SITUATION ANALYSIS
OF CHILDREN AND WOMEN IN IRAQ

UNICEF/IRAQ

30 April 1998


Turkey
IRAQ
Dohuk
Erbil
Ninevah
Syria
Suleimanayah
Tameem
Salahuddin
Iran
Diala
BAGHDAD
Anbar
Jordan
Babil
Wasit
Kerbala
Missan
Qadissiyah
Thiqar
Najaf
Basrah
Muthana
Kuwait
Km
100
200
Saudi Arabia

FOREWORD

Addressing the continued adversities of children and women in Iraq and linkage with Child Rights is UNICEF's major concern. The economic and political priorities with the embargo overwhelms their needed care. Malnutrition, a hidden emergency, has at last been exposed as affecting about 30% of children under five years of age by the end of 1996, a big increase since 1990. This has not improved as of March 1998, despite the oil for food programme. The protection of children and their due rights will be reflected by their nutritional status, which requires close attention and monitoring.

Attention to malnutrition's multi-sectoral causes is essential for adequate control. The economy, government resources in the public sector and their priorities will affect household food security, health and water/sanitation services. Rations (currently inadequate both in quantity and quality), even if adequate do not ensure proper child feeding; treatment of illness, even if improved does not ensure protection from diarrhoea and disease; provision of water and sanitation supplies does not ensure proper maintenance and use. Support for neglected key areas such as for electrical power, agricultural production and education is necessary.

The "oil-for-food" programme overlooks to a certain extent the special needs of children and women. Its thrust is for the rehabilitation of structures and provision of supplies/equipment in the major sectors of health, water/sanitation and education. It lacks the necessary resources to improve the quality and extent of services, including social mobilization and enhanced community participation. It does not provide cash assistance to support training, logistics and maintenance in Centre/South Iraq. Other funding sources are needed.

Specific current and projected problems are as follows:

1. Widespread protein energy malnutrition.
2. Pneumonia and diarrheal diseases, with malnutrition, responsible for high infant and under-5's mortality rates.
3. Uncertainty of polio eradication, measles control or neonatal tetanus elimination.
4. High rates of maternal mortality.
5. Inadequate water and environmental sanitation conditions especially in rural areas, combined with unsuitable health and food hygiene practices.
6. Limited access to and quality of education
7. The breakdown of the socio-cultural fabric of the society, due to the economic collapse and decline of basic services has resulted in a substantial increase of the number of female-headed households, working mothers, street children and child labourers.
8. The limited capacity of governorate, district and sub-district level sectoral staff and extension workers to improve the quality of basic services, as well as beneficiary demand for these services.
9. Current trends suggest that many of the goals and targets of the NPA will be difficult to achieve unless substantial additional physical and financial resources for child survival and protection are available in 1999 and 2000.
10. Unclear and isolated communication, information and education channels hinder achieving the behavioral changes required for the NPA goals. There is no integrated agreed strategy between the involved sectors to develop "core" materials and messages for adaptation to specific local requirements. In consequence, there is no proper sequencing for implementation.
11. Families, and especially women have insufficient access to the knowledge and skills for self-action in health and well being, and optimizing available services. The "Facts for Life" approach is not forcefully promoted.

When the economic situation improves, nutrition, health, water/sanitation and education will need support in the recovery period. Many of the current programme strategies will still be relevant, but need flexibility due to uncertainties of the future for Iraq.

ACRONYMS

ARI	Acute Respiratory Infection
BCG	Vaccine used against Tuberculosis in young children
CCCU	Community Child Care Unit
CDD	Control of Diarrhoeal Diseases
CEDAW	Elimination of All Forms of Discrimination Against Women
CEDC	Children in Exceptionally Difficult Circumstances
CRC	Convention on the Rights of the Child
CSO	Central Statistical Organization
CWC	Child Welfare Commission (Government of Iraq)
DPT	Diphtheria/Pertussis (Whooping Cough) /Tetanus combination vaccine
DU	Depleted Uranium
EPI	Expanded Programme on Immunization
FAO	Food and Agricultural Organization
GFIW	General Federation of Iraqi Women
GFIY	General Federation of Iraqi Youth
GOI	Government of Iraq
ID	Iraqi Dinar - Currency used for Governorates in the South/Centre
IDD	Iodine Deficiency Disorders
KAP	Knowledge, Attitudes and Practice
LPC	Local People Council
MCH	Maternal and Child Health
MICS	Multiple Cluster Indicator Survey (conducted in August 1996)
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
MOU	Memorandum of Understanding - between the UN and the Government of Iraq relating to the Oil for Food Programme
NPA	National Plan of Action
NRI	Nutrition Research Institute (Ministry of Health)
OPV	Oral Polio vaccine drops for young children
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PFA	Platform for Action (prepared at the Fourth World Conference of Women)
PHC	Primary Health Care
RCC	Revolutionary Command Council
SID	Swiss Iraqi Dinar - Currency used for Governorates in the Autonomous Northern Region
SRC	UN Security Council Resolution
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid - Vaccine for women to prevent tetanus mainly in their forthcoming children
UNDP	United Nations Development Programme
UNESCO	United Nations Education and Social Organization
UNICEF	United Nations Children's Fund
UNOHCI	United Nations Office of Humanitarian Coordinator in Iraq
UNSCOM	United Nations Special Commission
WATSAN	Water and Sanitation
WFP	World Food Programme
WHO	World Health Organization

IRAQ BASIC DATA

1. Child population (millions, 0-15) 1990/1996	8.3	9.23
2. Under 5 Mortality Rate (per 1000 live births) 1990/1994	52	140
3. Infant Mortality Rate(per 1000 live births) 1990/1994	31.7	111.7
4. Maternal Mortality Rate (per 100,000 live births) 1990/1994	117	310
5. Underweight (% moderate & severe) 1990/1996	4.5	23.4
6. Illiteracy rate (% Total/Male/Female) 1987-1993	27.4/20.2/34.5	40/30/51
7. Primary school net enrolment rate (Total/Male/Female) 1990/1- 1994/5	93.9/99.8/87.8	90.2/94.6/85.4
8. Primary school gross enrolment rate (Total/Male/Female) 1990/1-1994/5	107.8/116.9/98.2	102.4/109.4/95.0
9. Primary school dropout rate (Total/Male/Female) 1989/1990	2.1/1.7/2.5	2.4/2.1/2.8
10. Access to safe water (Total/Rural/Urban) (%) - 1995		77.5/44.2/91.9
11. Gross Domestic Product per capita ($US) 1990/1993	$3508	$761
12. One year old fully immunized against:		
Tuberculosis 1990/1995	81	97.9
DPT 1990/1995	63	89.3
OPV 1990/1995	63	89.2
Measles 1990/1995	52	95.0
13. Pregnant women immunized against tetanus (TT2) 1992/1995	58.4	70.0

First column is earlier date, second column later date when applicable

Sources of Data:

1. Central Statistical Organization
2-4. Human Development Report 1995
5. Human Development Report 1996, and Multiple Indicator Cluster Survey, 1996
6. MENARO, Education Unit 1993; Annual Statistical Abstract 1994 (Central Statistical Organization)
7-9. Ministry of Education
10. Water and Sanitation Survey 1995
11. Human Development Report 1996
12 Ministry of Health 1996
13 Ministry of Health

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INTRODUCTION

Ratification of the Convention on the Rights of the Child (CRC) and on the Elimination of All Forms of Discrimination Against Women (CEDAW) by member states of the U.N. are milestones in support of Human Development, but not sufficient to insure effective implementation. This is particularly true in situations such as Iraq's where the capacity of the state to exercise its responsibilities for social welfare have been subjected to serious constraints over the past seven years because of economic sanctions.

Commitment to the CRC is also clearly expressed in UNICEF's Mission Statement.[1] Gender equity constitutes an outstanding, with support of the rights of the girl child and of adult females. More recently, in relation to the Fourth World Conference on Women, priority areas for the Platform for Action (PFA) are girls' education; adolescent girls' and women's health; children's rights and women's rights.[2] Advocacy in these domains has progressed to implementation, with the development of new concepts.[3]

The ratification of the CRC (in 1994) by the Government of Iraq (GOI) and the approval of the National Plan of Action for Iraqi Children by the National Assembly (in 1995), has created a broad-based platform for children, to be placed in the centre of the political and social agenda. The Government prepared the initial State Party Report of Iraq on its compliance for CRC implementation.[4] The Committee on the Rights of the Child met with UN Organizations and bodies to discuss the GOI report on 27 January 1998 in Geneva, to be followed by a plenary session in September 1998.

However, effective implementation of the CRC and the CEDAW in Iraq is constrained by the adverse economic situation following the war with Iran during the 80's and the continued sanctions since 1990. This has resulted in decreased social sector support and a direct cumulative effect on the Iraqi people, in particular on the well-being of children and women. Hence a dynamic and historical view of economic and social development in Iraq is essential for an appropriate situation analysis.

By 1990, the Iraqi GDP per capita had risen to US$ 3,508 within the framework of an oil boom,[5] and enjoyed the largesse of the welfare state. The Economist Intelligence Unit remarks:

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[1] As approved by the Executive Board in January 1996 the Mission Statement reads: **"UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children."**

[2] UNICEF "Follow-Up to the Fourth World Conference on Women." (Item 10 of the provisional agenda of the Executive Board), January 1996.

[3] Urban Jonsson, Draft of "Realization of Children's Rights: Charity or Solidarity?" UNICEF South Asia Regional Office. Jonnson emphasizes the importance of addressing child rights which are respected, protected and fulfilled compared with considering child needs which can be met and fulfilled, but not necessarily sustained. Whereas rights imply a political choice, needs imply a less proactive political will.

[4] First Periodical Report on the Implementation of the Convention on the Rights of the Child - June 1996. Baghdad, 1996 (English translation)

> *The Iraqi welfare state was, until recently, among the most comprehensive and generous in the Arab World...It insured that Iraqis had the highest caloric consumption per head in the Middle East by the end of the (1980s)....*[6]

By 1990, Iraq's Human Development Index (HDI) had far surpassed that of the countries with which it now shares inadequate social sector support. The index also compared favourably with that of its regional neighbours and placed it among countries of the medium human development aggregates category in UNDP's first (1990) Human Development Report. This has now changed.

> *What we have in Iraq is a situation of rapid decline ...on the part of a society that had previously experienced... over three decades of successful development....By the end of the 1980s, 92% of the population had access to safe water, somewhat less enjoyed modern sanitation, and an impressive 93% lived in the catchment areas served by modern health facilities. The government's network of health centers and hospitals was well disseminated, well supplied, well staffed, and effectively-if rather clinically-engaged with the populations in their jurisdiction.... Iraq had converted oil wealth into enhanced social well-being with considerable success...Education expanded, child mortality declined, and life expectancy increased all quite impressively.*[7]

Against this background, recent restrictions on the capacity of public institutions to protect Iraqi children's lives and promote their welfare constrains implementing the U.N.-mandated conventions of the CRC and the CEDAW(/PFA. Economic sanctions on Iraq over the past seven years have had a devastating effect on the majority of the Iraqi people, particularly children.

