

IRAQI HOSPITALS AILING UNDER OCCUPATION

Dahr Jamail



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I. INTRODUCTION

II. THE STUDY

III. SUMMARY OF FINDINGS

IV. CASE STUDIES

A. Equipment and Medicine Shortages

B. US Military Interfering With Medical Care

C. Lack of Water and Electricity Affecting Medical Care

V. CORRUPTION AND CRIME

VI. BRAIN DRAIN

VII. RECONSTRUCTION CONTRACT WORK IN LIMBO

VIII. CONCLUSIONS

**IX. SECTIONS OF GENEVA CONVENTIONS I, III AND IV OF 1949,
RELEVANT TO HEALTH RIGHTS AND HEALTH CARE**

I. INTRODUCTION

Although the Iraq Ministry of Health claims its independence and has received promises of over \$1 billion of US funding, hospitals in Iraq continue to face ongoing medicine, equipment, and staffing shortages under the US-led occupation.

During the 1990s, medical supplies and equipment were constantly in short supply because of the sanctions against Iraq. And while war and occupation have brought promises of relief, hospitals have had little chance to recover and re-supply: the occupation, since its inception, has closely resembled a low-grade war, and the allocation of resources by occupation authorities has reflected this reality. Thus, throughout Baghdad there are ongoing shortages of medicine of even the most basic items such as analgesics, antibiotics, anesthetics, and insulin. Surgical items are running out, as well as basic supplies like rubber gloves, gauze, and medical tape.

In April 2004, an International Committee for the Red Cross (ICRC) report stated that hospitals in Iraq are overwhelmed with new patients, short of medicine and supplies and lack both adequate electricity and water, with ongoing bloodshed stretching the hospitals' already meager resources to the limit.¹

Ample testimony from medical practitioners in the interim in fact confirms this crisis. A general practitioner at the prosthetics workshop at Al-Kena Hospital in Baghdad, Dr. Thamiz Aziz Abul Rahman, said, "Eleven months ago we submitted an emergency order for prosthetic materials to the Ministry of Health, and still we have nothing," said Dr. Rahman. After a pause he added, "This is worse than even during the sanctions."²

Dr. Qasim al-Nuwesri, the chief manager at Chuwader General Hospital, one of two hospitals in the sprawling slum area of Sadr City, Baghdad, an area of nearly 2 million people, added that there, too, was a shortage of most supplies and, most critically, of ambulances. But for his hospital, the lack of potable water was the major problem. "Of course we have typhoid, cholera, kidney stones...but we now even have the very rare Hepatitis Type-E...and it has become common in our area," said al-Nuwesri, while adding that they never faced these problems prior to the invasion of 2003.³

Chuwader hospital needs at least 2000 liters of water per day to function with basic sterilization practices. According to Dr. al-Nuwesri, they received 15% of this amount. "The rest of the water is contaminated and

¹ Naomi Koppel, "Red Cross Says Iraq Hospitals Overwhelmed," Associated Press, April 9, 2004.

² Dahr Jamail, interview with Dr. Thamiz Aziz Abul Rahman at Al Kena Hospital, April 28, 2004.

³ Dahr Jamail, interview with Dr. Qasim al-Nuwesri at Chuwader General Hospital, June 14, 2004.

causing problems, as are the electricity cuts,” added al-Nuwesri, “Without electricity our instruments in the operating room cannot work and we have no pumps to bring us water.”⁴

In November, shortly after razing Nazzal Emergency Hospital to the ground,⁵ US forces entered Fallujah General Hospital, the city’s only healthcare facility for trauma victims, detaining employees and patients alike.⁶ According to medics on the scene, water and electricity were “cut off,” ambulances confiscated, and surgeons, without exception, kept out of the besieged city.⁷

Many doctors in Iraq believe that, more widely, the lack of assistance, if not outright hostility, by the US military, coupled with the lack of rebuilding and reconstruction by foreign contractors has compounded the problems they are facing.

According to *Agence France-Presse*, the former ambassador of Iraq Paul Bremer admitted that the US led coalition spending on the Iraqi Health system was inadequate. “It’s not nearly enough to cover the needs in the healthcare field,” said Bremer when referring to the amount of money the coalition was spending for the healthcare system in occupied Iraq.⁸

When asked if his hospital had received assistance from the US military or reconstruction contractors, Dr. Sarmad Raheem, the administrator of chief doctors at Al-Kerkh Hospital in Baghdad said, “Never ever. Some soldiers came here five months ago and asked what we needed. We told them and they never brought us one single needle... We heard that some people from the CPA came here, but they never did anything for us.”⁹

At Fallujah General Hospital, Dr. Mohammed¹⁰said there has been virtually no assistance from foreign contractors, and of the US military he commented, “They send only bombs, not medicine.”¹¹

International aid has been in short supply due primarily to the horrendous security situation in Iraq After the UN headquarters was bombed in Baghdad in August 2003, killing 20 people, aid agencies and non-governmental organizations either reduced their staffing or pulled out entirely.

Dr. Amer Al Khuzaie, the Deputy Minister of Health of Iraq, blamed the medicine and equipment shortages on the US-led Coalition’s failure to provide funds requested by the Ministry of Health.¹²

⁴ Ibid.

⁵ BBC News, “US strikes raze Fallujah hospital,” November 6, 2004.

⁶ Richard A. Opiel Jr., *New York Times*, “Early Target of Offensive Is a Hospital,” November 8, 2004.

⁷ Fares Dulaimi, *Agence France-Presse*, “Doctors, medical supplies scarce in Fallujah as major assault begins,” November 8, 2004.

⁸ “Bremer Admits Coalition Spending on Iraq Health Grossly Inadequate,” *Agence France Press*, February 15, 2004.

⁹ Dahr Jamail, interview with Dr. Sarmad Raheem at Al-Kerkh Hospital, June 19, 2004.

¹⁰ This doctor also asked that only his first name be used, due to his fear of military reprisals.

¹¹ Dahr Jamail, interview with Dr. Mohammed at Fallujah General Hospital, May 10, 2004.

“We have requested over \$500 million for equipment and only have \$300 million of this amount promised,” he said, “Yet we still only have promises.”¹³

According to *The New York Times*, “of the \$18.4 billion Congress approved last fall, only about \$600 million has actually been paid out. Billions more have been designated for giant projects still in the planning stage. Part of the blame rests with the Pentagon's planning failures and the occupation authority's reluctance to consult qualified Iraqis. Instead, the administration brought in American defense contractors who had little clue about what was most urgently needed or how to handle the unfamiliar and highly insecure climate.”¹⁴

The World Health Organization (WHO) last year warned of a health emergency in Baghdad, as well as throughout Iraq if current conditions persist. But despite claims from the Ministry of Health of more drugs, better equipment, and generalized improvement, doctors on the ground still see “no such improvement.”¹⁵

II. THE STUDY

¹² Dahr Jamail, interview with Dr. Amer Al Khuzai at Ministry of Health, June 24, 2004.

¹³ Ibid.

¹⁴ “The Iraq Reconstruction Fiasco,” *The New York Times*, August 9, 2004.

¹⁵ Matthew Price, “Hospitals Endure Iraqi Paralysis,” BBC News, March 17, 2005.

From April, 2004 through January, 2005, the author and his colleague surveyed 13 hospitals in Iraq in order to research how the healthcare system was faring under the US-led occupation. While the horrendous security situation in Iraq caused the researchers to confine the survey to hospitals primarily in Baghdad, hospitals west, north, and south of the capital are included in this report.

