The ghost of Saddam and UN sanctions

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Events in the past 10–15 years have meant that Iraq’s once highly sophisticated health-care system has fallen to rack and ruin. To fight the very low morale, Iraqi people are making use of many approaches, some of which are unconventional, such as circus entertainment to raise spirits in paediatric wards. This Reportage looks at the events that have lead to the current health-care crisis in Iraq through the eyes of those living and working there. It is based on interviews done by Jo Wilding, an independent humanitarian activist and writer working on various grassroots rehabilitation and solidarity projects in Iraq, in Al Mansour teaching hospital, Shahid Adnan hospital, the centre for Nuclear Medicine, and the Ministry of Health in Baghdad.

Salma Al-Hadad heads the Paediatric Oncology Unit at Al-Mansour Teaching Hospital in Baghdad. In her 25 years as a doctor, she has lived through a vicious dictatorship, one of the most punitive sanctions regimes ever imposed by the United Nations, and three major wars. She now describes Iraq’s health system as “collapsing”, and summarises her unit’s needs, starkly, as “everything”. Every day, she faces the heartbreaking task of distributing the few resources she has access to between the children in her care. “I try to treat all the children equally, even those who are beyond my help”, she says. “But sometimes doctors here have to be judges, not doctors”.

Yet Al-Hadad and her colleagues are working in the wreck of a system that had, in the mid-to-late 20th century, made large strides in treating cancer. Even as late as 1990, after the Iran–Iraq war, Iraq had one of the most sophisticated health-care systems in the Middle East. It was the UN sanctions, and the Ba’athist regime’s twisted sense of priorities, that first trapped hospitals in a time warp. “We have only two 20-year-old cobalt 60 machines working, and no linear accelerators”, explains Mahdi Al-Surej, assistant chief of the Centre for Nuclear Medicine in Baghdad. This is one of only two radiotherapy centres in the whole country (which has a population of 25 million); both adults and children from all parts of Iraq are referred there. Doctors and technical staff have found it almost impossible to keep even these machines in service during the sanctions, because of import restrictions, difficulties with equipment manufacturers, and bureaucracy. “We now have a 2–3 month waiting list for radiotherapy, even for brain tumours”, says Al-Surej.

Historically, drugs of all kinds were imported into Iraq by Kimadia, a state-owned monopoly. After the 1991 Gulf war, importation of chemotherapy drugs, particularly cytotoxic agents, almost stopped. Doctors initially managed with the stores they had built up, but these lasted no more than 3 years. After the Oil-for-Food Programme was introduced in 1998 the position improved a little, but the supply was still very erratic. No matter how severe the shortages were, Kimadia had a policy of keeping a “strategic reserve” of 25% of the imported drugs, for emergencies. “The reserve could also have been used to give to people in the government”, speculates Al-Hadad. Furthermore, imported drugs were also subjected to time-consuming tests, supposedly for quality control. “We were not allowed to use the drugs unless they had been tested…sometimes we waited a long time to get the result, or the result never arrived. Many drugs expired before we could use them, in spite of our very great need for them”, says Al-Hadad. Not surprisingly, mortality from many types of treatable cancers increased. “It was only those families who could afford to bring chemotherapy drugs in from neighbouring countries, such as Jordan, Syria, Turkey, and Iran, whose children could be cured”, she adds. "Many people sold all their assets to pay for this chemotherapy.” Most of the Iraqi population, however, cannot afford even this.

The supply of drugs is one of the few aspects of Iraqi medicine that has improved since the fall of Saddam Hussein’s regime. Shortages in drugs supplied through the Ministry of Health are being alleviated with the help of international non-governmental organisations, such as the Red Cross and the Middle Eastern Church Council. Iraqi doctors recognise that this must only be a response to an emergency, rather than a long-term solution. The US-led transitional authority is, predictably, attempting to deal with the problem by privatising Kimadia. Although the old system was at best inefficient and at worst corrupt, there is much controversy about whether privatisation can be made
to work. Whether it can or not, it is no solution for the medium term. “We need foreign companies to bring their representatives to the Ministry of Health to get authority to supply drugs”, says Al-Surej.

Most doctors in Iraq have little leisure to ponder complexities like the reform of the drug distribution system. Talaat Harb Al-Mukhtar, a young doctor at the Baghdad Medical Complex—the only hospital to continue functioning throughout the last war—spent that war living and working in the hospital, and thinks that little has changed since. “We have no nursing staff. I work as a surgeon, a scrub nurse, and a cleaner”, he says. The chaos that the war and the overthrow of Saddam Hussein left behind has not made life any easier for doctors, and although salaries have risen substantially, they have not kept up with the cost of basic goods.