These international developments affect national, household and individual levels in the form of deprivation, malnutrition amd disease. Commenting on this micro-macro linkage, Field remarks:

> *Let me say a few words about the embargo and sanctions. This is not something that we as a professional team (of Tufts University-UNICEF) were mandated to do or to comment on, but somehow you cannot escape the issue...*[8]

Since Field made this remark in August 1991, the effect of economic hardship on a once prosperous society has resulted in a cumulated series of setbacks, such as reduced food supply, polluted water, soaring inflation and deteriorating standards of education, posing a series of risks to Child Survival, a core principle of the CRC.

The food which Iraq was allowed to import in exchange for oil, within the framework of Security Council Resolution (SCR) 986/1111/1143/1153, was expected to reduce widespread suffering, providing that supplies would be received in full, in a timely manner, and in conjunction with other health related imports such as water/sanitation commodities and medical supplies. This expectation is yet to be fully

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[6] The Economist Intelligence Unit Iraq Country Report 1995-1996, p.6.

[7] John Field "From Food Security to Food Insecurity: The Case of Iraq, 1990-1991." GeoJournal 30(2):185-194. June, 1993, Kluwer Academic Publishers.

[8] From John Field's August 1991 testimony at the hearing held before the International Task Force of the Select Committee on Hunger, House of Representatives, U.S. Congress. Washington, D.C.. U.S. Government Printing Office, 1992.

realized as of April 1998.[9]

Commenting on the adequacy of food supplies in its July 1997 third quarter report, the Economist Intelligence Unit states: "*Food supplies have arrived in Iraq, but are not sufficient to meet demand, causing further currency depreciation and rises in inflation.*"[10] The Oil-for-Food Plan has not yet resulted in adequate protection of Iraq's children from malnutrition/ disease. Those children spared from death continue to remain deprived of essential rights addressed in the CRC[11].

Iraq faces a significant challenge in its efforts of operationalizing the U.N. General Assembly's directive "to help children...reach their **full** potential.[12] Under the present circumstances a clearly targeted "Safety Net" is essential as a means of addressing the basic needs of the most vulnerable children in Iraq.

The basic objective of this Situation Analysis is to lay a foundation for programmes relevant to current conditions in Iraq. The most recent information will be highlighted and linked to the past to show trends. Emphasis is given to special groups affected by the evolving situation - children who are malnourished, disabled, in child labour, on the streets, and of families in women-headed households. The analysis will relate to the implications of the CRC, the PFA and the related convention on gender equity (CEDAW). Its timing allows a useful baseline and progress for the effects of the implementation of Security Council Resolutions 986/1111/1143/1153 based on the "oil for food" programme.

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[9] Resolution 986 by the Security Council on April 14, 1995 enabled Iraq to sell up to US$ 1 billion worth of oil every 90 days for humanitarian needs. It went into effect on December 10, 1996. Resolutions 1111 and 1143 were made at six month intervals, while 1153 is now under consideration (for more details of the Oil for Food see section 1.5).

[10] The Economist Intelligence Unit "Iraq Country Report, 3rd Quarter." London, 1997.

[11] For a critique of Child Survival strategies in general -
N. Scheper-Hughes, ed. "Child Survival: Anthropological Perspectives on the Treatment and Maltreatment of Children." Boston: Reidel Publishers, 1987.
M. Nichter and E. Cartwright. "Saving the Children for the Tobacco Industry." Medical Anthropology Quarterly Vol 5:236-256, 1991.
For the Arab World specifically - S. Morsy and J. El-Bayoumi, op.cit., 1993 (reference 5).

[12] UNICEF Mission Statement, emphasis added.

PART ONE
IRAQ NATIONAL CONTEXT

1. Overview

1.1 Physical Environment

The Republic of Iraq covers an area of 435,052 Km^2. It is bounded by Turkey and Syria in the North and Iran in the East; Syria, Jordan and Saudi Arabia in the West; Kuwait, Saudi Arabia and the Gulf in the South.

Iraq is comprised of four major physiographic regions: mountain (21% of total), alluvial plain (30%), desert plateau (39%) and the upper plains/foot-hills (10%). Climatic variation ranges from cool to cold winters, and hot to extremely hot, dry summers. Regional differences are such that Baghdad is fairly dry; the South is very humid; the North is cool all year round, with very cold winters.

Of the total land area of Iraq, only 25% is arable. The rainfall pattern is one of great irregularity and ranges from under 100mm to about 1,000mm/year. Agricultural production, which covers about one-half of the country's arable land, is limited by inadequate land preparation and deterioration of soil quality, despite land reclamation. Irrigation has resulted in widespread water logging and salinity problems in one-half of the areas. Crop infestation has increased.

These problems, compounded by the limited availability of machinery, reliance on inadequate inputs and the general deterioration of irrigation facilities has resulted in reduced yields for cereal production in 1997 estimated at 2.2 million tons, the lowest since 1991.[13] Even in the fertile northern governorates, there was a drop of 30% in crop production for 1996.[14]

1.2 Political Organization

Iraq became a republic in 1958 following the overthrow of the monarchy. With the Revolutionary Command Council (RCC) assuming legislative powers, the Baath Party has ruled Iraq since 1968. Executive responsibilities are assumed by a cabinet of ministers with the President of the Republic also currently acting as Prime Minister. President Saddam Hussein has ruled since 1978.

Since its formation in 1980 the National Assembly assumed legislative powers but resolutions issued by the RCC continue to have the authority of law. Of the various National Assembly Committees, responsibility for implementation of the CRC is assigned to the Human Rights Committee. Other specialized committees operating in the National Assembly are as follows: Religious Affairs, Health and Social; People's Affairs; Information, Students and Youth; Environment; Financial and Economic; Industry, Oil and Minerals; Legal and Administrative; Agricultural Affairs; Arab and International Affairs.

The National Assembly has the power to invite a Minister or government official to discuss any

[13] FAO/WFP Food Supply and Nutrition Assessment Mission to Iraq, October 1997

[14] UNICEF Northern Iraq "Comments on the Situation Analysis Draft." 1997

issues related to people's lives. Children's issues in Iraq have priority and good support, and a responsible Minister has a commitment to the rights of the children.

The National Assembly consists mainly of males. The proportion of women members was 6.4% in 1980, rising to 13.2% in 1984, and declining to 10.8% in 1990.[15] As with the Popular Councils, legal guarantees of women's right to run for membership did not result in equitable representation in these political institutions. This also applies to Iraq's political parties (the ruling Baath, Kurdistan Democratic and Kurdistan Revolutionary Party).

The main administrative structure of the country is the governorate, of which 18 constitute the Republic of Iraq. As shown in Table 1.1, these are grouped as Northern, Central and Southern.

Table 1.1
Iraq's Regional Governorates

Northern Governorates*	Central Governorates	Southern Governorates
1. Nineveh	1. Baghdad	1. Thiqar
2. Ta'meem	2. Salahuddin	2. Missan
*3. Erbil**	3. Diala	3. Muthana
*4. Suleimaniyah**	4. Wasit	4. Basrah
*5. Dohuk**	5. Kerbala	
	6. Najaf	
	7. Babil	
	8. Anbar	
	9. Qadisiyah	

** Note that the "Autonomous Northern Region" forms only part of the "Northern Governorates" as indicated in the table*

Each of the 18 governorates is divided into districts (Qadha) and subdistricts (Nahiya). The latter consists of villages with a total of 10,000 over the entire country. The governorate is administered by a Governor, responsible for the implementation of the government policies, plans and development projects. The governors have strict control over the governorate, and their role is crucial for the successful implementation of CRC-related activities[16].

The qaimmakam is the administrator at the district level, while the mudeer al-nahia serves a similar function at the sub-district. At the local level, the mukhtar is the direct government representative to the people.

People's access to higher authorities is channeled through two main bodies; one is the Local People Councils (LPC's) at the governorate, district and sub-district levels, and the other is the National Assembly (Parliament). These two bodies provide a forum for participation in the political process, while at the same time assuring that government policy is implemented at the community level. The LPC's gained more power in 1996, when a law was issued specifying their tasks and jurisdictions. These councils are supported by the political leadership of the country and by the Baath Party (the ruling party).

[15] The National Report on Women." Report presented to the Regional Preparatory Meeting for the Fourth World Conference on Women by the General Federation of Iraqi Women (in Arabic), p.12.

[16] Involving the governors proved very effective in the establishment of the decentralized Mid-Decade goals monitoring system in 1994-1995. See "Iraq's Integrated Goals Monitoring System" in UNICEF/MENA Report, 1997, pp 36-7. Success was due to a strengthening of the Central Statistical Organization staff who in turn trained governorate CSO representatives. They reported regularly to their governors on progress.

Their members can be effective to help support the CRC locally. Professional and cultural organizations such as the General Federation of Iraqi Women (GFIW), the General Federation of the Iraqi Youth (GFIY), the Farmers Union, the Trade Union and other recognized groups are additional forums and means of communication between the government and the people.

The northern governorates of Erbil, Suleimaniyah and Dohuk are the Autonomous Region where Kurds predominate numerically. They were granted autonomy in 1973. Factional hostilities and armed conflict relate to territory control. The major groups, the Patriotic Union of Kurdistan (PUK) linked with Iran, the Kurdistan Democratic Party (KDP) and the Kurdish Turkistan Workers Party (PKK) - which is involved in border raids with Turkey - have created instability in the region (most recently in late 1996 and late 1997) and uncertainty about the future. Currently there are two separate administrations - one in Suleimanayah, the other in Erbil and Dohuk. The Government of Iraq provided public support to the region up to 1992.

Iraqi women have in general benefitted from the social programmes of the welfare state and some women reached positions of power in governorate institutions. However males predominate in Iraq's local, regional and national administrative structures.

1.3 Socio-Economic Development

1.3.1 The Era of Economic Prosperity

1.3.1.1 Iraq's Economy

The Iraqi economy has been dominated by the oil sector, which in 1989 comprised 61% of the Gross Domestic Product (GDP). Services come second (22% of GDP), then industry (12%) with a mere 5% from agriculture[17] .The substantial oil revenues brought prosperity for most Iraqis and high government expenditures in the public sector. Even so, the major consumption (56%) was in the private sector, followed by 33% for the public sector[18].

Oil wealth financed an impressive social sector infrastructure for both urban and rural areas. Benefits also extended to guest workers, including professionals from less affluent regions of the Arab World.

The First Five Year Plan in 1972 followed the nationalization of Iraq's oil resources. It emphasized water resource management with large scale land reclamation and construction of a complex network of drainage systems to containing soil salinity. Although the basic goal of agrarian development was food security, Iraq remained dependent on imports for most of its food consumption, which had increased with the raised living standards. This dependence included health, water and sanitation equipment and supplies.

[17] Country Profile 1996-1997 Economist Intelligence Unit (EIU) - 15 Regent St., London SW1Y 4LR, UK.

[18] Ibid.

1.3.1.2 Health Sector Development

As with other public institutions, the health sector grew with the economy. This included both preventive and curative (clinical) health care, with coverage extending to rural areas. By 1990 Iraq had over 9,000 physicians, many trained in the U.K. with about one- quarter who were board-certified specialists. Iraqi biomedical specialists provided some of the most sophisticated medical care in the Arab region, including kidney transplants, extrauterine fertilization and open heart surgery. Primary medical care reached about 97% of the urban population, and 78% of rural residents[19].

