private sector, such as the conditions imposed by the International Monetary Fund (IMF) in its 2015 loans, encouraged by international development agencies and donor countries.

The private sector avoided the health sector and was primarily interested in housing and other non-productive sectors (كاظم 2021, p. 165). However, the private sector's health investments increased during and after the COVID-19 crisis, mainly to



provide for required tests and documentation. Private hospitals, laboratories, and medical schools started to open, while medical clinics remained mostly individual and unorganized. Much of the private sector's health-related activities are affiliated with political parties and armed groups. The neoliberal policies, pushed by international parties in Iraq, have been distorted and led to strengthening political parties and their armed wings more than stimulating actual private sector activity.

The post-2003 period also saw the emergence of previously-forbidden CSOs. International and local non-governmental organizations (NGOs), volunteer groups, and religious and charitable institutions contributed to the rapid response to the displacement crisis during and after the war against ISIS. The UN Iraq Humanitarian Fund and other UN agencies, the European Union (EU), the Department of Population, Refugees and Migration in the United States Department of State, and the US Agency for Development (USAID) were among the most prominent international actors in financing the humanitarian response and providing legal and health support services. Locally, the host communities were the first and foremost responders, followed by volunteer teams and local organizations. The government's response was the slowest and least effective. On the other hand, the response of religious institutions was flawed by sectarian and religious bias and discrimination. However, the contribution of civil society to health beyond the displacement crisis is minimal due to the absence of right to health from the donors' priorities.

IRAQ TODAY

Based on estimates by the Central Statistical Organization in the Ministry of Planning (2022), Iraq's population is more than 42 million people, 28.8% of whom live in rural areas and 61.2% in urban areas. However, there has been no official census since 1997. The annual growth rate is estimated at 2%, and a healthy life expectancy at birth is 62 years. Socially, the illiteracy rate is 6% of the population (WHO 2022). The poverty rate reached 31.7% after the COVID-19 pandemic, according to the statement of the Minister of Planning (زيد 2022). Iraq also faces structural challenges to the right to health, mainly due to climate change. The consequent rise in heat, pollution, water scarcity, and desertification rates adversely impact food security. The impact of financial and administrative corruption in import operations and quality control on inequality in access to health services are discussed later in the report.

ASSESSING HEALTH DETERMINANTS IN IRAQ

This section provides an overview of Iraq's primary right to health indicators based on assessing health characteristics in 194 countries (Backman et al. 2008). Because these indicators are too many to be covered by this report, priority has been given to 33 indicators. The chosen indicators relate to recognizing health as a right, planning and community participation, access to information, non-discrimination, spending, budgets and debt, health and pharmaceutical services, and health workers.

LEGAL FRAMEWORK AND HEALTH POLICIES

The legal framework for the right to health in Iraq is inscribed in the Iraqi constitution, which guarantees social security and health services in the chapter on rights.

According to **Article 30** of the Constitution:

First

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 housing.

Second

The State shall guarantee social and health security to Iraqis in cases of old age, sickness, employment disability, homelessness, orphanhood, or unemployment.

Article 31 continues:

First

Every citizen has the right to health care. The state shall maintain public health and provide the means of prevention and treatment by building different types of hospitals and health institutions.

Article 33 guarantees every individual the right to live in safe environmental conditions.

Although these articles suggest that the constitution sees health as a right, they limit health to insurance and services (by reflecting on the wording used by the Arabic version of the constitution). Furthermore, there is a big difference between the provisions set forth by these articles and the actual situation.

In addition to the constitution, several laws govern health affairs, including the amended Public Health Law No. 89 of 1981, the Ministry of Health Law No. 10 of 1983, the Law of Apprenticeship of Medical and Health Professions No. 6 of 2000, and the Health Insurance Law No. 22 of 2020. However, while the first three laws are in force, the health insurance law is still suspended due to the failure to approve the federal budget since 2021, as confirmed by the Minister of Health in April 2022 (الملا 2022). In some areas, the Iraqi Ministry of Health recently launched the health insurance registration form as a trial phase.