Hospitals surveyed:

Al-Karama Hospital, Sheikh Marouf, Baghdad

Falluja General Hospital

Saqlawiya Hospital

Amiriat Al-Fallujah Hospital

Balad General Hospital

Alexandria Hospital, Babylon Province (just south of Baghdad)

Al-Kena Hospital, Baghdad (Prosthetics/Rehabilitation)

Yarmouk Hospital, Baghdad

Baghdad Teaching Hospital (Baghdad Medical City)

Chuwader Hospital, Sadr City, Baghdad

Al-Noman Hospital, Al-Adhamiya, Baghdad

Al-Kerkh General Hospital, Baghdad

Arabic Children's Hospital, Baghdad

III. SUMMARY OF FINDINGS

Early in 2004, prior to this report, Dr. Geert Van Moorter, a Belgian M.D., conducted a fact-finding mission to Iraq where he surveyed hospitals, clinics, and pharmacies. Van Moorter concluded: “Nowhere had any new medical material arrived since the end of the war. The medical material, already outdated, broken down or malfunctioning after twelve years of embargo, had further deteriorated over the past year.”¹⁶

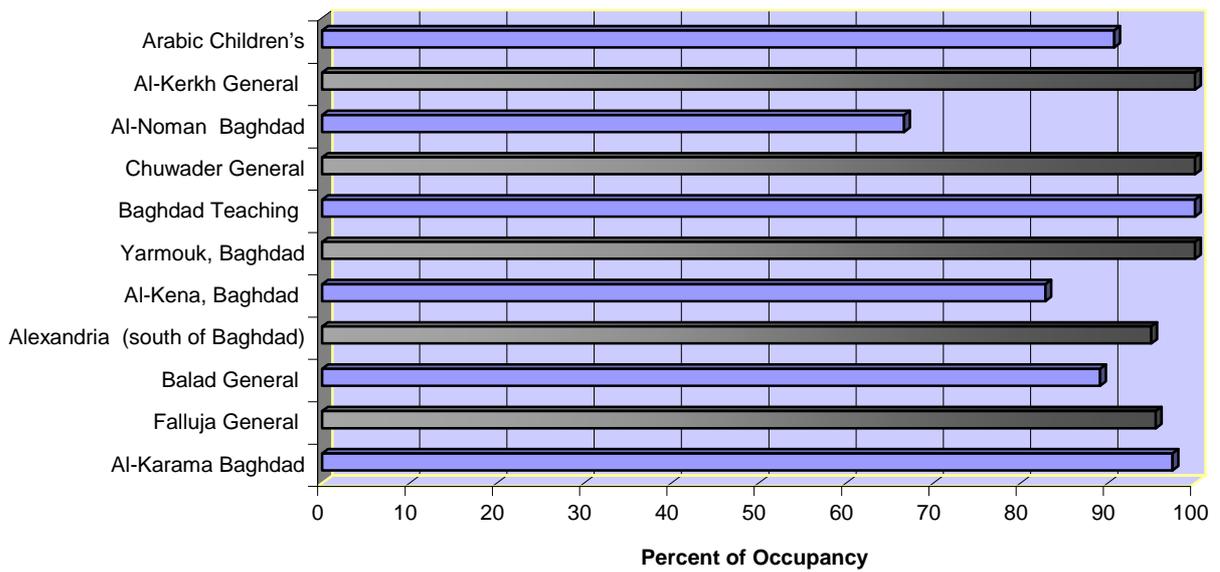
Findings in this report suggest that Dr. Van Moorter’s statement remains true today, albeit with the continued deterioration of equipment, supplies, and staffing, further complicated by an astronomical increase in patients due to the violent nature of the occupation of Iraq. This report documents the desperate supply shortages facing hospitals, the disastrous effect that the lack of basic services like water and electricity have on hospitals and the disruption of medical services at Iraqi hospitals by US military forces.

This report further provides an overview of the situation afflicting the hospitals in Iraq in order to highlight the desperate need for the promised “rehabilitation” of the medical system. Case studies highlight several of the findings and demonstrate that Iraqis need to reconstruct and rehabilitate the healthcare system. Reconstruction efforts by US firms have patently failed, while Iraqi contractors are not allowed to do the work.

The current model in Iraq of a “free trade globalized system,” limited in fact to American and a few other western contractors, has plainly not worked. Continuing to impose this flawed and failing system on Iraq will only worsen the current healthcare crisis.

¹⁶ Dr. Greet Van Moorter, M.D., “One year after the fall of Baghdad: how healthy is Iraq?”, Medical Aid for the Third World, April 28, 2004

Iraqi Hospital Occupancy Rates



Compounding the problems due to a lack of equipment and medicine in Iraqi hospitals, occupancy rates at all but one of the hospitals surveyed was between 80-100% because of heavy fighting, car bombs, and an exceedingly high crime rate in occupied Iraq.¹⁷

¹⁷ Saqlawiya and Amiriya Al-Fallujah Hospitals were not used in this graph as time constraints at each hospital prevented collection of this data.

Hospital	X-Ray	Ventilator	Ambulances	Pharmaceuticals	Lab Supplies	US Military Incursions
Al-Karama Baghdad	Have 6 Working..... 2 Total Needed ..6	Have 10 Working..... 4 Total Needed ..10	Have 4 Working..... 2 Total Needed .. 5	Supply Sporadic	Supply Sporadic	Sporadic
Fallujah General	Have 5 Working..... 2 Total Needed .. 7	Have 8 Working..... 3 Total Needed .. 8	Have 5 Working..... 2 Total Needed .. 6	Supply Sporadic	Supply Sporadic	Sporadic
Balad General	Have 3 Working..... 1 Total Needed .. 4	Have 5 Working.....2 Total Needed .. 5	Have 3 Working.....1 Total Needed ..3	Supply Sporadic	Supply Sporadic	Sporadic
Alexandria (south of Baghdad)	Have 3 Working..... 1 Total Needed .. 3	Have 3 Working..... 1 Total Needed .. 3	Have 4 Working..... 1 Total Needed .. 4	Supply Sporadic	Supply Sporadic	Sporadic
Al-Kena, Baghdad	Have 2 Working..... 1 Total Needed .. 4	Have 4 Working..... 2 Total Needed .. 4	Have 2 Working..... 1 Total Needed ..3	Supply Sporadic	Supply Sporadic	None
Yarmouk, Baghdad	Have 4 Working..... 3 Total Needed. 5	Have 28 Working..... 16 Total Needed...28	Have 6 Working..... 4 Total Needed... 6	Supply Sporadic	Supply Sporadic	Frequent
Baghdad Teaching	Have 7 Working..... 4 Total Needed.. 4	Have 20 Working..... ..20 Total Needed...0	Have 4 Working..... 4 Total Needed ... 6	Supply Sporadic	Supply Sporadic	None
Chuwader General	Have 13 Working..... 6 Total Needed .. 13	Have14 Working..... 7 Total Needed ..12	Have 5 Working..... 3 Total Needed .. 10	Supply Sporadic	Supply Sporadic	Frequent
Al-Noman Baghdad	Have 2 Working..... 1 Total Needed .. 3	Have 5 Working..... 3 Total Needed .. 6	Have 2 Working..... 1 Total Needed .. .3	Supply Sporadic	Supply Sporadic	Frequent
Al-Kerkh General	Have 6 Working..... 5 Total Needed... 5	Have 9 Working..... 3 Total Needed.. 9	Have 5 Working..... 2 Total Needed...5	Supply Sporadic	Supply Sporadic	Sporadic
Arabic Children's	Have 3 Working..... 1 Total Needed .. 5	Have 6 Working..... 3 Total Needed .. 8	Have 3 Working..... 3 Total Needed .. 0	Supply Sporadic	Supply Sporadic	None

White indicates critical needs, i.e., an area with an unsustainable level of operation, yellow demarcates a difficult level of operation that needs immediate attention, and green indicates an area in which a hospital is operating sufficiently and does not need assistance.¹⁸

¹⁸ Saqlawiya and Amiriya Al-Fallujah Hospitals were not used in this graph as time constraints at each hospital prevented collection of this data.

IV. CASE STUDIES

Highlighting some of the critical areas of need in the hospitals surveyed, the case studies focus on the following areas:

A. Shortage of Equipment and Medicine

In Baghdad, Al-Kena Hospital also serves as a prosthetics workshop and is the only facility that provides rehabilitation services for persons with disabilities in the entire country. It provides one example of how the US-funded Ministry of Health is abjectly failing to provide Iraqi hospitals with equipment, medicine, and funding.

A General Practitioner at the prosthetics workshop, Dr. Thamiz Aziz Abul Rahman, said they even lack the necessary machinery needed to make artificial prostheses. “We are using antiquated machinery from the 1970s which is missing parts,” he said while pointing to broken machinery in the dusty workshop.¹⁹ While holding a leg brace in need of repair, Dr. Rahman noted: “In addition to this, the lack of adequate funding means we are unable to treat more patients who need prostheses, as well as [having] a very long waiting list for people who need our care.”²⁰



Dr. Thamiz Aziz Abul Rahman, a General Practitioner at Al-Kena Rehabilitation Hospital in Baghdad. Al-Kena is the only hospital in Iraq that makes prosthetics and provides rehabilitation services. The hospital is critically under-funded and undersupplied.

¹⁹ Dahr Jamail, interview of Dr. Thamiz Aziz Abul Rahman at Al-Kena Hospital, April 28, 2004.

²⁰ Ibid.

Dr. Ahmed Kassen, a specialist in rheumatology at the hospital and supervisor of the workshop, said most of the materials used by the workshop for prostheses are imported from France and Germany. In a situation resembling that in other hospitals around the country today, Dr. Kassen added: “This takes time and we must await the shipments. They are also delayed by the security situation and delays at the Ministry of Health for approvals of these materials.”²¹

The prosthetics workshop has only one wheelchair to transport patients in and out of the clinic, and there is not enough funding to hire wheelchair assistants or purchase more wheelchairs. Thus, simply to reach the clinic, patients must bring friends or family members.