Child health indicators of the 1980's reflected the improved health conditions, for example the reduction of infant and under five mortality rates[20]. Iraq relied heavily on import-dependent, high technology, curative biomedicine with health promotion of secondary importance.

The 1985-1990 National Plan preparation started serious attention to social mobilization campaigns, the mass media, non-health sectors and popular organizations[21]. But traditional local health promoting practices were not promoted.[22] An important example is the decline of breastfeeding in favour of infant formula imported during the seventies and eighties. While 76% of newborns were breast-fed at three months of age, this declined to 45% by six months, and to 19% by 12 months of age as of the late 80's[23].

Water and sanitation services for treatment plants and networks were well developed, especially in urban areas and relied on centralized implementation using sophisticated technology. This has been seriously affected by the economic constraints, with a consequent increase in water and food-borne diseases such as diarrhoea, typhoid and cholera. These are major factors in the poorer health and nutrition of the population. The abundant power supply for water and sanitation services as well as other critical needs, such as in hospitals, is no longer available.

1.3.1.3 Public Education and Salaried Employment

Public expenditure also subsidized the expansion of the education sector, covering all levels of schools, from Kindergarten to University. Children's Right to education was insured by the Compulsory Education Law passed in 1976. This made primary level education mandatory and free. By the beginning of the nineties, primary school attendance became almost universal, reaching about 93%.

Except for primary education, male enrollment continued to outnumber that of females'. The gender specific educational/skill differential among Iraqis remains in favor of males. In 1994, when the need for additional income was increasing, women's participation in the formal economy labour force amounted to less than 25% of all women, compared to 78% for men. As observed for the Arab region in general, these official labour force statistics, which (by definition) focus on remunerated labour, greatly

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[19] Richard Garfield, Sarah Zaidi, and Jean Lennock "Medical Care in Iraq Following Six Years of Economic Sanctions." Unpublished report, September, 1996, p.3.

[20] UNICEF MENA Evaluation Series No.9, op.cit, 1990, p.45.

[21] Ibid, p.12

[22] This has been generally the case elsewhere in the Arab World and stands in contrast to practices in other societies of ancient literate medical traditions, notably China and India. But even compared to other Arab countries Iraq seems to represent an extreme case. Traditional preventive practices and cures, including herbal medicine have been to a large extent abandoned in favor of over-consumption of (imported) pharmaceuticals.

[23] James Grant, "The State of the World's Children."New York, Oxford University Press, p.104, 1990.

underestimate women's contribution to the national economy. This narrow focus bypasses women's informal sector role.

With the special demands during the Iran-Iraq war, women's industrial employment increased by 38%, compared with a decrease of 22% in men[24]. An additional burden during this time was that many Iraqi women, particularly widows, assumed the responsibilities of heads of households.

For women who are recognized as part of the labour force, those of Iraq's public sector have enjoyed a number of benefits in accordance with Labour Code 17 for the year 1987. This code and related legislation, notably the Law of Pension and Social Security (1971) and Maternal Law (1971), guaranteed women equal opportunity with men in civil service employment, a paid leave for one month before delivery and for six months after delivery (or a year with half pay).

Opportunities of public sector employment guaranteed to women by Iraqi law include those which require professional expertise. However, whereas female specialists and technicians just outnumber males, only 12% at the higher echelon of the administrative ladders are females (Table 1.2).

Table 1.2
Percentage of Female Employees by Profession, 1993

Profession	% of females to total employees
Administrative staff, secretaries and clerks	56
Selling activities	53
Specialists & technicians	52
Services	27
Legislators, Administrative Heads & Directors	12
Grand Total	**47**

Source: National Report on Woman Development, GFIW, 1994, pp15

1.3.2 The Economic Crisis of the Nineties

1.3.2.1 The Impoverishment of Iraqis

When the Gulf War broke out on January 17, 1991, the Iraqi economy was still under pressure from the effects of the Iraq-Iran war which continued for 8 years (1980-1988). This caused a reduction in Gross Domestic Product (GDP) and country's financial reserves with inflation, slowing in the industrial sector growth and the public budget, including that for the social sectors.

The embargo resulted in further rapid economic decline.[25] In 1991 the GDP dropped by about

[24] Calculated from the Annual Statistical Abstracts published in 1985 and 1991 by the Central Statistical Organization (CSO).

[25] The cumulated economic cost to Iraq as a result of the sanctions is very great. One estimate comes from the Human Development Report/Iraq 1995. Based on the expected GDP in the absence of sanctions minus the GDP obtained, the report (using fixed prices of 1990) estimates that $166.6 billion was lost in the non-oil sector (based on an exchange rate of $3.1/ID) and a total of $98.7 billion actual dollars for oil lost from 1990 to 1995.

three quarters of its 1990 value to approximate that of the 1940's.[26] By September 1995, the U.N.'s Department of Humanitarian Affairs estimated that about 4 million Iraqis (about 20%) lived in extreme poverty[27]. These are mainly Iraqis living in areas with underdeveloped infrastructure and limited economic opportunities. The people of the southern part of Iraq had already been devastated in the Iran-Iraq war and the Gulf War. Populations in border areas and those affected by continued hostilities in the Autonomous Region of the North are also especially vulnerable.

Unemployment is widespread and even those employed (particularly in the public sector) may go without pay for long periods. Most look for other work to supplement their income. Iraqi families are often forced to sell their household and personal assets when borrowing money is not an option. Increasingly, children work as shoe polishers, cleaners or selling items on the street.

Productive economic activities have stagnated due to lack of investment, acute shortage of supplies, spare parts, unreliable fuel and power supplies. There was a sharp decrease in the standard of living and employment opportunities. The northern governorates are also subjected to continuing political instability. For the Autonomous Region, the 1994 ODA Household Expenditure Survey reports that the poorest 10% of households earned only 3% of the average household expenditure[28].

The purchasing power of the local currency has greatly reduced, with the precipitous depreciation in the value of the Iraqi Dinar (ID). Its exchange rate dropped from the equivalent of US$3 in 1990 to $1/3,000 by the end of 1995, although has managed to be more stable at about $1/1500 during 1997.

Whereas low-income families came to bear the primary brunt of economic decline during the nineties, even senior officials with relatively high incomes are unable to satisfy their families' basic needs. With the average public sector wage declining to the equivalent of $3 to $5 per month, its earner can afford to purchase the minimum basic essentials. Important households at risk are these with widows and disabilities as a result of two recent wars.

1.3.2.2 De-Skilling of Professionals and Salaried Employment

A significant number of professionals have left Iraq due to the economic situation. Those who remain accept less skilled employment to make a living, many requiring two or three jobs to augment their needed in`come. It is not clear how the erosion of professional groups has affected their gender composition. This is an important concern, particularly for the health and education sectors where the presence of women doctors and teachers encourages the use of these services by females.

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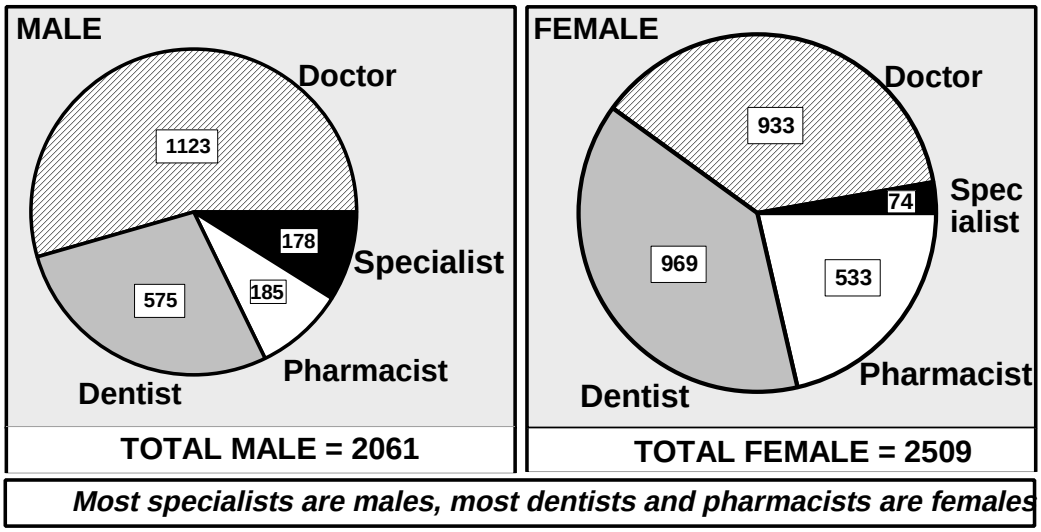
[26] Economist Intelligence Unit, Iraq Country Profile, 1996-1997, p.13

[27] U.N. Consolidated Inter-Agency Humanitarian Cooperation Programme for Iraq: (1995) Mid-Term Review

[28] Ward & M. Rimmer "Targeting Basic Assistance in Northern Iraq: Findings from a Household Expenditure Survey." 1994.

Figure 1.1 illustrates that in hospitals, female dentists and pharmacists (whose practices are more consistent with cultural perceptions of modesty) outnumber males, but male specialists predominate.

Figure 1.1:
Number of Male and Female Health Professionals in Hospitals - December 1993



Source: Annual Statistical Abstracts, CSO, 1994, table 11/7

Teachers Preparation Institutes continue to have larger proportions of females. The percentage of graduate female tea`hers has steadily increased from 51% in 1980 to 53% in 1985, to 60% in 1994. This is reflected in the increase of female teachers in primary schools as a percent of the total (48% in 1980 to 69% in 1994) and in secondary school (41% in 1980 to 54% in 1994). However the percent of females in technical schools and universities has not changed much from 1980 to 1994 (31% to 35%)[29].

The proportion of women has increased in the service sector from 11.9% in 1987 to 79% in 1992. In Iraq's large industries this rose from 13% to 21%, including the period from 1990 to 1993, when total employment dropped by 22% (Table 1.3).

Table 1.3
Number of Male and Female employees in Iraq's Large Industries 1984 - 1993

Year	Male	%	Female	%	Total
1984	148,019	87	21,975	13	169,994
1990	130,280	81	30,386	19	160,666
1993	98,277	78	27,079	22	125,356

Source: Calculated from the Annual Statistical Abstracts for the years 1985, 1991 and 1994, table 4/3, Central Statistical Organization.

[29] Annual Statistical Abstracts, Central Statistical Office, 1994

This development in labour force composition started with the Iran-Iraq war, then continued during economic austerity. One interpretation is that men leave the public sector in pursuit of higher income activities within or outside of Iraq; women are more restricted, with family and household responsibilities. Culturally, men continue as the primary "bread-winners", while women's contributions to household incomes are regarded as complementary. As second-income holders, women public sector employees/mothers are in a better position to remain in their jobs, given the sector's relatively limited demands on their time. Benefits of maternity leave and extended leaves without pay also contribute to the stability of female public employees.

The importance of education (Article 10 of the CEDAW) as a means of allowing women access to a steady income comes into focus. Within the prevailing economic crisis, this income may be the crucial means of ensuring children's survival. Without it, many Iraqi families and their children suffer the consequences.