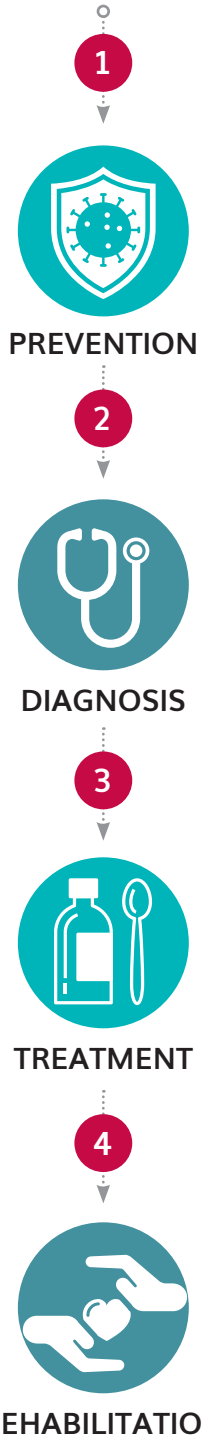
As for the health-specialized bodies, the Parliamentary Health and Environment Committee is a permanent committee in the Iraqi parliament. It is concerned with reviewing health policies, caring for medical and health staff, and protecting the environment. Nevertheless, it is not usually considered an essential committee in the parliamentary quota system, like the Finance Committee, the Integrity Committee, and the Legal Committee.

The Supreme Committee for Health and National Safety in the General Secretariat of the Council of Ministers was established in response to the COVID-19 pandemic. Its work was limited to organizing public life during the pandemic and providing vaccines. It lacked a clear plan to improve the infrastructure necessary to deal with the pandemic (الألوسي 2021).

In addition to the above, Iraq approved a national health policy for 2014 to 2023 at the beginning of 2014. It was mainly developed by the Iraqi Ministry of Health, the Parliamentary Health and Environment Committee, the WHO, government agencies, and some trade unions. There is also a reference to USAID's participation. However, neither Iraqi civil society nor local communities were involved in its formulation.

The national health policy referred to the link with sustainable development goals (SDGs) in its introduction. Nevertheless, while the first principle guiding the policy indicates that "health is a guaranteed right for every human being," the phrase immediately defines this right as obtaining health care only. It also defines the "human being" exclusively as an Iraqi individual: "Access to healthcare is one of the rights of Iraqi

THE NATIONAL HEALTH POLICY



individuals" (وزارة الصحة 2014) and does not include non-Iraqis. On the other hand, it failed to mention IDPs completely, perhaps because it was prepared and launched when the displacement crisis was not yet apparent. There are no signs of work to prepare a new policy, noting that the current policy's implementation period ends this year.

The policy also emphasized the equal provision of health services. However, although it mentioned a few forms of discrimination, such as socioeconomic status, origin, sex, and geographical location, it did not include discrimination based on gender, sexual orientation, religion, disability, age, or skin color. The policy was built on the assumption that the public health sector would remain the primary healthcare provider and be developed on that basis. This is translated on the ground that the state subsidizes public health services at a fraction of the cost in the private sector. However, the current neoliberal policies transfer health services from the public to the private sector contradict the health policy. The Iraqi state also opened private departments in most public hospitals and specialized centers that operate at prices similar to the private sector, but their revenues go to the state.

Although the policy covers reproductive health, it links it to children and mothers only. Moreover, it neglects the term sexual health, possibly due to social considerations. Policy-makers also linked mental health with combating addiction, confusing the matter and causing more social stigma towards people with psychological problems. In all cases, neither mental health patients nor addicts can access basic rehabilitation services in Iraq.

The national health policy also clearly includes comprehensive care and the three stages of primary, secondary, and tertiary health care: prevention, diagnosis, treatment, and rehabilitation. The author's practical experience in Iraqi health institutions shows that there are programs specialized in prevention, such as vaccination and awareness campaigns, and periodic examinations for children and pregnant women, for example, with follow-up and documentation records. However, these programs are applied inefficiently, and their documentation is inaccurate. In addition, health teams often fake the data that requires time and routine work. For example, the students' lists get falsely filled without conducting examinations or after examining only a few primary school students. Thus, many children are deprived of treatment and preventive health services, negatively affecting their future health.