The clinic also received broken promises made by coalition authorities. After the invasion of Iraq, US personnel from the Ministry of Health came to the workshop to find out what supplies were needed. Dr. Kassen said he provided both a catalogue and a computer disk of the materials the workshop needed but never heard from the officials again. “The Americans who came here didn't even know what a clinic like this was for,” he exclaimed. “Of course we got no assistance.”²² Both he and Dr. Rahman said that the workshop had yet to receive any new materials from the Ministry of Health since the 2003 US-led invasion of Iraq.



Reasonable accommodation? A broken wheelchair at Al-Kena physical rehabilitation hospital. Most patients with mobility impairments have no access to the services at Al-Kena because there are not enough wheelchairs.

²¹ Dahr Jamail, interview of Dr. Ahmed Kassen at Al-Kena Hospital, April 28, 2004.

²² Dahr Jamail, interview of Dr. Ahmed Kassen at Al-Kena Hospital, April 28, 2004.

The workshop lacks even the most basic materials necessary for constructing prosthetics, such as leather, pins, metal bars and joints. Reliant upon the Ministry of Health for these supplies that are not forthcoming, hospital personnel are forced to obtain from the market what they can afford with their meager funds. “We don't have enough money, and barely enough of the most simple supplies we need to treat amputees,” explained Dr. Rahman. “Of course we've had a dramatic increase in the number of amputees because of the invasion and now the occupation.”²³ While helping a small boy with a new back brace to counter the effects of scoliosis, Dr. Kassen added: “We lack locking joints for prosthetics. Most of the time we are unable to serve smaller children and geriatrics. And if one component from the prosthetics is missing, we cannot help the people.”²⁴



Scoliosis patient at Al-Kena Hospital being fitted with a back brace. The hospital usually lacks the parts necessary to serve its patients properly.

²³ Dahr Jamail, interview of Dr. Thamiz Aziz Abul Rahman at Al-Kena Hospital, April 28, 2004.

²⁴ Dahr Jamail, interview of Dr. Ahmed Kassen at Al-Kena Hospital, April 28, 2004.

Like nearly every hospital in Baghdad during the aftermath of the invasion, the hospital and workshop were looted heavily and have received neither funding nor supplies from the US-funded Ministry of Health for compensation.

At the Arabic Children's Hospital which treats young cancer patients in Baghdad, Dr. Waad Edan Louis, the Chief Visiting Doctor, said that before the war most of the cancer cases came from the south, but now the doctor says there are numerous cases from Baghdad as well and this has caused a great strain on their supplies and staff.²⁵ While the extent of this increase in cancer rates are difficult to substantiate owing to inadequate disease surveillance or working cancer registries, this problem highlights the additional strain applied on the already struggling healthcare system overburdened by the costs of the invasion and military operations under the occupation.



Children in the cancer ward at the Arabic Children's Hospital in Baghdad oftentimes have to bring their own food since the hospital lacks the funding needed to offer meals.

Dr. Louis said the cancer rate jumped dramatically in the late 1990's, and his hospital alone is treating four new cases each week.

While the Pentagon admits to using over 300 tons of Depleted Uranium (DU) munitions on Iraq in the 1991 Gulf War, the actual figure is closer to 800 tons. Thus far in the current war there have been 200 tons of DU used in Baghdad alone, according to Al-Jazeera.²⁶

²⁵ Abu Talat, interview of Dr. Waad Edan Louis at Arabic Children's Hospital, July 24, 2004.

²⁶ Lawrence Smallman, "Iraq's real WMD Crime," Al-Jazeera, October 30, 2003.

As far as availability of medical supplies, Dr. Louis said there are always shortages, and what they need varies from week to week. At present they are lacking IV sets for blood transfusions and cannulas. Patients are compensating for this by purchasing their own supplies that they bring with them to the hospital.²⁷

Dr. Louis stated that these deficiencies are due to a lack of money from the US that supplies the Ministry of Health with its funding.²⁸

Dr. Namin Rashid, the Chief Resident Doctor at Yarmouk Hospital, echoed this opinion when he stated that the only medical help his hospital had received lately had been a load of medical supplies from Grand Ayatollah Ali Al-Sistani.

He complained that the Ministry of Health consistently does not give them enough supplies, and his hospital currently only had 100 sets of IVs and blood transfusion equipment. He added: "We are getting less medical supplies now than we were during the sanctions!"²⁹

He said his hospital is receiving only one half as much supplies as it was prior to the invasion. This is also compounded by the fact that Iraqi companies have yet to be identified or allowed to participate in supplying equipment and medicine to the hospitals.

A doctor at the Al-Karama hospital speaking on condition of anonymity also said: "Things for us here now are worse than they were during the sanctions. We have certain items that we have shortages of -- kidney transplant supplies, immuno-suppressive drugs, anti-rejection drugs, gauze, IV supplies and antibiotics."³⁰

He said that they have received no funding from the US reconstruction funds, and that most of the minimal funding they are receiving has come from NGO's.³¹

A doctor at Al-Kerkh Hospital said that the hospital is lacking IV supplies and blood transfusion fluids. Most operating tables there were broken. Also speaking on condition of anonymity due to fear of US military reprisals, a second doctor working as an administrator doctor there reported, "the hospital is currently in a very bad situation. Before the invasion we had a much better supply situation, 80% better than now."³²

²⁷ Abu Talat, interview of Dr. Waad Edan Louis at Arabic Children's Hospital, July 24, 2004.

²⁸ Ibid.

²⁹ Dahr Jamail, interview of Dr. Namin Rashid at Yarmouk Hospital, April 8, 2004.

³⁰ Dahr Jamail, interview of a doctor who asked to remain nameless at Al-Karama Hospital, April 8, 2004.

³¹ Ibid.

³² Dahr Jamail, interview of doctor who asked to remain nameless at Al-Kerkh Hospital, April 8, 2004.



Operating tables in many Baghdad hospitals are in dismal condition while hospitals attempt to function without necessary funding, equipment and medicine.

B. US Military Interfering With Medical Care

Another common impediment affecting Iraqi hospitals under occupation is interference by the US military. While this intrusion has most often taken the form of soldiers entering hospitals to interrogate or detain alleged resistance fighters, perhaps the most glaring example of the US military impeding medical care of Iraqis occurred in Fallujah during the heavy fighting of April, 2004.

Doctors from Fallujah General Hospital, as well as others who worked in clinics throughout the city during the US siege of Fallujah reported that US Marines obstructed their services and that US snipers intentionally targeted their clinics and ambulances.

“The Marines have said they didn't close the hospital, but essentially they did,” said Dr. Abdulla, an orthopedic surgeon at the General Hospital who spoke on condition of using a different name. “They closed the bridge which connects us to the city [and] closed our road...the area in front of our hospital was full of their soldiers and vehicles.”³³

He added that this prevented countless patients who desperately needed medical care from receiving medical care. “Who knows how many of them died that we could have saved,” said Dr. Abdulla. He also blamed the military for shooting at civilian ambulances, as well as shooting near the clinic at

³³ Dahr Jamail, interview of “Dr. Abdulla” at Fallujah General Hospital, May 10, 2004.

which he worked. "Some days we couldn't leave, or even go near the door because of the snipers," he said. "They were shooting at the front door of the clinic."³⁴



Medical workers in the city claim that Marine snipers deliberately targeted several ambulances operating in Fallujah during the US siege of the city.

Dr. Abdulla also said that US snipers shot and killed one of the ambulance drivers of the clinic where he worked during the fighting.

Dr. Ahmed, who also asked that only his first name be used because he feared US military reprisals, said: "The Americans shot out the lights in the front of our hospital. They prevented doctors from reaching the emergency unit at the hospital, and we quickly began to run out of supplies and much needed medications."³⁵ He also stated that several times Marines kept the physicians in the residence building, thereby intentionally prohibiting them from entering the hospital to treat patients.

"All the time they came in, searched rooms, and wandered around," said Dr. Ahmed, while explaining how US troops often entered the hospital in order to search for resistance fighters. Both he and Dr. Abdulla said the US troops never permitted the delivery of necessary medicine or supplies to assist the hospital when they carried out their incursions. Describing a situation that has occurred in other hospitals, he added: "Most of our patients left the hospital because they were afraid."

Dr. Abdulla said that one of their ambulance drivers was shot and killed by US snipers while he was attempting to collect the wounded near another clinic inside the city.

³⁴ Ibid.

³⁵ Dahr Jamail, interview of "Dr. Ahmed" who asked to use this false name to protect his identity at Fallujah General Hospital, May 10, 2004.