1.3.2.3 Economic Austerity and Social Deprivation

Economic deterioration correlates with an increasing number of street children, adult beggars and theft. Child labour, often seen on the streets of Baghdad, is linked to an expanding informal sector. A worse fate, that of delinquency, increasingly threatens children.

The interruption of the flow of oil revenues dealt the public sector a severe blow. Its current state of near dormancy affects many facets of social life, including those relevant to children's rights and gender equity. Education and public health are especially affected.

The decline in public education is reinforced by the increased responsibility for family welfare and income on children. While child labour outside the household in the public sphere may be primarily associated with boys, girls' responsibilities of income generation within the domestic domain limits continued school attendance, and by extension, the promotion of girls' education. The increased reliance on boys' income generation is even greater as shown by secondary education enrolment. Whereas this increased for girls from 29% in 1981 to 39% in 1990/91, it declined in boys from 71% to 61% over the same period[30].

In the health sector, the combination of severe compromises in the country's food security profile, economic decline, and destruction of Iraq's infrastructure particularly in relation to the supply of safe water, had major consequences for child health. It is estimated that by 1995 the IMR doubled as compared with 1990.[31]

[30] UNICEF Situation Analysis, 1992, p.48.

[31] Human Development Report/Iraq, 1995, page 19

1.3.2.4 Food Rations

Were it not for public food rations, famine would have caused even more deaths of Iraqi children. The distribution of these government-supplied rations began in September 1990, one month after the start of the embargo, for all 18 governorates. Rations were crucial given their high market value compared to incomes based on the rapidly devalued ID. With an energy value of 1225kcal /person/per day, the ration was inadequate for people's needs and represents about half of the 2500kcal daily requirement set by WHO (Table 1.4)

Table 1.4
Per Capita Monthly Public Ration
Pre-MOU*

Item	Ration kg/pc/month	Calory content kcal/pc/day	Protein gm/pc/day	Fat gm/pc/day	Subsidy price ID/ month	Market price ID
Wheat Flour	7.00	817	27	3.5	-	9,800
Rice	1.25	150	3	0.21	-	1,875
Vegetable. Oil	0.75	221	0	25	-	1,800
Sugar	0.50	67	0	0	-	1,500
Total		**1,225**	**30**	**29**	**50**	**14,975**

***** *Prior to the "Oil-for-Food" period*

The ration distribution provides equal amounts of food for all families with no selectivity for most needy. Those who could afford it, supplemented the ration with fruit and vegetables. The increased demand for these foods led to a large price increase and encouraged expansion of vegetable production over an additional 1% of the total cultivated area, increasing it to 9%. Whether such expansion will also be true for other food items seems doubtful, given the greatly increased cost of agricultural production. Further, the relatively lower market prices of wheat and rice will tend to discourage local production of these cereals.

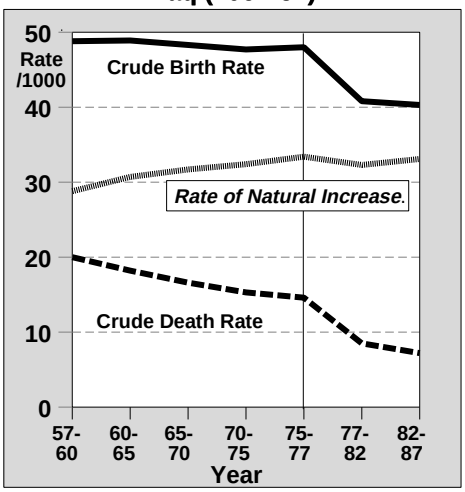
Following the outbreak of military hostilities between forces of the Kurdish-dominated northern region of Iraq and those of the central government after the Gulf war in the early 90's, the central government administration withdrew from the northern region and ceased public support in September 1992. Since then, government rations were restricted to the South/Centre. The north has relied on external donors for added support and food.

1.4 Demographic Trends

The demographic expressions of increased national wealth and social sector development of earlier decades are reflected in the decline of Crude Death Rates (CDR) and Crude Birth Rate which dropped from 48.8 to 40.3/1000 between 1957 and 1987[32] (Fig 1.2).

Since the 70's, development programmes, especially in the health sector, were oriented to achieving reduction in mortality rates and encouraging high fertility rates. The natural growth rate in the population is determined by the difference between two main factors; crude birth and death rates. Birth rates started to fall during the eighties due to the Iraq-Iran war, which balanced the decline in death rates, slowing down the growth rate increase to 3.3% per annum

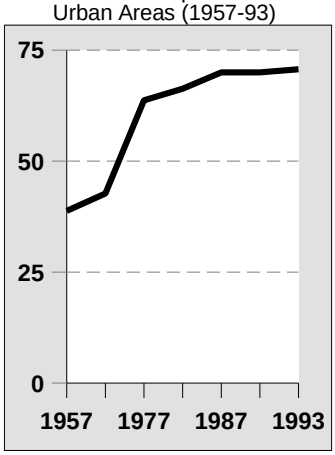
Figure 1.2
Crude Birth and Death Rates Iraq (1957-87)



Rate of Natural Increase = Crude Birth - Crude Death Rate
Source: State of the Iraqi Child, Ministry of Planning, 1991

Urbanization: The percent living in urban areas grew rapidly from 1957 to 1980 (from 39 to 66%), reflecting the increased investment in urban areas (eg industry) as compared with agriculture. The percent urbanized slowed from 1980 to 1987 (from 66 to 70%) and since then has remained about the same according to projections (Fig 1.3).

Figure 1.3
Percent of Population in Urban Areas (1957-93)



Source: Dr. M. Al-Rawi. Development activities and demographic changes in Iraq, 1994

1.4.1. Population Structure and Distribution

Iraq's population of about 20 million is still youth-dominated. The 1987 census shows people under 20 years comprised 56.9% and those under 15 years, 45.2% of the population. The Central Statistical Organization projected that by 1995, Iraq's under fives' population would be 15.5% of the total.

Preliminary results of the October 1997 National Census show the total population at 22 million and the percentage of women slightly higher than men (50.3% vs 49.7%). More detailed results are not

[32] Ministry of Planning, Government of Iraq

expected until later in 1998[33].

Ethnic and religious diversity characterize Iraq's population. According to official statistics Arabs make up 80%, Kurds 15%, and the remaining 5% is constituted of Turkoman, Yazidis, Sabeans and Armenians[34]. Kurds dominates in the three northern governorates of Erbil, Dohuk and Suleimaniyah. The majority of Turkoman reside in Kirkuk, the capital of Al Ta'meem governorate; Yazidis are found mostly in Sinjar in the northern governorate of Nineveh and Armenians are mainly in Baghdad.

About 95% of Iraqis are Muslim and more than half of these are Shiites. Christianity is the religion of about 4% of Iraqis and the remainder includes those of the Yazidi and Jewish faith.

Most of the population live in the Mesopotamia region bounding the Tigris and Euphrates rivers and in the cities of Baghdad, Mosul and Basrah. Other parts of Iraq are relatively sparsely populated. South/Central Iraq has permanently settled populations[35] .In the three northern governorates of Erbil, Dohuk and Suleimaniyah the population is more mobile, displacement (estimated at 180,000 by UNHCR) has resulted from inter-factional armed conflict, where internal political instability and military incursions.

Iraq also has over a hundred thousand refugees, including Eritreans, Iranians, Palestinians and Turks. Females constitute a slight majority of 52% over males, and children below the age of 14 make up about 55% of the refugee population. Most of the Kurdish and Palestinian refugees are integrated into local communities and their civil structures. Iranian female refugees are camp based. Within the framework of UNHCR programmes the Iranian women undergo training in carpet weaving, sewing, and knitting, as well as ceramic and pottery making. Camp based women refugees are also provided with sanitary assistance and health care. Child education is dependant on outside support[36].

1.4.2 Population Policies and Family Planning

Decline in birth rates during the years of the Iran-Iraq war prompted the government to provide financial incentives to boost population growth. Child support allowances were given to either parent for having three or more children. The extended duration of the war offset the effect of this scheme. Hence, growth rates declined slightly, from 3.3% in the 70's to 2.7% in the 80's (Fig 1.4).

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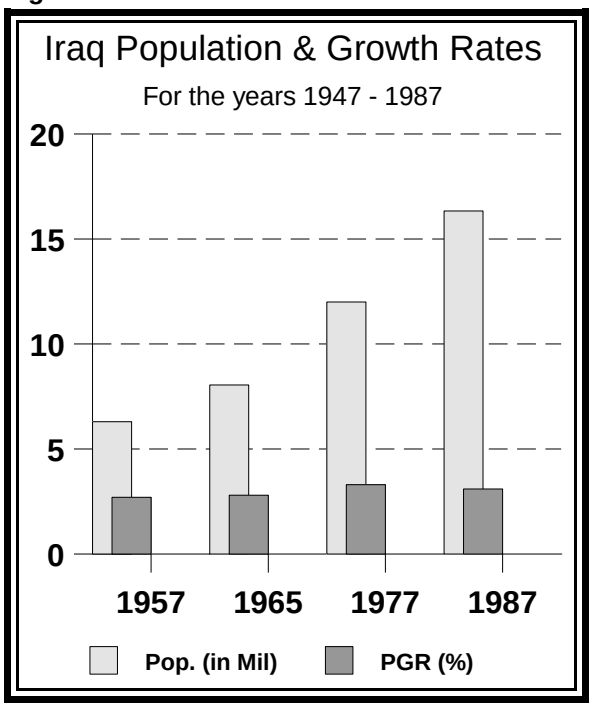
[33] Data on census categories were not available at the time of this document. Detailed information on gender relevant to programmes would be useful, but is generally unavailable, including that for women-headed households. U.N. programmes which follow the gender equity principles of international conventions, including CEDAW and PFA, generally define women headed families as a "most vulnerable group". This would also be the case in Iraq at this time of economic austerity.

[34] Due to political implications the accuracy of official statistics is always subject to questioning.

[35] Shifts do occur, especially during the Iran-Iraq War which particularly affected Basrah, Missan, Wassit, Diala, Erbil and Sulamanayah.

[36] U. N. High Commissioner For Refugees, Office of the Chief of Mission, Baghdad, Memorandum "Report on Refugee Women and Children," August 10, 1997.
UNHCR has built five primary schools in Al-Tash camp where there are 5600 students, and support 52 private classes. The government of Iraq provides teachers for the five schools, which follow the curriculum of Iraqi public schools. The private classes teach Kurdish and Farsi.

Figure 1.4



Access to contraceptives is subject to medical judgement and authorization. This has improved as a result of a ministerial directive[37] in 1991, influenced through promotion by the International Family Planning Association/Iraq (FPA/I) with national organizations and unions. This political legitimation is a significant step towards the effective implementation of the international conventions for women to which Iraq is a signatory[38]. However, medicalization of reproduction may be considered as a means of social control[39], which may compromise the principles of the CEDAW and PFA (Plan For Action).