SPENDING, FINANCE, AND BUDGETS

Iraq's annual budgets are often delayed due to the sectarian and partisan quota policy in the parliament. It has become a political norm that the budget is not approved when there is a disagreement between the political parties that control the parliament. Therefore, the last approved budget was in 2021. The 2020 and 2022 budgets have not been approved as of the writing of this report. The government resigned at the end of 2019 after the October demonstrations in the same year. A new government was formed, and early elections were set. However, political tension followed the COVID-19 pandemic in 2020 and the failure to form a new government after the October 2021 elections.

Political forces tried to compensate for the absence of a budget. They approved Law No. 2 of 2022 for Emergency Support for Food Security and Development after the start of the Russian-Ukrainian war, especially with the rise in global oil prices and the increase in the Iraqi Central Bank's dollar reserves (البنك المركزي العراقي 2022). However, since the Ministry of Health and Environment is not accorded a "sovereign" status[1], it is not considered a priority when forming the government using the partisan quota method, unlike the Ministries of Interior, Defense, Finance, Oil, and Electricity that have high budgets.

According to the World Bank, the share of the Ministry of Health and Environment was 2.47% of the total 2019 budget. Government spending on health in the same year represented 4.7% of total government spending and 4.5% of the GDP, which amounted to $222.4 billion (The World Bank 2022b). The Ministry's share in 2021 was 2.11%. However, it is unclear whether this spending responds to the population's health needs, as it mostly goes to operating expenses such as the salaries of about 116,000 employees.

Despite the pressure on health services and infrastructure due to the COVID-19 crisis, the Ministry of Health and Environment's allocations decreased between 2019 and 2021. The decline is equivalent to roughly 880 million USD, considering the increase in the exchange rate between the USD and IQD, despite an additional 16 thousand new employees. Thus, the 2021 health budget could be considered operational only. According to the 2020 report, 98.2% of the Ministry of Health and Environment's spending was operational, i.e., salaries and supplies. Investment expenses amounted to a mere 1.8%, indicating the lack of strategic direction for the state to improve health services and

[1] Sovereignty Ministries is a term widely used by the government officials, political parties and media to refer to the 'important' ministries such as The Ministries of Interior, Defense, Finance, Oil, Electricity that take up most of the budget.

infrastructure. According to a report by the Minister of Health (العلوان 2019), improving the health infrastructure depends on investment expenditures.

Table 1. Government expenditure on health

Budget Year	No. Employees	Health Ministry Budget (1000 IQD)	Total Government Budget	Health Share of Total Budget	1000 IQD per US Dollar	Health Ministry Budget (USD)
2019	99,630	3,291,900,658	133,107,616,412	2.74%	1.200	2,743,250,548.33
2021	116,460	2,748,783,082	129,993,009,291	2.11%	1.475	1,863,581,750.51
Difference	16,830	- 543,117,576	- 3,114,607,121	- 0.36%	0.275	- 879,668,797.82

On the other hand, the security and military budget represents 18.14% of the 2019 budget, which points to the Iraqi government's neoliberal orientation in its spending, in line with the conditions of IMF and World Bank loans from 2015 when oil prices collapsed. In 2020, Iraq requested an additional IMF loan to mitigate the economic crisis and the collapse of oil prices during the COVID-19 pandemic. However, its request was rejected because it failed to implement its promises to reform the economic system, except for a small loan ($98 million) to provide COVID-19 vaccines (The World Bank 2022c).

The austerity budget in 2021 tried to bridge the financial deficit by borrowing from multiple parties. However, the decrease in the Ministry of Health and Environment's budget between 2019 and 2021 is about 543 billion IQD (about 368 million USD). The actual decrease is much more significant, considering the decline in the IQD's value against the USD dollar. It is closer to 880 million USD if both budgets are compared using the applicable USD/IQD exchange rates. This drop came despite having to respond to the COVID-19 crisis.

The high military spending during the war against ISIL from 2014 to 2018 coincided with the fall in global oil prices and its ramifications on Iraq's largest source of income. Almost 94% of Iraq's Gross Domestic Product (GDP) comes from oil.