“The major problem we found were the American snipers,” said Dr. Rashid who worked at another clinic in the Jumaria Quarter of Fallujah. “We saw them on top of the buildings near the mayor's office.”³⁶

Dr. Rashid told of another incident in which a US sniper shot an ambulance driver in the leg. The ambulance driver survived, but a man who came to his rescue was shot by a US sniper and died on the operating table after Dr. Rashid and others had worked to save him. “He was a volunteer working on the ambulance to help collect the wounded,” Dr. Rashid said.³⁷

During a visit to the hospital in May, two ambulances in the parking lot sat with bullet holes in their windshields, while others had bullet holes in their back doors and sides.



Several ambulances sit in the parking lot at the general hospital in Fallujah with bullet holes in the drivers' side of the windshield.

“I remember once we sent an ambulance to evacuate a family that was bombed by an aircraft,” said Dr. Abdulla while continuing to speak about the US snipers. “The ambulance was sniped -- one of the family died, and three were injured by the firing.”³⁸

Neither Dr. Abdulla nor Dr. Rashid said they knew of any medical aid being provided to their hospital or clinics by the US military.

³⁶ Dahr Jamail interview of “Dr. Rashid” who asked to use this false name to protect his identity at Fallujah General Hospital, May 10, 2004.

³⁷ Ibid.

³⁸ Dahr Jamail, interview of Dr. Abdulla at Fallujah General Hospital, May 10, 2004.

Targeting ambulances and impeding operations of medical facilities in Fallujah directly violates the Fourth Geneva Convention, which strictly forbids attacks on emergency vehicles and the obstruction of medical operations during wartime.³⁹ Chuwader General Hospital in Sadr City has reported similar illegalities, as have other hospitals throughout Baghdad.

Dr. Abdul Ali, the ex-Chief Surgeon at Al-Noman Hospital, admits that US soldiers have come to the hospital asking for information about resistance fighters. To this he said: "My policy is not to give my patients to the Americans. I deny information for the sake of the patient."⁴⁰

During an interview in April, he admitted this intrusion occurred fairly regularly and interfered with patients receiving medical treatment. He noted: "Ten days ago this happened--this occurred after people began to come in from Fallujah, even though most of them were children, women and elderly."⁴¹

A doctor at Al-Kerkh Hospital, speaking on condition of anonymity, shared a similar experience of the problem that appears to be rampant throughout much of the country: "We hear of Americans removing wounded Iraqis from hospitals. They are always coming here and asking us if we have injured fighters."⁴² The November 2004 U.S.-led siege of Fallujah posed similar difficulties for the operation of health care services in that city.

Burhan Fasa'a, a cameraman with the Lebanese Broadcasting Corporation (LBC), witnessed the first eight days of the fighting. "I entered Fallujah near the Julan Quarter, which is near the General Hospital," he said during an interview in Baghdad. "There were American snipers on top of the hospital," who, he testified, "were shooting everyone in sight."⁴³ The Iraqi Red Crescent would have to wait a full week before being permitted to dispatch three ambulances into the city.⁴⁴

Similar testimony emerged from hospitals in other cities during the same period. In Amiriyat al-Fallujah, for instance, a city some ten kilometers east of Fallujah, the main hospital was raided twice by US soldiers and members of the Iraqi National Guard, doctors say. "The first time was November 29 at 5:40am, and the second time was the following day," said a doctor at the hospital who did not want to give his real name for fear of US reprisals. "They were yelling loudly at everyone, both doctors and patients alike," the young doctor said. "They divided into groups and were all over the hospital. They broke the gates outside, they broke the doors of the garage, and they raided our supply room where our food and supplies are. They broke all the interior doors of the hospital, as well as every exterior door."

³⁹ Martin Zwanenburg, "Existentialism in Iraq: Security Council Resolution 1483 and the law of occupation," *International Review of the Red Cross*, Number 856, p. 750.

⁴⁰ Dahr Jamail, interview of Dr. Abdul Ali at Al-Noman Hospital, April 22, 2004.

⁴¹ Ibid.

⁴² Dahr Jamail, interview of doctor who asked to remain anonymous at Al-Kerkh Hospital, April 8, 2004.

⁴³ Dahr Jamail, interview of Burhan Fasa'a, Baghdad, December 4, 2004.

⁴⁴ Dahr Jamail, *The Ester Republic*, "An Eyewitness Account of Fallujah," December 16, 2004.

He was then interrogated about resistance fighters, he said. “The Americans threatened to do here what they did in Fallujah if I didn't cooperate with them,” he added.⁴⁵

A second doctor, speaking on condition of anonymity, said that all of the doors of the clinics inside the same hospital were kicked in. All of the doctors, along with the security guard were handcuffed and interrogated for several hours, he said. The two doctors pointed to an ambulance with a shattered back window. “When the Americans raided our hospital again last Tuesday at 7 pm, they smashed one of our ambulances,” the first doctor said. His colleague pointed to other bullet-riddled ambulances, saying: “The Americans have snipers all along the road between here and Fallujah. They are shooting our ambulances if they try to go to Fallujah.”⁴⁶

In nearby Saqlawiyah, Dr Abdulla Aziz reported that occupation forces had blocked any medical supplies from entering or leaving the city. “They won't let any of our ambulances go to help Fallujah,” he said. “We are out of supplies and they won't let anyone bring us more.”⁴⁷

“We were tied up and beaten despite being unarmed and having only our medical instruments,” Asma Khamis al-Muhannadi, a doctor who was present during the US and Iraqi National Guard raid on Fallujah General Hospital told reporters later. She said troops dragged patients from their beds and pushed them against the wall. “I was with a woman in labor, the umbilical cord had not yet been cut,” she said. “At that time, a US soldier shouted at one of the (Iraqi) national guards to arrest me and tie my hands while I was helping the mother to deliver.”⁴⁸

Clearly, the US Federal Government needs to launch a broad inquiry into these matters so that those responsible for these acts are brought to justice and Iraqi medical personnel are free to perform their jobs.

C. Lack of Water and Electricity Affecting Medical Care

Dr. Qasim al-Nuwesri, the head manager of Chuwader Hospital, was quick to point out the struggles his hospital is facing under the occupation. “We are short of every medicine,” he said while telling that the extent of these shortages rarely occurred before the invasion. “It is forbidden, but sometimes we have to reuse IV's, even the needles. We have no choice.”⁴⁹

His hospital treats an average of 3000 patients each day. Dr. Nuwesri said that one major issue that compounds all of their other problems is the lack of clean water. “Of course we have typhoid, cholera,

⁴⁵ Dahr Jamail, interview of Amiriyat al-Fallujah doctor who asked to remain anonymous, Baghdad, December 13, 2004.

⁴⁶ Dahr Jamail, interview of a second Amiriyat al-Fallujah doctor who asked to remain anonymous, Baghdad, December 13, 2004.

⁴⁷ Dahr Jamail, Inter Press Service, “U.S. Military Obstructing Medical Care,” December 13, 2004.

⁴⁸ Dahr Jamail, interview of Dr. al-Muhannadi, Baghdad, December 13, 2004.

⁴⁹ Dahr Jamail, interview of Dr. Qasim al-Nuwesri at Chuwader Hospital, June 14, 2004.

kidney stones...but we now even have the very rare Hepatitis Type-E (HEV)... and it has become common in our area.”⁵⁰

HEV, transmitted via the fecal-oral route, is also primarily associated with ingestion of feces-contaminated drinking water. While it has a low case fatality rate in the general population, fetal loss among pregnant women infected with the disease is common, along with casualty rates between 15-25% among pregnant women as well. There have also been reports of perinatal transmission. Obviously, the best prevention from being infected with HEV is to avoid contaminated water. But in a place like Sadr City, a sprawling slum area of Baghdad with over two million residents, this is impossible for most of the residents.

Dr. Qasim al-Nuwesri said that one German non-governmental organization was bringing in water trucks, but the hospital still only had 15% of the necessary clean water supply to operate hygienically.



Dr. Qasim al-Nuwesri, the head manager of Chuwader Hospital, struggles daily to operate a huge hospital that suffers from a desperate lack of supplies, horribly contaminated water and frequent incursions by US soldiers.

In a room upstairs in the hospital with 7 younger doctors, one of their top concerns was also the water. “The most important thing is no clean water,” said Dr. Amer Ali, while the other six doctors in the room nodded in agreement. The 25-year old resident doctor continued: “This problem is affecting us so much.”⁵¹

⁵⁰ Ibid.

⁵¹ Dahr Jamail, interview with Dr. Amer Ali at Chuwader Hospital, June 14, 2004.