Despite the ministerial direction, less than half of women of child bearing age use modern methods of family planning, although most are aware of these methods. Further, these services are not provided at PHCs (see fn. 40)

The Safe Motherhood Initiative, which had been accepted in other Arab and Islamic countries since the eighties was adopted by Iraq's Ministry of Health in 1995. This Initiative relates primarily to the issue of safety and only partly to the right to health. It does not address women's individual right to fertility regulation. In the Iraqi context the major concern with Safe Motherhood may be women's contribution to social reproduction. It is argued that:

> *Mothers are Iraq's main human resource, involving all social groups and families. Achieving the objectives through effective implementation of programmes and services will improve not only the mother's health and well being, but also that of her foetus, with safe delivery of a healthy child to help insure a more productive future for the nation. For this reason, a key factor is the training, supervision, practices and support of birth attendants.[40].*

In Iraq, the Safe Motherhood Initiative promotes Reproductive Health through improvements in antenatal and delivery services, particularly in relation to the activities of midwives, nurses and birth

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[37] Memo 5812, Minister of Health, Republic of Iraq, Technical Section 5/5/1991. The Minister of Health directive was to lift the ban imposed on contraceptives and allow their distribution without restriction.

[38] This legitimation was implicit in an earlier statement by the President of Iraq who stated "...***I am against limiting population, but it is imperative to have family planning in such a way as to allow parents to raise children properly, and parents must avoid compromising the welfare of the child in order to increase the numbers, but I am for the increase in the size of the family***."(Translation of the Arabic text on the wall of the entrance hall of the FPA/I.

[39] See, for example, Faye D. Ginsburg and Rayna Rapp, eds. "Conceiving the New World Order: The Global Politics of Reproduction." Berkeley: The University of California Press, 1995.

[40] "Survey of Family Planning, Delivery Services and Birth Attendants in Iraq." Conducted by TBA Programme, Ministry of Health with the participation of UNICEF/Iraq, WHO and the IFPA/Iraq, 1996

attendants. Family Planning is promoted as conducive to the protection of mother and child, and, more generally, the social good. At times, male authority as in other countries can override women's need for/right to contraception:

> *Results showed that about one in three currently married Iraqi women of child bearing age now use family planning and most of these had begun only within the past two years...The main reasons for use included limiting the burden of added family members, economic and health..... The major reasons for not using family planning measures were that the husband refuses to use any and the desire for more children. Health, religion or fear of side effects were rare reasons for non-use.* [41].

Women's right to fertility regulation is an important determinant of her health and nutrition, as well as that of her newborn and other young children, especially during times of economic austerity. This may lead to some mothers' perceived inability to breast-feed their infants when their own health is poor.

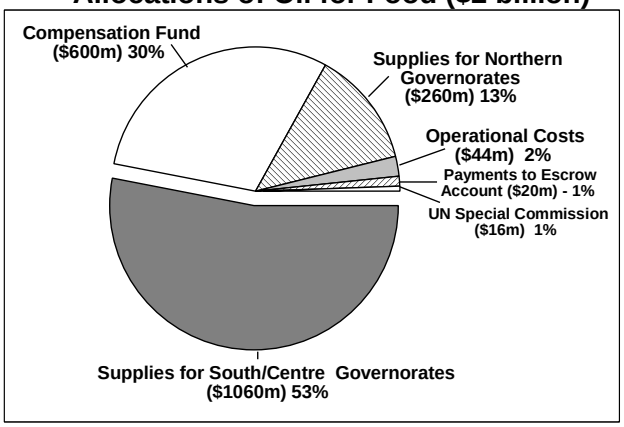
[41] Ibid, p.i-ii.

1.5 Oil for Food

The May 1996 Memorandum of Understanding (MOU) between the United Nations Secretariat and the Government of Iraq allowed Iraq to sell two billion (US) dollars' worth of oil over a 180 day period to buy humanitarian supplies[42]. Proceeds from these sales would be placed in a UN-controlled escrow bank account at the Banque Nationale de Paris.

Figure 1.5

Allocations of Oil for Food ($2 billion)



Of the $2 billion from oil revenues for each 180 days, 30% ($600 million) was for payment by Iraq as Gulf War reparations; 13% ($260 million) for the three autonomous governorates of the North 2.2% for UN operational costs ($44m) and 1% ($20 million) for payments to escrow. The remaining 53% ($1.06 billion) of the oil revenues allowed Iraq to purchase humanitarian supplies for the South/Centre, with a population of over 18 million (*Figure 1.5*).

The allocations per sector for Iraq (by percent) were as follows: food and detergent (68.6%); health, mainly medicines (16.7%), electricity and energy (4.5%); agriculture and water/sanitation (each 3.3%); education (2.1%); resettlement (0.9%); nutrition (0.4%) and de-mining (0.2%). The food allocation was relatively greater in the South/Centre compared with that of the three Northern governorates (73.9 vs 47.1%) allowing a greater percent allocated to other sectors in the north. Further, the north receives about US$ 87 per capita from humanitarian supplies, while the South/Centre receives less-about US$ 60 per capita.

In the South/Centre, the Government of Iraq would be responsible for the procurement and distribution of supplies; in the North, the UN would assume this responsibility as well as to undertake monitoring throughout Iraq.

On an annual basis, the $2 billion for all humanitarian supplies in the South/Centre governorate does not even reach FAO's estimate of the $2.7 billion needed to make up for the shortage in the food supply for the year 1996-97. It also represents only half of the UN Secretariat and UN agencies' estimated $4 billion needed annually for food and medicine alone, without taking into account upgrading and repair of the most crucial public works, notably water and sewage plants[43]. For comparison, 1989 Iraq's civilian imports cost $5 billion. [44]

Security Council Resolution 1111 of June 4, 1997 comprising Phase II, extended the Oil for Food

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[42] The Security Council Resolution 661 of August, 1990 imposed economic sanctions on Iraq, including a full trade embargo barring all imports from and exports to Iraq, except medical supplies, foodstuff and other items of humanitarian need, as determined by the Security Council Sanctions Committee (SCC). Resolution 986 of April 14, 1995 enabled Iraq to sell up to $1 billion worth of oil every 90 days and use the proceeds for humanitarian supplies to the country. It did not go into effect until eight months later (December 10, 1996), while the first food shipment arrived a further three months later (March 20, 1997).

[43] According to the 1991 estimates of the UN Secretary-General attention to all needs would cost $22 billion -

[44] Economist Intelligence Unit, op.cit., 3rd quarter 1997, p.5

programme for 180 days, with the sale of a further $2 billion Iraqi crude oil. The sectoral composition of the funds in the distribution plan was similar to that for phase I. The U.S. and U.K.'s ambassadors to the U.N. demanded rigorous monitoring of the distribution of humanitarian supplies and more detailed information in U.N. monitored distributions in the North.

Following a fact-finding tour to Iraq in mid 1997 by Under Secretary-General for Humanitarian Affairs, Yasushi Akashi confirmed that UN World Food Programme (WFP) observers had been allowed access to every Iraqi governorate and village. Mr Akashi concluded "on a prima facie basis, one could say that the government was making a good effort to distribute food on an equitable basis[45]. He also reported that less than one third of the SCR 986 food commodities allocated for the first six months (Phase I to June 1997) had been distributed by the end of May, 1997[46]. Even more so than the food, delays in the delivery of other commodities to Iraq continued to be a problem, both in the South/Centre and the North. The first significant supplies for health, water/sanitation and education began later in 1997.

As of March 15, 1998, of the allocations for Phase II (from June to December 1997) for medicines/health, about 75% had arrived in-country for the South/Centre and 50% for the North; for water/sanitation, 59% and 27%; education 37% and 45%; and for electricity/power 48% and 10% each respectively for South Centre and North.

Monthly rations are meant to provide 2,030kcal/person/day (Table 1.5). Although short of WHO's set amount of 2,500kcal, this is almost two-thirds more than was distributed prior to the passage of SCR 986, at 1225kcal/person/day. For the Autonomous Northern Governorates where the GOI had not been distributing food since 1992, the SCR 986-linked ration was a significant improvement in access to basic sustenance.

Table 1.5
Per Capita Monthly Food Ration - Under MOU - 1997

Commodity	Monthly Ration kg/person/month	Daily Ration gm/person/day	Calorie content kcal/person/day	Protein Content gm/person/day
Wheat Flour	9.00	300	1050	34
Rice	2.50	83	300	6
Sugar	2.00	67	267	0
Tea	0.15	5	0	0
Cooking Oil	1.00	33	300	0
Pulses	1.00	33	113	7
Iodized Salt	0.15	5	0	0
Total	**15.80**	**526**	**2030**	**47**
Milk Powder*			2.70	425

** For infants below one year Source: FAO/Iraq*

[45] The Economist Intelligence Unit Iraq Country Report, 3rd Quarter, 1997, p.13. Ibid.

[46] The problem is compounded by several factors, such as the late start for implementing the MOU, time to process contracts, approval by the SCC and clearance of disbursement rom the Banque de Paris.

Phase III was officially begun in December, based on Security Council Resolution 1143 to continue the oil for food for a further 180 days. The GOI distribution plan received the following month was similar to that of phase I and II. Based on the recommendations of the UN Secretary-General which indicated that the current amount is insufficient for the needs of health, nutrition and other key concerns, Security Council Resolution 1153 on February 20 permitted an increase of oil exports up to a value of $5.206 billion for the 180 day period from December 4, 1997[47]. This would entail an increase of 160% over the prior allocations for humanitarian supplies; with the same increase for compensation and UN monitoring costs. This is being considered by the GOI.

1.6 The CRC and the National Plan of Action

The National Plan of Action, developed with UNICEF participation as a follow-up to the World Summit for Children in 1989, was prepared in 1995. Three phases of implementation were identified, the first ending in 1995 (mid-decade), the second from 1995 to 1997 and the third by the year 2000. With the ratification of the CRC in 1994, the Department of Human Rights (Ministry of Foreign Affairs) became the Focal Point for reporting on CRC implementation progress. The Childhood Welfare Commission (CWC), headed by the Minister of Labour and Social Affairs (MOLSA) is responsible for monitoring. The Minister in turn reports to the Vice President.

Iraq's ratification of the CRC in 1994 occurred under very difficult circumstances - after a decade of wars, the economic embargo and internal armed conflict which ended the control of the central government over three of its governorates in the north. Hence, the "available resources," to be guaranteed for implementation (Article 4 of the CRC) continue to be restricted.

A minimum level of food intake to maintain survival continues as top priority. More generally, of the four classifications of children's rights (Survival, Development, Participation and Protection)[48], that of Survival is the most important in Iraq's CRC implementation strategy.

Beyond the right to life, Survival Rights embrace:

> *(the right) to a name, an identity, a nationality and thereafter, the economic and social rights that promote and maintain the right to life represented in health care, combating disease and malnutrition; encouraging breast feeding; diminishing infant and child mortality; The right of the child to an adequate standard of living, especially concerning nutrition and freedom from hunger[49].*

The health focus of Survival Rights resembles the health development programmes of pre-1991 Iraq prior to the ratification of the CRC. However, the government of Iraq cannot afford the US$400 million per year for health as in the past. An outline of the first CRC/Iraq report is presented on page 21 (Box 1).

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[47] These series of events were complicated by the problems of Iraq with UNSCOM, with the threat of military action.