It also coincided with the internal displacement of more than five million people (Warda and Shihab 2021). Consequently, the Abadi government adopted austerity measures, including reduced spending on the health sector and increased reliance on foreign NGOs, the UN, and other international agencies. For example, the Iraq Humanitarian Fund covers health, other essential services, and legal and financial assistance.

In 2019, spending on health was around 151 USD per person, of which 78.5% was out-of-pocket (WHO 2020, p. 14) due to the country's lack of health insurance systems. Programs offered by some hospitals and private companies are merely a form of pre-payment for health services before they are needed. Thus, the most significant burden in obtaining health services falls on individual citizens, meaning their ability to access these services depends on their economic status. Meanwhile, low-income people are left without adequate healthcare and rely on government health facilities alone.

HEALTH SERVICES AND ACCESS TO INFORMATION

Iraq's health policy and the Ministry of Health and Environment's directives aim to provide comprehensive health coverage. Iraq has 295 governmental and 155 private hospitals, at a rate of 1.2 beds per thousand people, providing secondary and tertiary health services. As for primary health care, 2,805 centers (وزارة الصحة والبيئة 2021) that provide regular care for children and pregnant women, including free vaccination, exist (وزارة الصحة والبيئة 2022). Moreover, in 2019, a special budget was allocated for purchasing medicines, independent of the Health Ministry's budget.

On the other hand, the public health insurance clinics that used to provide medications are generally inactive. They are remnants of the popular clinic system established during the economic blockade after the first Gulf War. After being incorporated into primary health care centers at a later stage, they became dispensaries for high blood pressure and diabetes medications.

Regarding access to health information, a unified electronic registration system for births, deaths, and civil status was established by National Card Law No.3 of 2016. Meanwhile, family primary health centers use a paper-based registration system for obtaining health services. Data on health services and communication between primary health centers and sector administrations in health departments are still mostly

paper-based and follow a system set by USAID. However, the information is also shared electronically between sectors, health departments, and the Ministry, which usually issues detailed annual statistics on the health services provided and the available infrastructure.

Nevertheless, data collection and codification contain many errors, either due to beneficiaries submitting inaccurate information or because the staff fills the fields in by default. Moreover, health centers and hospitals in several governorate health departments still depend on paper due to the staff's inability to use the electronic system. Therefore, the two systems are used in parallel. Although the periodic reports distribute data by region and gender, they do not include information related to economic, social, or educational status, for example.

HEALTH WORKERS

Health and medical professionals must work in the public sector for at least three years of medical apprenticeship, based on the fourth amendment to the instructions of the Health and Medical Professions Law No. 1 of 2020. They may not work in the private sector except outside working hours exclusively and only after completing the apprenticeship. However, although the syndicates regulate practice licenses, the work of those completing their apprenticeship in the private sector is widespread and unregulated (WHO 2020). Health service providers rarely adhere to this law.

Moreover, the law instructions include sending professionals to villages and remote and rural areas lacking specialized health services. However, many use their connections to transfer to city centers, leaving those areas without adequate health services.

Most employees of the Ministry are nursing and health personnel, while doctors, dentists, and pharmacists represent about 13%. Moreover, the total number of employees mentioned in the Ministry's 2021 statistical report is 259,269 (except for the Kurdistan region), while the budget states 116,451 employees. The difference could be related to contractual employees not being included in the budget. However, the statistical report does not explain the issue.

THE RIGHT TO HEALTH IN IRAQ: MAIN CHALLENGES

This section discusses three selected challenges and their impact on the right to health in Iraq today. It begins with environmental challenges related to climate change, such as water scarcity, heat waves, and dust storms. Then it moves to analyze the risks facing food security in Iraq. The third challenge concerns the impediments to accessing adequate health services and resulting inequalities.

THE ENVIRONMENT AND CLIMATE CHANGE

In just two months during spring 2022, more than 11 dust storms hit the country. Most were severe and disrupted daily life activities and air travel, leading local governments to announce holidays for three days. Thousands of people went to the hospitals with respiratory problems, especially those more vulnerable due to factors such as asthma and allergies. The air is usually saturated with dust outside storm days as well, especially in the central and southern governorates. According to the Ministry of Health and Environment, the past 20 years averaged between 243 and 272 dusty days annually. The number is expected to reach 300 days annually in the coming years (Miri 2022). The term “allergies” is popularly used to refer to a broad spectrum of respiratory diseases caused by these pollutants.