Dr. Ali also described more of the horrendous conditions the hospital has faced under the occupation. These conditions include the ongoing power, water, medicine and equipment shortages. The other doctors nodded in agreement. “I think the cause of these worse conditions is the Americans,” he said firmly.⁵²



Many hospitals surveyed in Baghdad could not afford to hire cleaners. This is a toilet in the intensive care ward in Al-Kerkh Hospital in Baghdad.

⁵² Ibid.

Highlighting the difficulties medical personnel faced because of electrical shortages, Ahlan Bari, the Manager of Nurses at Yarmouk Teaching Hospital in Baghdad told of a horrendous incident.



Ahlan Bari is the Manager of Nurses at Yarmouk Teaching Hospital, where frequent power cuts led to the death of a patient in the operating room.

“We had a power outage while someone was undergoing surgery in the operating room,” she said in her office, “And [he] died on the table because we had no power for our instruments.”⁵³ While the hospital has generators, at times the generators don’t perform correctly because the hospital lacks parts or runs out of fuel due to ongoing fuel shortages.

Most of the hospitals surveyed did not have fully functioning backup generators and lacked either funds or parts to have them repaired.

V. CORRUPTION AND CRIME

Corruption and crime existed under the regime of the former ruler Saddam Hussein, but both are much more rampant under the US-led occupation. One of the glaring instances of corruption is evident in the lack of proper allocation of US funds within the Ministry of Health.

The Deputy Minister of Health, Dr. Amer Al Khuzai, said the Ministry of Health was allocated \$1 billion of the \$18.6 billion the US set aside for rebuilding Iraq. During an interview in his office in

⁵³ Dahr Jamail, interview with Ahlan Bari at Yarmouk Teaching Hospital, April 8, 2004.

June, 2004 he clearly stated that Bechtel, via USAID, had the contracts for distributing the subcontracts and money for rebuilding/rehabilitating the hospitals.



Deputy Iraqi Minister of Health Dr. Amer Al Khuzai, who when asked what funding his ministry has received from the US-led coalition replied, “We only have promises.”

When asked why he felt the work of rebuilding/rehabilitating the hospitals and medical infrastructure was not being done, Dr. Khuzai replied: “Usually they use the excuse of the security situation in Iraq. But then why don’t they allow Iraqi companies to do the work?”⁵⁴

Dr. Khuzai said frankly, “Surely every country passes their money through their contractors,” when referring to what he felt was the root of the problem that the hospitals are facing under the occupation. “We could do the work and use Iraqi subcontractors,” he continued. “The problem is that they [USAID/Bechtel] want their own companies to do it.”

According to the Deputy Minister, the Ministry of Health was supposed to have received \$300 million of the \$1 billion of US funds allocated for the medical infrastructure, but still had not received any money.

While Dr. Khuzai stated that the rampant looting of hospitals and warehouses following the invasion has aggravated the shortages of equipment and medicine, the main reason for the shortfalls has been that the former Coalition Provisional Authority (CPA) was slow to issue “Letters of Credit” for the Ministry of Health. “Letters of Credit are simply how we ask them for the money we need to operate,”

⁵⁴ Dahr Jamail, interview with Dr. Amer Al Khuzai at Ministry of Health, June 24, 2004.

said Dr. Khuzaie, “and the CPA consistently holds these up for two months for us and this hurts us very much.”

“The US has opened the door to share the contracts with its companies and this made the delay for us,” said the Deputy Minister while leaning forward to make his point. “This is what caused the delay in opening our Letters of Credit and this contributed to the drug shortages. This delay with the Letters of Credit happens every time we make a request. We have requested over \$500 million for equipment, and only have \$300 million of the Letters of Credit, but none of the money yet. We only have promises.”⁵⁵

Dr. Khuzaie’s comments highlight the imperative need for US funds to be released to the Ministry of Health so that the necessary medicine and equipment can be purchased and distributed to hospitals throughout Iraq. Along with releasing the funds, proper monitoring and oversight of their dispersion is necessary as well.

Iraqi drug companies are another source of corruption. According to the Deputy Minister, the lack of oversight, since the infrastructure in his country was shattered and the former regime overthrown, has led to this corruption. “Kymadia is the Iraqi company [that] used to supply the drugs,” added Dr. Khuzaie. “They still do, but due to no infrastructure and lack of oversight, the company has become completely corrupted.”⁵⁶

Dr. Sarmed, a medical doctor who specializes in ophthalmology, voiced a similar concern. “There is no government office to complain to when the pharmacies are overcharging us or patients because we have no infrastructure,” he said in his Baghdad home.⁵⁷ Dr. Sarmed pointed out that the black market for medicine was common before the invasion because doctors only made \$3 per month and some doctors illegally sold medications to augment their incomes; however the situation is worse now.

“Medicines used to be limited because of the sanctions, but now the drugs are pouring in from everywhere; thus [they] are unregulated and not certified,” said Dr. Sarmed. He then added that another problem is that the distribution of narcotics is out of control and is thus being abused.⁵⁸

Wa’al Jubouri, a student of Pharmacology at Baghdad University who is currently interning at a pharmacy, also felt that corruption is a greater problem now than prior to the invasion. “Each pharmacy now is like a black market,” he said of his experience working in a pharmacy. “They can sell drugs for a very high price because there is no regulation like before.”⁵⁹ Mr. Jubouri added that the

⁵⁵ Dahr Jamail, interview with Dr. Amer Al Khuzaie at Ministry of Health, June 24, 2004.

⁵⁶ Ibid.

⁵⁷ Dahr Jamail, interview with Dr. Sarmed at his home in Baghdad, June 26, 2004. Dr. Sarmed spoke on condition of using a pseudonym.

⁵⁸ Ibid.

⁵⁹ Dahr Jamail, interview with Wa’al Jubouri at his home in Baghdad, June 26, 2004. Mr. Jubouri spoke on condition of using a pseudonym.

medicine Iraq is receiving from other countries is usually outdated and unregulated material, further complicating the medicine shortage.

Another problem consistently plaguing the struggling healthcare system in occupied Iraq is that important and vital drugs are oftentimes available on the black market, but not in the hospitals. Dr. Sa'alm Shadid, a resident doctor in Baghdad, believes that the black market is a very big problem. "We don't get the drugs we need now, whereas even during the sanctions we were able to get them," he said. "So people smuggle them in and make more on the black market for them."⁶⁰

The fact that drug companies have been forced to by-pass normal sales methods in order to make up for funds lost during the rampant looting which followed the fall of Baghdad also exemplifies how the lack of infrastructure in Iraq after the US-led invasion has led to corruption that affects medical services.

Dr. Thadeb al Sawah is the assistant manager of Samarah Drug Industries. He is also the head of Inspections and Quality Control at the factory of Samarah Drug Industries. Dr. Sawah said: "After the invasion, my company owed the Ministry of Health 1.5 million Iraqi Dinar and had to begin selling our drugs to the pharmacies to make up our money to pay the Ministry of Health... We sold them medicines we knew were on the Ministry's list of needs at slightly higher prices. Consequently, the pharmacies could sell these medicines in turn to the Ministry of Health."⁶¹

Practices such as these have further aggravated the lack of funds of the struggling Ministry of Health and have contributed to shortages of medicine for both hospitals and patients.

Criminal activity in occupied Iraq has further deteriorated the healthcare system. Organized crime is running rampant in Baghdad, resulting in the kidnapping of doctors and severe staffing shortages at some of the hospitals. "The prominent docs are being warned and told to leave by organized crime," said Dr. Sa'alm Shadid in Baghdad. "It is very unsettled here for us. People want to leave mostly because of the security situation."⁶²

Dr. Shadid explained that since doctors are now paid more than before the invasion, they have become higher profile targets for organized crime gangs who kidnap them for large ransom sums. In addition, street criminals have been targeting doctors' homes as well. "Kidnapping for money is happening often with doctors because we don't have bodyguards," added Dr. Sarmed while further explaining the problem.⁶³

⁶⁰ Dahr Jamail, interview with Dr. Sa'alm Shadid at his home in Baghdad, June 26, 2004. Dr. Shadid spoke on condition of using a pseudonym.

⁶¹ Abu Talat, interview with Dr. Thadeb al Sawah in his office in Samarra, July 26, 2004.

⁶² Dahr Jamail, interview with Dr. Omar Sa'ad at his home in Baghdad, June 26, 2004.

⁶³ Dahr Jamail, interview with Dr. Sarmed at his home in Baghdad, June 26, 2004.

Dr. Sarmed cited several instances of the kidnapping of doctors: a famous neurosurgeon was kidnapped, humiliated and beaten before a ransom of \$30,000 was paid; a famous ophthalmologist was released when a ransom of \$70,000 was paid; the son of a famous surgeon was released for \$30,000 and many, many others. "The most famous one is Dr. M. al-Rawi, ex-president of Baghdad University and ex-dean of my medical college," added Dr. Sarmed. "Right after the war he was shot in the head in his private clinic."