[48] This quadruple classification is also used in other countries of the Arab region and globally where CRC has been ratified.
See Basil Yousif, "Towards the Implementation of CRC in Iraq: the Reality and Constraints." Study commissioned by UNICEF Baghdad, 1995.

[49] Ibid, p. 5

The NPA sets specific goals to reduce infant and maternal mortality. Objectives include the expansion of preventive health care for childhood diseases, nutrition and reproductive health. Added objectives are the reduction of communicable diseases, promotion of dental hygiene, and to safeguard children's sight and hearing.

The anticipated benefits of SCR 986/1111/1143 are yet to be realized. The only recent progress in the implementation of the NPA, for example in the health sector, has been in regular programmes heavily supported by UNICEF (MCH, EPI, CDD, and ARI). This has been especially effective for EPI, where coverage in 1995 reached or approached the decade goals, based on reports from the Vital Statistics Section, Ministry of Health. The issue is how vertical programmes such as EPI can be integrated with other broader-based programmes, such as MCH.

Box 1: IRAQ's First Periodical Report on the Implementation of the Convention on the Rights of the Child - June 1996 - Listing of Articles

Article 1	Definition of a child
Article 2	Elimination of all forms of racial discrimination
Article 3	State institutional care
Article 4	Laws and legislation to guarantee the economic, social, cultural educational and legal interests
Article 5	Support of children in disrupted families
Article 6	Maternal and child care and family health, with regular medical examinations of children
Article 7,8	Right to a name and nationality
Article 9	Juvenile Welfare Laws to protect the child from either spouse or guardian
Article 10	Support of healthy familial ties; Passport law regarding citizen's right to travel
Article 11,36	Protection from sexual commercial exploitation
Article 12,13	Right to freedom of opinion, publication, assembly and demonstration
Article 14	Freedom of religion
Article 15	Freedom of affiliation to societies, art and sports clubs (GFIY more than 1.5 million members)
Article 16	Child care and protection from harm; confidentiality of correspondence
Article 17	Role of the Ministry of Culture and Information
Article 18	Juvenile probation and rehabilitation for crimes
Article 19	Protection from child exploitation; role of institutions
Article 20	State responsibility for child when his/her interests, welfare and growth are threatened
Article 21	Regulations for foster parents (adoption not permitted)
Article 22	Political refugees coming to Iraq
Article 23	Care and rehabilitation for disabled children (physical and mental)
Article 24	Health care - basic services such as immunization, ARI, CDD, MCH, environmental (water/sanitation)
Article 25	Care in state homes
Article 26,27	Subsidy salary for groups in difficultly to support their child (e.g. widows, the very poor)
Article 28	Free education and compulsory primary education; literacy; comprehensive school card for students
Article 29	Adequate quality and depth of education
Article 30	Education and cultural minority rights
Article 31	Leisure, sports, music, arts and culture
Article 32	Restricting the minimum age of employment to 15; and to protect those 15-18 from hazardous labour
Article 33	Upholding strict exclusion of drug trafficking and addiction
Article 34	Protection from all types of sexual exploitation
Article 36	Protection from all types of harmful exploitation
Article 37	Rehabilitation of juvenile delinquents
Article 38	Protection of children from armed conflicts; compulsory service only for those exceeding 18 years
Article 39	Types of state rehabilitation homes for convicted juveniles

Chapter 2 provides details on the adverse effects of the economic embargo in terms of health (medical, surgical and diagnostic services, marked increase of communicable diseases, malnutrition and mortality); education (buildings, equipment and materials, manpower, training, school attendance); social (child early employment, beggary, crimes and reduction in institutional capacity for welfare and the disabled, and in subsidies for needy families); psychological impact on children and freezing cultural relations and agreements abroad. It also lists targets for health objectives.

Highlights of the CRC

The Juvenile Welfare Law (1983) uses the terms small child (under 9 years), juvenile (9 years and under 18) and a boy/girl (15 and under 18 years). The CRC/Iraq recognizes the rights and duties of parents/guardians for their children and has legal/social/material mechanisms for support in case of need. It also provides for child protection both within and outside the family, with appropriate legislation.

Iraq guarantees religious, cultural and educational rights to minorities.

The CRC supports the Public Health Law (1981) for "maternal and child care... with regular medical examination of children to ensure their growth, protect their health, provide guidance on the diet they should enjoy and adhering to the immunization schedule." The section on health care is comprehensive, including workshops for health workers and village workers to improve mothers' child care practices.

Every disabled child has the right for care and rehabilitation, free of charge.

Education has high priority: free for all and compulsory for primary schoolers. "Each student would have a school card with information on social, physical and health conditions of the student...."

The Ministry of Culture and Information has allocated several radio and TV programmes for children.

The Labour Law (1987) prohibits juveniles under 18 from hazardous jobs and those 15-18 from night work; the minimum age of employment being 15 years. Beggary among adults or children is prohibited, especially when connected with an economic activity, such as selling cigarettes, newspapers, shoe polishing and food.

1.7 Gender Equity

Iraqi women are guaranteed equal opportunities in schooling, work, health care, and social security. Legislated civil rights resembles elements of the CEDAW, ratified by Iraq in 1986. Matters of personal status (marriage, divorce, child custody and inheritance) in predominantly Muslim Iraq, are subject to Islamic law. Both civil and personal rights are being influenced by the prevailing national economic crisis[50].

The economic situation also threatens the implementation of existing rights, such as education, which especially affects the female child. The combination of Iraqi Law on Compulsory Education (1976) and RCC resolution Number 102 closely resembles the CRC. These influence the elimination of illiteracy.

In 1978, Iraq had an effective illiteracy eradication program which targeted women in particular. As a result of this national campaign (for which Iraq was awarded a UNESCO prize) female illiteracy was reduced from 62.4% in 1977 to 25.2% by 1978. Corresponding figures for males are 24.4% and 13%[51]. There are no official published statistics on current rates of illiteracy among women. But a trend of increasing illiteracy was reported by the General Federation of Iraqi Women, starting with the Iran-Iraq war and continuing to 1994[52].. A study[53] reported that an increased educational level for Iraqi women is much more likely to be related to a lower fertility rate and lower infant mortality rate, an increased age of marriage and a greater involvement in the workforce.

Women's involvement in politics, the labour force and education has been detailed in this chapter. It is useful to summarize some of the pertinent aspects[54] as presented in Table 1.6.

Table 1.6: Some gender indicators (1993)

Percentage of female share in parliamentary representation	11.0
Percentage of female share in administrative & organizational posts	12.7
Percentage of female share in professional & technical posts	43.9
Female percent in economically active population	11.5
Ratio of female wages to male wages (except agriculture sector)	80.0

[50] See, for example, Farida Banani "The Status of Marriage Partners in the Legalistic Familial Model." In "Arab Women and the Challenge of (Our) Era." Proceedings of the conference in celebration of the First Arab Women's Book Fair. Cairo: Nour Feminist Publishing House, 1996, pp.63-76.

[51] Additional campaigns followed in 1979, 1980 and 1985, Human Development Report, Iraq, P.45.

[52] GFIW National Report, op.cit. 1994, p.36.

[53] Human Development Report/Iraq, 1995, Table 48.

[54] Ibid, Table 53.

PART TWO

CHILD SURVIVAL, RIGHTS AND BASIC NEEDS

The U.N. throughout its history has produced a series of legal frameworks in support of human rights. These cover specific social areas such as age, gender, race, religion, and cultural heritage, with mutually reinforcing principles in support of human rights and basic needs. Such international legal frameworks progress to joint declarations by UN member countries (e.g., World Summit for Children in 1989) followed by national plans for action.

Of the cluster of Survival Rights of the CRC, Article 27 on the right to adequate nutrition and freedom from hunger is very relevant to Iraq. Further, the concern for "Children in Especially Difficult Circumstances (CEDC)", generally reserved for a minor segment of Iraq's child population, is increasingly applicable to a large number of children since the economic embargo. Article 24 of the CRC asserts child's right to *the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.*

Economic hardship has led to widespread food insecurity. Reinforced by the lack of resources such as economic, environmental and health services, such food insecurity seriously compromises children's basic needs, rights and welfare. Iraq's situation is unusual having a prior high level of consumption, even over-consumption. This pre-sanction "oil for imported food" provided two thirds of national food availability.

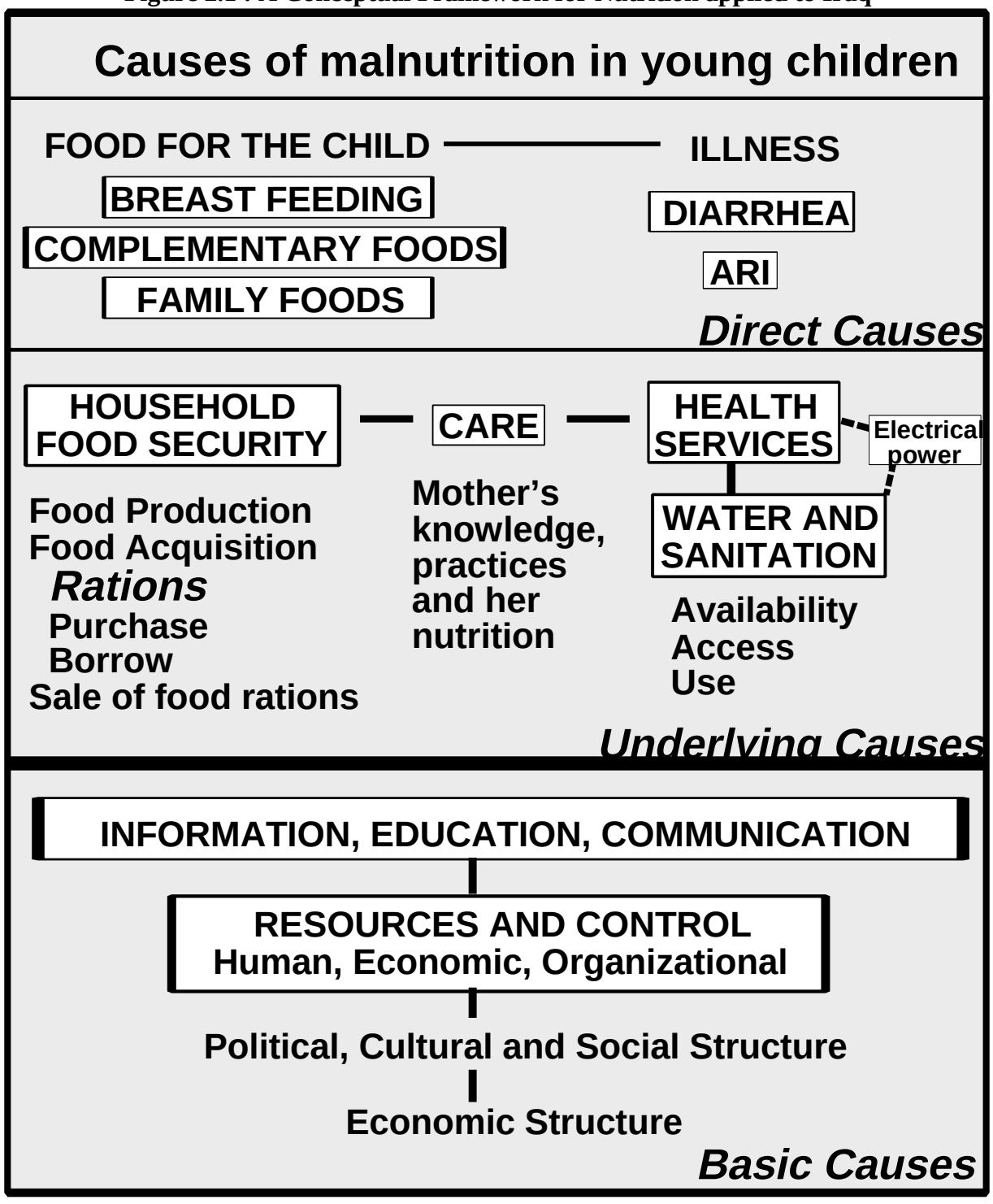
Malnutrition was not a public health problem in Iraq prior to the embargo. Its extent became apparent during 1991 and the prevalence has increased greatly since then (18% in 1991 to 31% in 1996 of under fives with chronic malnutrition). By 1997, it was estimated that about one million children under five were malnourished.