Dust storms result from high temperatures and drought, as the last two years have witnessed low rainfall rates. Creeping desertification is another factor. Think Hazard states Iraq ranks first in high heat and water scarcity risks. These environmental factors are beginning to have an impact on Iraqi communities. The International Organization for Migration (IOM Iraq 2022) recorded the displacement of more than 20,000 people from 10 out of 18 Iraqi governorates due to environmental degradation and climate change. Most of them migrated from the countryside to the city.

Moreover, water levels in the Tigris and Euphrates rivers have dropped due to Turkish dams and Iran changing the course of tributaries (Khalaf 2019; Price 2018). In 2018 and 2019, the scarcity of potable water, the wave of poisoning caused by water salinity, and poor health services were the primary factors that triggered the demonstrations in Basra (International Republican Institute 2020). Water pollution

places tremendous economic pressure on families to provide safe drinking water. Selling water treated with reverse osmosis technology has become a natural part of daily life in most governorates and has become a common profession in the informal private sector. Although 85.7% of Iraqis have access to drinking water services, the water is usually unsuitable for drinking (UNICEF 2019, p. 275-293).

Climate change and environmental problems are major causes of disease in Iraq including respiratory problems, sunstroke, food poisoning, and cholera. The latter is endemic to the country and its prevalence in the summer of 2022 was higher than in previous years. The Ministry of Health and Environment took several measures, including banning certain types of food in restaurants to prevent cholera spread.

Such problems reduce the efficiency of services, which already suffer from structural problems. The pressure on health services during dust storms and heat waves reduces their ability to accommodate routine cases. Heat waves also put pressure on the electricity grid due to higher energy loss during transmission and the increased need for cooling. Water scarcity reduces drinking water quality and increases the need for treatment facilities.

Consequently, families are forced to choose economically costly alternatives due to pressure on services. To compensate for the lack of electricity supply hours, Iraqis spend about four billion dollars annually on private generators (خليّة الطوارئ للإصلاح الاقتصادي 2020). Such expenditures extend to home reverse osmosis systems and filters, filtered or packaged water, and more efficient cooling devices in high-temperature conditions. As a result, lower-income families living in densely populated areas face unprecedented challenges that expose them to health risks. Moreover, since lower-income workers usually operate in open spaces and exert physical effort, such as in construction and agriculture, they are at a greater risk of direct environmental effects.

On the other hand, awareness of climate change's effects and dangers has grown recently. CSOs started focusing on the issue, encouraged by the change in donor policies. More recently, the government has started to pay more attention to climate change. It ratified the Paris Agreement in 2021 and launched the Ministry of Planning's work on a Green Paper to confront climate change (IOM 2022). However, government efforts in this regard remain very limited, without a clear impact, and rarely link climate change and pollution to health.

Pollution, especially in water and air, is a major environmental factor that negatively impacts health. For example, Iraq ranked ninth out of 117 countries in the IQAir (2022) index for the most air-polluted countries in 2021. In addition to dust, air pollution is also caused by private electricity generators, estimated at 4.5 million generators by the Iraqi Energy Institute, the 7,027,000 cars counted by the Ministry of Planning in 2020, oil wells, refining stations, and factories, most of which operate using archaic systems.

On the other hand, water pollutants include sewage waste dumped in rivers. For example, the sewage disposal site is located in Najaf on the Euphrates River, about a kilometer and a half before the water filtration plant, increasing the risk of drinking polluted water. Regarding factory waste, Shatt al-Arab, for example, recorded high levels of heavy metal pollution between December 2012 and January 2013, during which pollution is usually lower than in summer when the water level is low (Al-Hejuje, Hussain, & Al-Saad 2017).