All of the doctors interviewed about this topic believe that the horrible security situation under the occupation permits organized crime gangs in Baghdad to kidnap and rob doctors at will.

There is no indication that conditions have improved in the time since these interviews were conducted. According to the Iraqi Ministry of Health, such violence against doctors is increasing.⁶⁴ A recent study of corruption in the healthcare sector found that "bribery, nepotism and theft are rife, with the problem so serious that the health of patients is suffering."⁶⁵ Kareem al-Ubaidy, a senior official at the Medical City Hospital in Baghdad, said that corruption had left the medical sector in worse state than it was under the previous regime.

VI. BRAIN DRAIN

Iraqi hospitals are also attempting to cope with brain drain -- an event that commonly occurs during wars where trained and talented personnel immigrate to other nations because of the troubled situation in which they are living.

Doctors and medical students in Iraq today agree that this is occurring at an alarming rate, again with kidnapping being a large part of the impetus. "Security is causing so many doctors to leave, as are the kidnappings," said Dr. Wijdi Jalal, the executive manager of Baghdad Teaching Hospital.⁶⁶ Dr. Sarmed, an ophthalmologist working in the capital city, agreed. "The brain drain here is very bad," he said. "Regular doctors still don't make enough money to leave Iraq, so they don't. But the more senior doctors are leaving because they can afford to."⁶⁷

Doctor Sarmed also claimed that the situation is so desperate that medical universities in Iraq have ceased providing their graduating doctors with certificates in order to force them to remain in Iraq to practice medicine.

Even though the pay for doctors in Iraq is now far superior to what it was prior to the US-led invasion, morale has dropped because Iraqi doctors remain acutely aware of the fact that they are still paid very

⁶⁴ Institute for War and Peace Reporting (IWPR) Iraqi Press Monitor, No. 227, "Attacks on Iraqi Doctors Rising," April 25, 2005.

⁶⁵ Yaseen al-Rubai, Iraqi Crisis Report (ICR) No. 119, "Health Service Mired in Corruption," April 1, 2005.

⁶⁶ Dahr Jamail, interview with Dr. Wijdi Jalal at Baghdad Teaching Hospital, June 12, 2004.

⁶⁷ Dahr Jamail, interview with Dr. Sarmed at his home in Baghdad, June 26, 2004.

little compared to doctors practicing in other countries. “We all know that we don’t make much money compared to if we were practicing in a western country,” said Dr. Sarmed. “Everything is worse now for doctors in Iraq than during the sanctions, except the pay.”⁶⁸

Dr. Sarmed is paid \$161 per month from the Ministry of Health. His colleagues with higher training are paid up to \$313 per month, but are still not satisfied with this amount. Why? Because, according to Dr. Sarmed, they are paid the same amount as other government workers with far less education. Yet, they have much greater responsibilities and face many more difficult working conditions. Furthermore, compared to doctors in developed countries, Iraqi doctors are only earning a fraction of the income.

He said that while he was optimistic after the invasion, because he believed he would be allowed to travel and earn degrees abroad, he was suffering from poor morale since none of his aspirations has occurred. In addition, religious sects and political parties have begun struggling for control of the hospitals in Baghdad. This means Sunni are excluding Shia members, and Dawa Party members are discriminating against other political parties, and so on.

Wa’al Jubouri, a pharmacology student at Baghdad University said; “Everyone is asking himself if he’ll go or stay. But we just live day by day. We all want to get out because the situation is so bad.”⁶⁹

VII. RECONSTRUCTION CONTRACT WORK IN LIMBO

But the present crisis in Iraqi healthcare is dwarfed, perhaps, by the new Iraqi government’s promise of free enterprise to reconstruct healthcare services.

Let us briefly consider some preconditions of this promise.

Antonia Juhasz recounts that prior even to war in Iraq, USAID requested proposals to bid on contracts to select firms. “Excluded from the secret bidding process, were, among others: Iraqis, humanitarian organizations, the United Nations and any non-US businesses or organizations.”⁷⁰ Billions of dollars in US and Iraqi public funds have already been doled out in such “expedited” reconstruction contracts, with billions more on the way. From the outset, “free enterprise” in Iraq, then, was anything but free.

Such contracting, as well as subsequent changes in ownership, was facilitated by transformations in existing Iraqi law. (The transformation of an occupied country’s laws violates the Hague regulations of 1907, the 1949 Geneva conventions—both ratified by the United States—and the US Army’s Law of Land Warfare.) These transformations were largely made possible by the executive orders of

⁶⁸ Ibid.

⁶⁹ Dahr Jamail, interview with Wa’al Jubouri at his home in Baghdad, June 26, 2004.

⁷⁰ Antonia Juhasz, Left Turn Magazine, "The Corporate Invasion of Iraq," August/September 2003.

Presidential Envoy to Iraq and Administrator of the Coalition Provisional Authority, L. Paul Bremer. Juhasz describes the impact of the executive orders on public services as fundamental and far-reaching. Order #39, for example, “allows for the following: (1) privatization of Iraq’s 200 state-owned enterprises; (2) 100% foreign ownership of Iraqi businesses; (3) “national treatment” of foreign firms; (4) unrestricted, tax-free remittance of all profits and other funds; and (5) 40-year ownership licenses. Thus, it allows the US corporations operating in Iraq to own every business, do all of the work, and send all of their money home. Nothing needs to be reinvested locally to service the Iraqi economy, no Iraqi need be hired, no public services need be guaranteed, and workers’ rights can easily be ignored. And corporations can take out their investments at any time.”⁷¹ Little surprise, perhaps, that in such a context US corporations are essentially unaccountable for their actions. “Order #17 grants foreign contractors, including private security firms, full immunity from Iraq’s laws. Even if they do injure a third party by killing someone or causing environmental damage such as dumping toxic chemicals or poisoning drinking water, the injured third party can not turn to the Iraqi legal system, rather, the charges must be brought to US courts under US laws.”⁷² As David Fidler suggests, such ordinances are reminiscent of a system of political, economic, and legal thinking that created and maintained the colonial order of the late 19th and early 20th centuries.⁷³ In the colonies, as one contemporary account put it, the idea was

to exempt foreigners from the civil and criminal jurisdiction of the local magistrates and tribunals, and make them subject only to the laws and authorities of their own country, thus creating a kind of extra-territoriality for all citizens of the contracting States resident in or visiting any part of the East where the treaties obtained.⁷⁴

Little surprise, then, that despite the ample reconstruction contracted by the US Agency for International Development, the Iraqi healthcare system remains dysfunctional. Bechtel Corporation was hired to deliver a comprehensive analysis of all damage following the US invasion and to identify priority reconstruction projects, including those in the healthcare sector. Bechtel completed minor repair work in about fifty primary healthcare centers around the country and handed the rest over to US AID.

On April 30, 2003, USAID awarded Boston-based Abt Associates a contract worth up to \$43.8 million⁷⁵ to “ensure the rapid normalization of health services in Iraq while strengthening the overall health system in the country.”⁷⁶ According to the Center for Public Integrity, Abt Associates had earlier agreed to pay the US government \$1.9 million as part of a settlement in October 1999 after being “accused of billing several federal agencies prematurely during a 10-year period starting in 1988.”⁷⁷

⁷¹ Antonia Juhasz, *Foreign Policy in Focus*, “The Hand-Over That Wasn’t: How the Occupation of Iraq Continues” July, 2004.

⁷² *Ibid.*

⁷³ David Fidler, “A Kinder, Gentler System of Capitulations?” *Texas International Law Journal*, Summer 2000.

⁷⁴ Sir Sherston Baker, *1 Halleck’s International Law*, 3rd edition, 1893, pages 387-88.

⁷⁵ U.S. AID, [Fact Sheet](#), May 1, 2003.

⁷⁶ Abt Press Release, April 30, 2003.

⁷⁷ André Verlöy, “[Windfalls of War](#),” Center for Public Integrity.