Children's right to survival requires due attention, not only to household availability and access to food, but also to other causes which influence malnutrition, a condition responsible for over one-half the deaths of young children and a key element for child growth and development. These multi-sector concerns involving food, health and care, must be addressed by a Safety Net for both households and for their vulnerable members - children and mothers.

The conceptual orientation (Figure 2.1, page 24) is a useful tool to analyse the various factors affecting the situation of children and women. It outlines the three layers of causes of malnutrition and consequent mortality. Each has relevance to promoting Child Rights, Survival and Protection. Such layers start with direct causes (feeding[57] and illness) involving the child. These are influenced by underlying causes (household food security, care, health services and water/sanitation). Care is a crucial, often neglected element which is especially needed to compensate for the constraints of food and health. The third layer comprises basic causes of which the economic structure is the dominant component. This is apparent in the reduction of GDP per capita from $3,508 in 1990 to $761 in 1993; also in the reduction of family purchasing power by several fold. The three causal layers affect all aspects pertaining to malnutrition through nation to household to child.

[57] In the first six months of life breast milk is the ideal and complete food, to be continued well into the second year. After six months of age, the child needs frequent small servings added caloric dense semi-solid to solid foods (with adequate protein, minerals and vitamins) often in the form of complementary foods. During the second year the child can share food with the family.

Figure 2.1 : A Conceptual Framework for Nutrition applied to Iraq



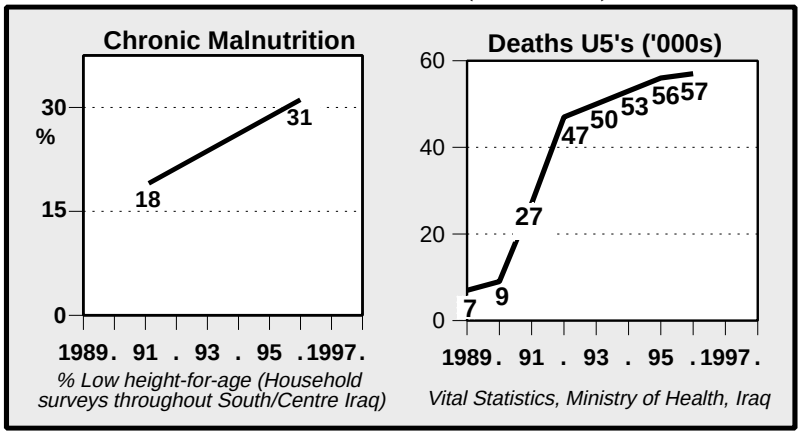
There is no single cause for malnutrition. Nor can attention limited mainly to one cause solve the problem. Thus food acquisition by the household (such as with food rations, perhaps complemented by the current limited means from other sources) does not necessarily insure that the child receives an appropriate diet. Further, even if the child was adequately fed, this alone does not insure protection from malnutrition and death. Illness such as from diarrhoeal episodes, acute respiratory infections, and others such as malaria and kala-azar are also potentially lethal, especially when untreated.

In the following section, the changes from 1989 to 1997 (or the year with the most current information) is applied to components for each causal layer.

Malnutrition and Mortality:

Increased malnutrition is a potent factor for increased mortality in young children. Since August 1991, when sanctions had already been in effect for one year, chronic malnutrition rates for under 5's in the South/Centre (based on a low height-for-age; less than -2SD from WHO reference) have increased by 70%. Deaths rose several fold (Figure 2.2). The exponential link between malnutrition and mortality has been well documented.[58]

Figure 2.2:
Malnutrition and Deaths in Under 5's (1989-1996)

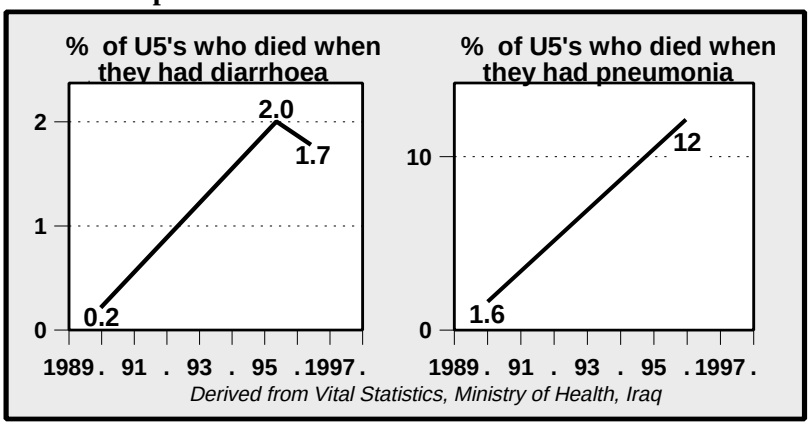


Infections: The lethal synergy between malnutrition and infection is illustrated in Figure 2.3.

A child with diarrhoea in 1990 had a 1/600 chance of dying; in 1996 this became 1/50. A child with pneumonia in 1990 had a 1/60 chance of dying; in 1996, 1/8 children with reported pneumonia died.

Both malnutrition and infection perpetuate each other. Young children with recent or chronic illness fail to resume their diet (already often inadequate) due to apathy, loss of appetite and the direct effect of the malady, such as fever.

Figure 2.3:
The percent of children under 5 years who died when they had diarrhoea or pneumonia

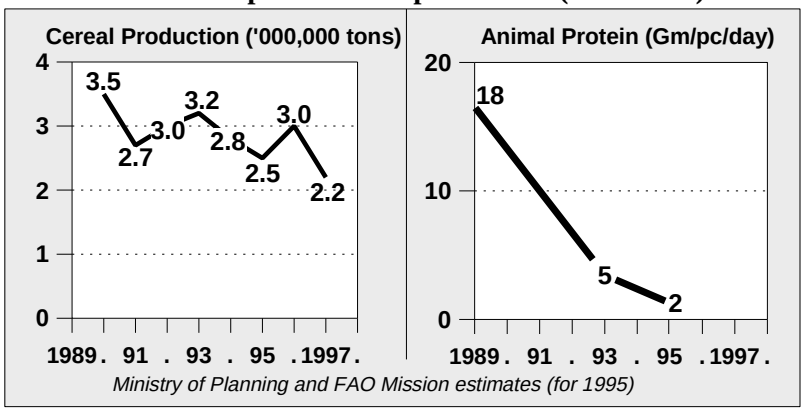


[58] Pelletier et al., 1994. Based on multi-country studies the risk of a young child dying if moderately malnourished is about four times those with no malnutrition and eight times greater when severely malnourished. This is compounded further if combined with unfavourable practices such as bottle feeding in infants with lack of breast milk.

Child feeding: Feeding patterns in young children indicate that the prevalence of breast feeding has increased recently, probably due to economic reasons. However, the quality of breast feeding is sub-standard. A survey throughout the South/Centre during October 1997[59] , showed 87% of infants aged 0-5 months were not exclusively breast-fed (only breast milk); 21% of infants were bottle fed and 24% aged 6-8 months did not receive any complementary food at all. Similar problems at least with inappropriate breast feeding probably existed in the past, but were compensated by the better economic and health situation..

Household food security depends on several factors such as food availability (e.g. production and imports), direct acquisition by households through rations, purchase or borrowing and the need to sell food. Figure 2.4 illustrates the trends for two aspects - cereal production and animal protein availability. The decrease in cereal production is evident as well as the precipitous drop in animal protein, which is greatly due to the expense of these items. It is significant that the present rations contain no animal protein, apart from the infant formula. There is no current information on sale of foods nor distribution within the household.

Figure 2.4:
Trends in selected aspects of food production (1989-1997)



Ministry of Planning and FAO Mission estimates (for 1995)

Aspects of child care are critical for proper nutrition. This pertains to care for women, home hygiene and health practices and child feeding[60]. Care of the mother's health and nutrition will reflect on the resulting care of her child. Recent surveys in Baghdad indicate that anaemia occurs in more than one-half of pregnant women[61] and chronic energy malnutrition (based on weight and height) occurs in more than 10% of women aged 25 to 35 years. Further, most mothers were unaware of signs of young child malnutrition[62].

Health Services (both preventive and curative) and the environmental situation, principally water and sanitation are other underlying causes of malnutrition. The depletion of health service support (structure, supplies and function) is considered in more detail elsewhere.

[59] Nutritional Status Survey of Infants in Iraq, October 1997. MOH/UNICEF - Iraq

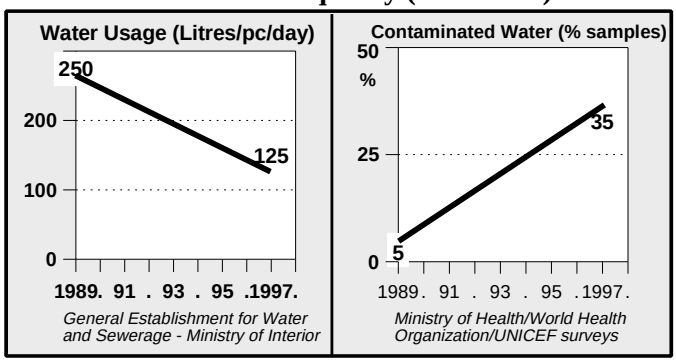
[60] The Care Initiative - assessment, analysis and action to improve care for nutrition. Nutrition Section, UNICEF/New York. April 1997

[61] Dr. Isshan, MOH 1996

[62] FAO/WFP Mission to Iraq, June 1997

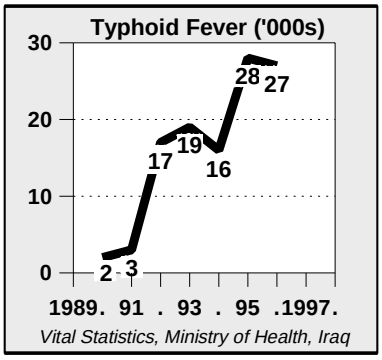
The water usage per capita in the South/Centre has been halved since 1989. Contaminated water based on bacteriological testing of major outlets in three governorates in the South/Centre has increased greatly. This is expected to be much worse at village and household levels (Figure 2.5).