It is, however, unfair to place all the blame on the occupation, the war, or the sanctions for deficiencies in nursing care in Iraq. Nursing has been historically undervalued as a profession there. Rasmiey Abd Al Sala, a nurse of 32 years’ experience, most recently in Al-Hadad’s paediatric oncology unit, explains how nurses are trained. “We spend 3 years in nursing school, but that is the equivalent of high school, so most nurses begin work at only 15 or 16 years old. There is no possibility of specialist training in, for example, cancer nursing.” Graduates of the only nursing college in Iraq all leave the country after their training for higher paid and higher status jobs in nearby countries. Al Sala’s descriptions of conditions in the oncology unit echo those of Al-Mukhtar, working in general medicine. “There is only one cleaner for the unit…she has to do the windows, the toilets, everything. There isn’t anyone to make sure the cleaning is done properly. The patients’ families do the cleaning on the wards.” When asked what her greatest need was, she answered, simply, “A manager”.

When Iraqi oncologists were asked the same question, the single issue that was raised most often—by postgraduate students and by Professor Hadi Khalili, Vice Chair of the Iraqi Cancer Board—was that of training. Iraq has been almost completely isolated from the international community for more than a decade; medical journals and even textbooks were unavailable, and there were no opportunities for doctors to travel abroad. Many doctors, even senior ones, have only diplomas, and they want to do master’s degrees and doctorates.

Oncologists across Iraq report that they have seen large increases in the incidence of many types of cancer during the 1990s. Khalili reports that the biggest increases have been in the south of the country, and in breast, gastrointestinal and brain cancers, and leukaemia. Al-Hadad has seen an increase in the number of cases of many types of childhood cancer, but Al-Surej is more concerned about the changing nature of the tumours he treats. “Cancers which are normally seen in older patients, such as gastric and urinary cancers, are now more often seen in younger people.”

This mostly anecdotal evidence is backed up by statistics held in the Iraqi cancer registry, which was set up in 1974. This registry now uses the internationally recognised CanReg3 registration criteria and contributes to the International Agency for Research on Cancer’s Globocan database. Epidemiologists worked heroically to maintain this database through the darkest days of 2003. Dr Ahmed, an epidemiologist working with the cancer board, remembers, “We moved into the hospital in the first days after the war, when no-one else was working, and managed to save all our data. Everything was kept safe…and not destroyed by fire and looting.”

The cases recorded in the registry are bound to give an underestimate of Iraq’s cancer burden. Many cancer patients, particularly in rural regions and in the poorest communities, never reach a hospital and so their cases are not recorded in the registry. Al-Hadad cannot even be sure that the incidence of cancer is increasing in children. “This is a reference centre. I don’t know whether the increases I see reflect a real increase, or better awareness, or more referral”, she says. Furthermore, diagnosis cannot be as accurate as it is in the developed world. “We depend on morphological diagnosis…we don’t have the advanced technology for immunological or cytological diagnosis”, says Al-Hadad. An Iraqi patient suffering from any of 20 different lymphoma subtypes is normally just diagnosed with “lymphoma”.

The most pessimistic estimates for cancer incidence in Iraq over the next 20 years are truly frightening. Many Iraqi
oncologists have linked their experience of increasing cancer incidence in the population to exposure to depleted uranium. UN studies, however, have so far produced ambiguous results—results compounded by the fact that the effects of depleted uranium can take up to 25 years to manifest biologically. Nevertheless, the small increase in cancer incidence in the north of the country, where these munitions were not used, might ultimately prove significant.

On October 28, 2003, The Lancet published a special report on medicine in Iraq 6 months after the fall of Saddam Hussein. It ended, “The time for rebuilding Iraq and the equitable provision of health care is long overdue. The international community must commit itself now to the security and health of all Iraq’s people—before it is too late.” Iraqi oncologists are certainly in desperate need of support from their colleagues throughout the world. Maybe their most important need is simply to restore links damaged by decades of dictatorship, sanctions, and war. Yet these links are still there, and small but important steps are being taken.

Al-Hadad was one of five paediatricians who recently spent a month visiting colleagues in the UK for clinical observation. The visit was coordinated by the Royal College of Paediatrics and Child Health. She is now promoting a scheme to “twin” hospitals, and medical schools, in Iraq with counterparts in western countries (see News in Brief, page 142). Since medical education in Iraq is based on the British model, they are focusing on the UK. “We are hoping that, through twinning schemes, UK doctors will be able to come to Iraq and Iraqi doctors to visit the UK and learn from the foremost experts there”.

Khalili is more direct in his invitation to western doctors. “Visit Iraq and see with your own eyes what we are facing”, he says.