A full year and a half later, reconstruction of Iraqi medical facilities can at best be called superficial. As Baghdad Medical City began to look nice in its new coat of paint, Dr. Hammad Hussein, ophthalmology resident at the center noted: "I have not seen anything which indicates any rebuilding aside from our new pink and blue colors here where our building and the escape ladders were painted." He said that "what this largest medical complex in Iraq lacks is medicines. I'll prescribe medication and the pharmacy simply does not have it to give to the patient." The hospital is "short of wheelchairs, half the lifts are broken, and the family members of patients are being forced to work as nurses because of shortage of medical personnel," he added.⁷⁸

That very day, the Yarmouk hospital in Baghdad was given new desks and chairs. The new desk delivered to Dr Aisha Abdulla sits in the corridor outside her office. "They should build a lift so patients who can't walk can be taken to surgery, and instead we have these new desks," she said. "How can I take a new desk when there are patients dying because we don't have medicine for them?"⁷⁹

The latest reports are not hopeful. "The cost of maintaining the gardens of Medical City was 68 million dollars, the cost of painting the building was 150 million dollars and the cost of repairs was 18 million dollars, but when you enter the hospital you don't feel any changes from the time of Saddam's regime. On the contrary, it's getting worse. There's theft and embezzlement."⁸⁰ As a consequence, according to pharmacist Muhamad Abbas at the Adnan Khairulal Surgical Hospital, "We can only give patients half the drugs that have been allocated to them because we don't have enough", and "we don't even have some varieties of drugs, such as insulin and certain antibiotics." Amir Batrus, who led the inquiry, found a more generalized restriction of basic services.⁸¹

⁷⁸ Dahr Jamail, interview of Dr. Hammad Hussein, Baghdad, December 7, 2004.

⁷⁹ Dahr Jamail, interview of Dr. Aisha Abdulla, Baghdad, December 7, 2004.

⁸⁰ Yaseen al-Rubai, Iraqi Crisis Report (ICR) No. 119, "Health Service Mired in Corruption," April 1, 2005.

⁸¹ Ibid.

VIII. CONCLUSIONS

This report takes as its central subject Iraqi healthcare as reflected by the condition of Iraqi hospitals. Such an approach necessarily excludes considerations that, however unrelated to hospitals, are fundamentally related to healthcare. Such exclusions from our thinking about healthcare reflect prior exclusions of persons from comprehensive medical care. Their mention here, however passing, is hoped to broaden avenues whereby medical care for all Iraqis can be envisioned and, without further delay, delivered.

One such exclusion is that of a civilian population, having already been subject to attack and displacement, from basic medical services. Interviews conducted in the aftermath of the November siege of Fallujah indicate a comprehensive denial of such services to the refugees who emerged from the rubble. "The ministry of health instructed us not to provide aid for Fallujans," said Dr. Aisha Mohammed from Baghdad.⁸² "But then they have not done anything to help them during the siege, and very little at the refugee camps in Baghdad." Dr. Mohammed reported last November that she and several doctors from her hospital had struggled to get supplies from the ministry of health to refugees stranded in camps around Baghdad. "Only when we fought them did they allow us to have some supplies. What they eventually let us have after we demanded it, is still not nearly enough for all of the camps. We are in a crisis." Shehab Ahmed Jassim of the Iraqi Ministry of Health admitted that "in the camps now there are severe problems of diarrhea, colds, flu and lack of electricity and clean water."⁸³ Abel Hamid Salim, spokesman for the Iraqi Red Crescent (IRC) in Baghdad, reported that "while the MOH (ministry of health) gave their approval to transport aid to the refugees of Fallujah, they had provided the IRC no support of materials."⁸⁴

There is increasing evidence that such shortages are especially pronounced in detention facilities. A recent report from the Abu Ghraib Field Hospital, for instance, describes the situation accordingly.

At times the hospital lacked basic supplies, according to members of the clinical staff, and at times it maintained a surgical service without surgeons. Sometimes the hospital ran out of chest tubes, intravenous fluids or medicines. Medical staff members improvised, taking tubes from patients when they died and reusing them, without sterilization.

Physician's assistants and general practitioners amputated limbs, a dentist did heart surgery, and Dr. Auch begged and bartered with other medical units for drugs and intravenous fluids. When they ran out of blood sugar test strips for Abu Ghraib's many diabetics, according to a medic assigned to the unit, they gave insulin by guessing the dose and watching for bad reactions.⁸⁵

⁸² Dahr Jamail, interview of Dr. Aisha Mohammed, Baghdad, November 30, 2004.

⁸³ Dahr Jamail, interview of Shehab Ahmed Jassim, Baghdad, November 30, 2004.

⁸⁴ Dahr Jamail, interview of Abel Hamid Salim, Baghdad, November 30, 2004.

⁸⁵ M. Gregg Bloche and Jonathan H. Marks, "Triage at Abu Ghraib," *The New York Times*, February 5, 2005.

The same report cites the underlying basis for the now famous photographs of Dr. David Auch's response to an episode of psychosis at the prison. Without straitjackets and psychiatrists who could prescribe medication, Dr. Auch prescribed a leash to restrain the patient, recounting, "my concern was whatever it took to keep him from getting hurt."

The account resembles those emerging from detention pens at Guantanamo Bay, where former prisoners describe medical treatment as contingent on their "cooperation,"⁸⁶ and when offered, as often little more than "prescribing Prozac across the board."⁸⁷ Individual Iraqis, such as Sadiq Zoman, have undergone similar treatment. 55 year-old Zoman, detained in a home raid by US soldiers that produced no weapons, was taken to a police office in Kirkuk, the Kirkuk Airport Detention Center, the Tikrit Airport Detention Center and then the 28th Combat Support Hospital, where he was treated by Dr. Michael Hodges. Dr. Hodges' medical report listed the primary diagnoses of Zoman's condition as hypoxic brain injury (brain damage caused by lack of oxygen) "with persistent vegetative state," myocardial infarction (heart attack), and heat stroke. The same medical report did not mention the bruises, lash marks, head injury, or burn marks found on Zoman's body upon his arrival at Tikrit hospital days later.



There was no mention in Dr. Michael Hodges' medical report on Sadiq Zoman of a head injury.

⁸⁶ Shafiq Rasul, Asif Iqbal and Rhuheel Ahmed, "Composite statement: Detention in Afghanistan and Guantanamo Bay," July 23, 2004, 299.

⁸⁷ *Ibid.*, 274. Also see 151.



Nor was there mention in Michael Hodges' medical report of Sadiq Zoman of electrical burns on his feet or genitals.

Such evidence that doctors, nurses, and medics have been complicit in torture and other illegal procedures in post-Saddam Iraq is already ample. As Dr. Robert Lifton writes,

We know that medical personnel have failed to report to higher authorities wounds that were clearly caused by torture and that they have neglected to take steps to interrupt this torture. In addition, they have turned over prisoners' medical records to interrogators who could use them to exploit the prisoners' weaknesses or vulnerabilities.⁸⁸

Far more common, of course, than the direct administration of torture by medical authorities is the role that medical treatment has played in rehabilitating those subject to torture (often followed by further detention) while doing nothing to report and thereby abate its cause. Dr. Lifton writes that

Even without directly participating in the abuse, doctors may have become socialized to an environment of torture and by virtue of their medical authority helped sustain it. In studying various forms of medical abuse, I have found that the participation of doctors can confer an aura of legitimacy and can even create an illusion of therapy and healing.⁸⁹

⁸⁸ Dr. Robert Jay Lifton, "Doctors and Torture," *New England Journal of Medicine*, Volume 351:415-416, July 2004.

⁸⁹ *Ibid.*

By failing to report on the root of the physical and psychological trauma caused by torture—this root being the torture itself—medical authorities, by mitigating its excesses (providing temporary respite, tending to mere symptoms, suggesting alternative interrogation techniques, whatever the particular case may require) and thereby conferring legitimacy upon the military-clinical institutions that they serve—effectively facilitate the torture that they treat. As billions of dollars are deployed to create Iraqi security forces and hundreds of millions more for the reconstruction and modernization of detention facilities,⁹⁰ there seems little to indicate that Iraqi sovereignty over the police-state that is emerging represents a meaningful improvement for the healthcare of Iraqis. The exclusions from comprehensive health care here touched on suggest that medical facilities in Iraq serve as petty functionaries of this police-state. I write with regret that the contents of this report appear to do little more than confirm this reality.

Where does this leave us? “Security” has made several appearances throughout this report; it has been the basis for a primary complaint leveled by medical providers against occupation authorities—that of the latter’s failure to create safe, secure conditions in which to work. But in the presiding language of occupation authorities—language that in fact prefigured such complaints in the form of a promise—“security” means home raids, capable weaponry, and state of the art detention facilities, which is to say security for property above persons. Although life would seem a necessary prerequisite to liberty, and the pursuit of happiness, today in Iraq there is, at best, security for expropriated property. In this light, then, the following conclusions represent only a return to old principles.

This report supports the conclusion of many observers that the war and occupation -- and sanctions prior to that -- are primarily to blame for the appalling state of healthcare in Iraq today. Up to 1990, Iraq had one of the best healthcare systems in the Middle East. This was the result of a deep commitment by the Iraqi health professionals to serve their patients well; a long-term, quality-oriented planning by successive Iraqi governments since the 1930s; and well-functioning and disciplined -- albeit sometimes heavy-handed -- government structures.