FOOD SECURITY

Although Iraq's population increased by 66% from 2000 to 2019, domestic food production increased by only 40%. The urban population doubled in the same period due to migration from the countryside to the city (Fathallah 2020), especially among those searching for government jobs. Agriculture was left behind and has become economically insignificant due to outdated irrigation systems and scarce water. Agricultural land owners close to cities convert their land into residential areas and sell them illegally. Contrariwise, the government neglects the Ministry of Agriculture. It received only 0.32% of the 2021 budget spent on salaries and purchasing local crops without clear development plans.

Iraq is a net importer of essential food items and other food products. Thus, the Russian-Ukrainian war increased local prices, especially of oil and grains (WFP 2022), prompting the Iraqi parliament to pass the emergency support law for food security. However, the law compensated for the absent annual budget rather than supporting food security. The share the parliament allocated to the Ministries of Agriculture and Trade remained low.

The decline in agricultural production and increased food prices impose additional economic pressure on low-income people and vulnerable groups, especially those below the poverty line. They become exposed to the risks of malnutrition or spending

more on food, which prevents them from obtaining other services and meeting other essential needs. Moreover, food products are mainly imported from neighboring countries. The imports go through a corrupt customs process, spreading expired products. One of the priorities of the Al-Kazemi government was to fight customs corruption indicating its significance.

At the local level, public health departments in the governorates' health directorates are responsible for following up on food security. They monitor restaurants, cafes, and markets, issuing health licenses and conducting inspections. Local news often contains reports on destroying large quantities of expired food products.

ACCESS TO HEALTH SERVICES

The public and private sectors provide health services in Iraq. Services in the public sector are subsidized by the state, especially in primary and secondary care, where the cost does not exceed 3,000 IQD or about 1.6 USD. Emergency services are also covered (وزارة الصحة والبيئة 2022). All health workers are employed by the state, including doctors and nurses. In the private sector, most health workers work part-time in addition to their public sector jobs.

Private health services are considered expensive by Iraqi standards. The sector is divided into three sections: private units within hospitals and public centers, private hospitals and centers, and unorganized private clinics and pharmacies. In both sectors, the distribution of hospitals and health centers does not conform with population density. For example, New Baghdad, home to around one million people, has no hospital.

Access to quality health services depends on income since a high proportion of spending is out-of-pocket due to the lack of a proper health insurance system. Thus, public health services are limited to essential procedures, often of a lower quality than what can be obtained in the private sector. Ironically, private departments in government hospitals are usually cleaner and provide better services than the ones provided by the same hospital, mainly due to the additional financial incentives and fixed government salaries.

Consequently, vulnerable classes, those below the poverty line, those with limited incomes, and even the lower middle-income groups are highly dependent on public services. Simultaneously, higher income groups can obtain higher quality services from

the private sector. They can also travel to other countries such as Lebanon, Iran, India, Turkey, and Jordan for treatment, which is not usually reimbursed by the state.

Health providers have lost the trust of beneficiaries, who are deprived of their rights in the public sector and usually exploited by the private sector. Meanwhile, public health workers believe they are confined by routine, lack of funding, financial corruption, lack of space to grow, and fixed salaries regardless of the quality and quantity of services. The frustrating situation for beneficiaries and workers in the public sector has usually led to tensions and aggression. Health workers are subjected to daily attacks by unsatisfied beneficiaries. In fact, 22% of health workers in Iraq left the country between 2004 and 2007 due to violence and threats (Burnham, Riyadh, & Shannon 2009), which affected 80% of doctors in emergency units (Donaldson et al. 2012).

The absence of transferable medical records between the public and private sectors also hampers access to health. Health service providers often start from scratch with each patient, starting with the medical history and other information that relies entirely on the patient's memory, increasing the chance of inappropriate or repetitive interventions and, thus, failure. The private sector is also highly disorganized and lacks structured communication channels between its providers.

In addition to the above, women and girls are often deprived of access to adequate health services due to prevailing gender and social norms. For example, married rural women and those from religious families often consult gynecologists for all health matters to avoid going to a male doctor. Moreover, despite improving women's access to health services overall, the gap between rural and urban areas has increased dramatically (Abdulrahim & Bousmah 2019), mainly due to patriarchal gender norms. For example, hospitals often deny women of surgical procedures without the consent of a male family member, fearing tribal retribution. Furthermore, some medical specialties, such as surgery and orthopedics, are male-dominated, thus preventing some women from accessing their services.