Since a few months, an autonomous government is claimed in Iraq, although both its legitimacy and its autonomy are highly questionable. It can easily be argued, based on international law, that the existence of this government doesn’t change the US’s status as an occupying power. In any case, the US was the occupying power in Iraq for the period covered by this report. As such, the US was responsible for conforming with all international law, especially humanitarian law and human rights law, regarding the situation of healthcare in Iraq.

The Fourth Geneva Convention contains specific provisions pertaining to the delivery of healthcare services:

⁹⁰ Tens of millions were recently reallocated from penal to detention facilities; see US Department of State, Section 2207 Report to Congress on the use of Iraq Relief and Reconstruction Funds, Appendix 1, p. 19, April 5, 2005. Such reallocations would seem to serve the interest of interrogations and confinement less hampered by legal considerations.

Article 55

To the fullest extent of the means available to it the Occupying Power has the duty of ensuring the food and medical supplies of the population; it should, in particular, bring in the necessary foodstuffs, medical stores and other articles if the resources of the occupied territory are inadequate. (...)

Article 56

To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health and hygiene in the occupied territory, with particular reference to the adoption and application of the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics. Medical personnel of all categories shall be allowed to carry out their duties. (...)

This report clearly illustrates the abject failure of the US to carry out even minimal humanitarian duties as occupying power. More importantly, it paints a picture of a healthcare system that has deteriorated since the start of the war, and of a failure to fundamentally reverse this decline. From a public health point of view, an end to occupation, with a scheduled withdrawal of all foreign troops, appears to be a major requirement.

In the meantime, actions must be undertaken that would constitute small but important steps in securing a more functional healthcare system for the Iraqi people. Thus, this report concludes with the following calls to action:

1. The fact that the US government has released so little of the \$1 billion in reconstruction funds allegedly allocated to the Ministry of Health should be subject to an immediate congressional investigation to scrutinize the US government's expenditures and actions, as well as the expenditures and actions of western companies that have been awarded contracts in Iraq regarding the healthcare system. Investigators should be given the power to impose or seek punitive measures for contract violations and over-expenditures and to provide oversight, regulation and accountability of the work of these companies in regard to their individual contracts.
2. This abuse of resources and widespread corruption seems a natural consequence of the lack of oversight of multinational corporations, owing perhaps primarily to their immunity under Iraqi law as established by Executive Order #17. An institutional regime consisting of international oversight, which would include a legitimate body of experts on essential services and representatives of the country's medical society, should be created and put to work immediately.

3. An independent investigation should be launched to probe the actions of the US military regarding its alleged interference with Iraqi healthcare personnel and facilities, specifically with regard to the city of Fallujah. This investigation should include a more general appraisal of US military actions that have interfered with efforts to provide both healthcare and emergency services to a population under occupation. The investigation should also examine the issue of accountability to clearly identify who is accountable for this state of affairs. In order to facilitate independent inquiries into these and other human rights issues, the post of UN Human Rights Rapporteur, vacant since 2003, should be filled immediately.

4. Every Iraqi who has suffered the loss of a loved one, injury or property damage as a result of the invasion and ensuing occupation should immediately be compensated in full by western standards, not the \$2500 payout the US military has set as the standard fee for a dead Iraqi.

Contributors

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Omar Khan (author/editor, USA)

Dr. Bert De Belder (Coordinator of Medical Aid for the Third World)

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as well as the other members of the **BRussells** Tribunal Executive and Advisory Committee.

Endorsers

This report is endorsed by the **BRussells** Tribunal, El Taller International, Asian Women's Human Rights Council, Association of Humanitarian Lawyers, SOS Iraq, and Medical Aid for the Third World, a.o. I'd also like to thank 11.11.11 (a consortium of NGO's.), who offered their facilities for the presentation of this report to the press.

X. SECTIONS OF GENEVA CONVENTIONS I, III AND IV OF 1949^[1] RELEVANT TO HEALTH RIGHTS AND HEALTH CARE

GENEVA CONVENTION I (Protection for sick and wounded combatants on land)^[2]

Article 7: Wounded and sick, as well as members of the medical personnel and chaplains, may in no circumstances renounce in part or in entirety the rights secured to them by the present Convention . . .^[3]

Article 12: [Combatants] who are sick and wounded . . . shall be treated humanely and cared for by the Party to the conflict in whose power they may be without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any similar criteria. Any attempts on their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated, subjected to torture or to biological experiments; they shall not be willfully left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.

Only urgent medical reasons will authorize priority in the order of treatment to be administered.

Article 15: At all times, and particularly after an engagement, Parties to the conflict shall, without delay, take all possible measures to search for and to collect the wounded and sick, to protect them against pillage and ill-treatment, to ensure their adequate care, and to search for the dead and prevent their being despoiled.

Article 16: Parties to the conflict shall record as soon as possible, in respect of each wounded, sick or dead person of the adverse Party falling into their hands, any particulars which may assist in his identification.

Article 19: Fixed establishments and mobile medical units of the Medical Service may in no circumstances be attacked.

Article 24: Medical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, staff exclusively engaged in the administration of medical units and establishments, as well as chaplains attached to the armed forces, shall be respected and protected in all circumstances.

Article 33: The material of mobile medical units . . . shall be reserved for the care of wounded and sick.

The material and stores defined in the present Article shall not be intentionally destroyed.

GENEVA CONVENTION III (Protection for prisoners of war)

Article 13: Prisoners of war must at all times be humanely treated. Any unlawful act or omission by the Detaining Power causing death or seriously endangering the health of a prisoner in its custody is prohibited, and will be regarded as a serious breach of the present Convention.

Likewise, prisoners of war must at all times be protected, particularly against acts of violence or intimidation and against insults and public curiosity.

Article 30: Prisoners of war suffering from serious disease, or whose condition requires special treatment, a surgical operation or hospital care, must be admitted to any military or civilian medical unit where treatment can be given . . .

The cost of treatment . . . shall be borne by the Detaining Power.

GENEVA CONVENTION IV (Protection of the civilian populations)

Article 18: Civilian hospitals organized to care to the wounded and sick, infirm and maternity cases, may in no circumstances be the object of attack, but shall at all times be respected and protected by the Parties to the conflict.

Article 20: Persons regularly and solely engaged in the operation and administration of civilian hospitals, including the personnel engaged in the search for, removal and transportation of and caring for the wounded and sick civilians, the infirm and maternity cases, shall be respected and protected.

Article 21: Convoys of vehicles or hospital trains on land , , , conveying wounded and sick civilians, the infirm and maternity cases, shall be respected and protected in the same manner as the hospitals for in Article 18.

Article 23: Each High Contracting Party shall allow for the free passage of all consignments of medical and hospital stores . . . intended only for civilians of another High Contracting Party, even if the latter is its adversary. It shall likewise permit the free passage of all consignments of essential foodstuffs, clothing and tonics intended for children under fifteen, expectant mothers and maternity cases.

Article 55: To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring food and medical supplies of the population; it should, in particular, bring in the necessary foodstuffs, medical stores and other articles if the resources of the occupied territories are inadequate.

Article 56: To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical

and hospital establishments and services, public health and hygiene in the occupied territory, with particular reference to the adoption and application of the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics. Medical personnel of all categories shall be allowed to carry out their duties.

In adopting measures of health and hygiene and in their implementation, the Occupying Power shall take into consideration the moral and ethical susceptibilities of the population of the occupied territory.

Article 147 :^[4] Grave breaches . . . shall be those involving any of the following acts, if committed against persons or property protected in the present Convention: willful killing, torture or inhumane treatment, including biological experiments, willfully causing great suffering or serious injury to body or health, unlawful deportation or transfer or unlawful confinement of a protected person, . . . taking of hostages and extensive destruction and appropriation of property, not justified by military necessity and carried out unlawfully and wantonly.

^[1] Geneva Convention II addresses wounded, sick and shipwrecked naval personnel, and does not apply to the conflict in Iraq. The United States has not ratified the two Protocols Additional, adopted in 1977. However, some of their provisions are viewed as binding customary international law and should be consulted in the context of health rights and health care.

^[2] The whole of Convention I addresses the medical rights of sick and wounded combatants. This selection is only meant to provide the framework articles.

^[3] The rule of non-renunciation of rights is found in all four Conventions, and applies to the particular persons addressed in each. As the language is essentially identical it will not be set out under the other Conventions.

^[4] There is a grave breach (war crimes) article in each Geneva Convention. In Convention I it is Article 50; in Convention III it is Article 130; in Convention IV it is Article 147. While nearly identical, each specifically addresses the “protected” persons or property, so we have set out Article 147 of Convention IV as the most relevant here.