Domestic violence is also a major challenge in the absence of a law protecting victims of abuse. Husbands sometimes prohibit their wives from leaving the house to receive medical care or refuse to give them the documents needed to obtain a health card. The author of this report encountered such cases repeatedly in primary health care centers in crowded

areas. However, health staff are not sensitized on the issue and cannot rely on legal procedures or referral systems. Many cases of domestic violence have been condoned or mocked in such centers. The term "hysteria" is also still widespread in emergency units. Despite being eliminated from medical textbooks and practices long ago, emergency health workers use it as a preliminary diagnosis until an alternative is proven, leading to fatal medical errors.

Finally, challenges related to access to mental health services are the most severe in the absence of adequate infrastructure and personnel. According to the WHO (2019), there are less than two mental health professionals for every 100,000 Iraqis. The situation is made worse by the social stigma preventing people from seeking services. However, two types of services are provided. The first is psychosocial support, where NGOs provide relatively good services. The other option is psychiatry and medication.

CONCLUSIONS AND RECOMMENDATIONS

The availability and quality of health services in Iraq suffered greatly due to the violent conflicts and many wars it witnessed, hindering the ability to achieve the right to health for all. The period after the Second Gulf War and the ensuing international sanctions dealt a harsh blow to the health of Iraqis. The country is still reeling under the wars' impacts, such as the destruction and deterioration of infrastructure, the culture of aggression between beneficiaries and healthcare providers, and the rampant administrative and financial corruption in state institutions and the private sector. As a result, right-to-health indicators recorded low values. The rentier nature of the state's economy also established a harmful dependence on state provisions, which barely cover the operating expenses of inadequate facilities.

Structural problems persist, such as the absence of a unified and digitized medical and health records system, the lack of integration between public and private sector services, the largely unorganized private sector, and the lack of an efficient health insurance system. The impact on vulnerable groups is severe. In parallel, environmental challenges are multiplying. Unless the government prioritizes it, Iraq is expected to be one of the countries most severely impacted by climate change.

Following are some recommendations to address the challenges discussed above:

To state institutions:

- Prioritize the Health Insurance Law No. 22 of 2020 implementation in relevant state entities, especially the Ministry of Health and Environment, to provide fair access to health services in the public and private sectors.
- Establish a unified, electronic medical record system for individuals that can be transferred, updated, and shared. This could increase the integration of health and medical services between the public and private sectors.
- Increase attention to health issues with social stigma, primarily mental and psychological health, and domestic violence in health and education plans and through government spending.

- Develop urgent plans to deal with climate change and pollution threats and intervene immediately due to the enormous impact on human health and security.
- Provide greater flexibility for health workers to move between the private and public sectors to improve health services; and activate and modernize continuing medical education systems.
- Understand and address the barriers that prevent women and girls, especially in rural and slum areas, from accessing health services. This should be combined with analyzing the economic, social, environmental, and cultural factors that threaten their right to health.

To civil society organizations and unions:

- Intensify advocacy efforts with the relevant state entities and hold them accountable to provide the right to health for all. This includes the urgent implementation of the health insurance system, focusing on mental and psychological health, addressing the dangers of climate change, and developing laws and procedures to guarantee the right to health for individuals and groups beyond health services and without discrimination.
- Advocate for adopting a Domestic Violence Law and referral systems that may contribute to saving victims, women and children in particular, and protect health service providers who report such cases.
- Advocate with international bodies to pressure the Iraqi government to address the priorities above and provide the necessary funding for issues related to the right to health, in line with the SDGs.
- Contribute to spreading the culture of the right to health, preserving the environment, and dealing with the dangers of climate change at the community level.
- Facilitate mechanisms for joint action between the government, civil society, and local communities on challenges to the right to health, and set indicators to measure progress and produce periodic reports.
- Provide non-traditional methods of mediation between health sector workers and beneficiaries to address the aggressive interactions by promoting peaceful alternatives and such as communication skills.

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