Figure 2.5:
Trends in water use and quality (1989-1997)



A relevant indicator for water/sanitation provision and use is the extent of certain communicable diseases, such as typhoid fever. Previously rare in Iraq, it is now a major health problem (Figure 2.6).

Figure 2.6:
Trends in Prevalence of Typhoid Fever



Basic causes of malnutrition are dominated by the economic situation where the GDP per capita has reduced from $3500 to $600 and the current salary of public workers now averages about $3 to $5 per month, compared with $50-100 prior to 1990. This influences diverse aspects of the human basic needs, for example electrical power (Figure 2.7), especially important for health and water/sanitation services, and the level of school attendance (Figure 2.8).

Figure 2.7:
Trends in Electrical Peak Power (1990-1996)

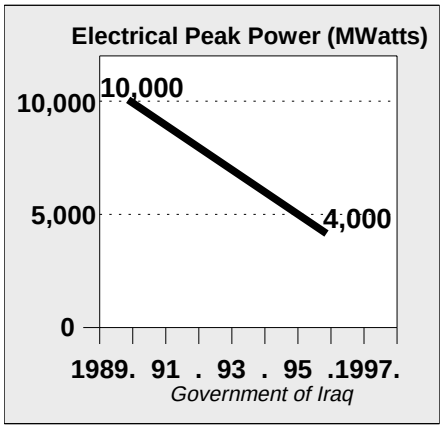
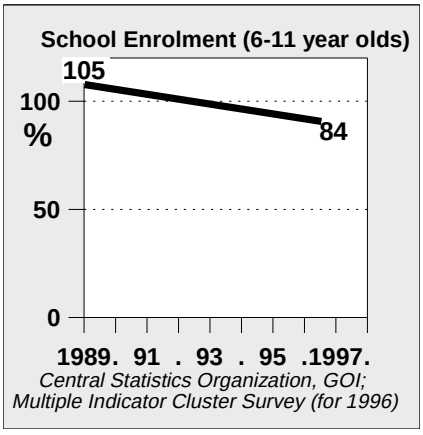


Figure 2.8
Trends in School Enrolment (1989-1996)



2.1 Food Availability and Access

2.1.1 Reduced Local Production

With the interruption of food importation in 1990, Iraq came to rely on domestic food production, which continues to be far from adequate in meeting the needs of the population. To encourage local production of food, the GOI raised the price of cash crops significantly. For example, between 1990 and 1993 the price of wheat per ton increased from ID500 to ID1,000.

However, with increased production costs despite subsidies and related decline of the value of the ID, such incentives were less than effective. Cereal production continued to decline from 3.4 million tons in 1990 to 2.8 million tons in 1994 and 2.5 in 1995. Decline in production extended to livestock (cows, sheep, goats, buffaloes) which decreased from 11.5 million in 1990 to 6.3 million in 1995.

Although there are no official statistics available for 1996, FAO estimates the crop harvest for wheat and barley was 30% less than that of the previous year. For rice and maize, which account for 15-20% of total cereal production, although cultivated area increased, the yield per unit area declined from its level in 1990.

In the northern governorates there occurred a decrease in the total cultivated area, yield and production of wheat. As illustrated in the graphic representation of Figure 2.9, and based on FAO estimates, wheat production declined from its 1993 level of 500,151 tons to 312,318 tons in 1996.

Whereas the relative decline for the years 1994 and 1995 is due to unfavourable climate, the drastic decline in 1996 is probably the result of a conscious decision on the part of farmers not to cultivate wheat. With publicity about Oil-for-Food plan, a price reduction of locally produced wheat was expected.

Further problems were of the breakdown of the agricultural infrastructure, and the end of extension services once provided by the Iraqi Ministry of Agriculture.

The agricultural potential of the northern region is also threatened by environmental degradation. Deforestation results in shortages of heating and cooking fuel which was once available at government subsidized prices.

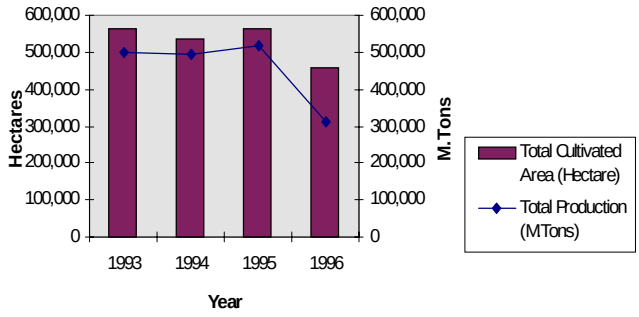


Figure 2.9
Area of Cultivation and Yield of Wheat
Northern Governorate, 1993- 1998

Source: FAO/ Iraq Report, 1996.

Livestock production has been affected by the decline of veterinary services. Further, as elsewhere in Iraq, high dependence on imported technology in the past could not continue, for example, the vaccination of animals. Livestock diseases re-emerged. Lack of imports of poultry raising supplies has reduced production. Of the 600 chicken farms functioning in the northern governorates prior to 1990 only 23 remain in operation.

For the South/Central governorates, the increase in the area of vegetable production from 8 to 9% of the total cultivated land has been offset by decreased yield and poorer quality, 3.2 to 3.5 million between 1991 and 1995[63]. This reduced yield is due to the poor quality of available seeds and their limited supply. Shortages affecting vegetable production extend to other agricultural inputs including pesticides, fertilizers and agrarian mechanical devices.

The export of dates, a traditional valued Iraqi crop, has been curtailed to meet increasing local needs. But the supply remains limited due to damaged palm trees during the Iran-Iraq war. The number of palm trees declined from 21 million in 1981 to 16 million in 1991; to 15 million in 1995.

Currently, local agricultural production for the country as a whole continues to be limited and provides about a third of the needed food. The food available within the framework of the Oil-for-Food Plan, far from representing an amount causing a glut in the cereal markets as anticipated, is not sufficient to meet Iraq's needs.

Household food production is also constrained by family's inability to purchase the necessary agricultural inputs and maintain infrastructure. This especially affects the small and subsistence farmers.

2.1.2 Reduction of Family Purchasing Power

Accessibility to food beyond the amounts provided through public rations is limited by soaring food prices[64]. FAO reports that the Family Purchase Power Indicator (FPPI) for Iraq has been in constant decline[65]. Starting at 3.62 in 1990, the FPPI dropped to 0.15 in 1993, and to 0.06 in 1995. The post-1990 FPPI values are well below the 1.25 level which FAO considers as a signal of household nutritional deficiency; such a level means that at least 80% of a family's income is spent on food.

For the northern governorates, civil servants receive pay which is in rarely sufficient to provide a minimum standard of living[66]. For example, currently (1997) the salaries of civil servants are 200 to 500 Swiss Iraqi Dinars (SID, the local currency). A minimum of 1500-2000 SID are needed to support a five member family.

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[63] FAO "Technical Cooperation Programme: Evaluation of Food and Nutrition Situation in Iraq," Sept. 1995

[64] Ibid

[65] The FPPI is the ratio between the lowest monthly income and the total cost of a basic food basket for a six-member family, including an infant. It is not clear whether the government ration was included in the estimates.

[66] UNICEF Situation Report, Suleimaniyah, Northern Iraq, April 1997.

Universal rationing addresses the issue of equity only in terms of equal distribution while side stepping the more basic one of unequal access to complementary resources (as extension of socio-economic differentiation). Hence, an objective national programme of Poverty Assessment would allow the identification of the most deserving/vulnerable groups. Even assuming the nutritional value of the food basket (supplied within the framework of the Oil for Food programme) is adequate, this may not be fully consumed by the household or used according to the needs of the members, including women and children. Access is not to be equated with actual consumption. Sale/exchange of some of the food basket to meet other urgent needs, such as buying medicine, often recurs. Further, accessibility to food has been jeopardized by the irregular or non-arrival of food basket components.

2.2 Food as Sustenance

As noted in Part One, compared to the ration distributed prior to 1997, the one planned under the MOU represents an improved nutritional value. Yet this ration, composed primarily of cereals, has nutritional limitations not restricted to its low caloric value (2,030kcal/day/per person compared to the WHO set amount of 2,500kcal\person\day). The needs are greater than the set amount due to the depressed nutritional status of the ration recipients. Many experienced the cumulative effect of almost seven years of inadequate diets and other adverse elements, such as polluted drinking water or fuel shortages in the cold winter months, as is the case in the northern governorates.

Protein derived from cereal alone is an inadequate means of body-building and tissue maintenance. The ration food basket is almost totally lacking in vitamins A and C, and the levels of calcium, riboflavin, vitamin B6, and zinc are very low. Moreover, the ration is deficient in fat, providing only 16% of daily food energy; its deficiency in vitamin C and meat (animal protein) compromises the body's utilization of iron[67].

The number of families who are able to supplement the food ration diet, is not known. However, it was noted by the observers that often the ration lasted only three weeks of the expected four.

Nutrition is affected by contaminated water and poor sanitation due to diarrhoea and communicable disease. The 1996 Water and Sanitation Survey revealed that only 44% of the rural population has access to potable water.

[67] FAO/WFP "Special Report". FAO/WFP Food Supply and Nutrition Assessment Mission to Iraq, 1997.

2.3 Water and Sanitation (WATSAN)

The CRC entitles Iraqi children to clean water and obliges their government to protect their health from environmental risks through provision of safe water and sanitation. These risks result in water-borne communicable diseases, primarily diarrhoea, but also others, such as typhoid and the continuing threat of cholera outbreaks. These are principal causes of malnutrition, illness, malaise and death in young children. A crucial risk applies to infants who receive contaminated water or milk, especially in a bottle, with breast feeding compromised by misuse of infant formula. It is likely that lack of safe water and sanitation has contributed greatly to the steep rise in malnutrition rates and mortality. In accordance with this basic right, the goal for the year 2000 for universal access to safe drinking water and sanitary means of excreta disposal, is unlikely to be achieved with the continuation of the embargo.

There are two major institutions in the South/Centre responsible for the provision of water and sanitation services in Iraq: the Baghdad Water Supply Administration (BWSA) and Bagtdad Sewerage Board (BSB) for the capital; and the General Establishment for Water and Sewerage (GEWS), Ministry of Interior for elsewhere.

2.3.1 Water supply

South/Centre Iraq had an advanced system of 210 fixed water treatment plants which served urban and major rural areas and 1,200 compact mobile plants for mainly rural areas, with an extensive system of distribution pipes[68]. Almost all water comes from the Tigris, the Euphrates, their branches and tributaries. Being surface water, most of the water systems require liquid chlorine gas and alum for treatment. In the North, springs and wells are the main source for rural areas.

Prior to 1990 over 90% of the urban and 70% of the rural population had an ample supply of potable water. However, government non-military expenditure was constrained by the Iraq-Iran war[69]. After 1990, the per capita share of water decreased from 330 to 180 litres/day in Baghdad city, from 270 to 135 litres/day for other urban areas, and from 180 to 60 litres/day for rural areas[70].

Water quality has also greatly deteriorated. Bacteriological contaminated samples ranged from 25-40% in Basrah and from 10-20% in Babil, with Ninevah being less affected during the period January to June 1997. Results of similar order were found for the adequacy of chlorine levels (Figure 2.10)

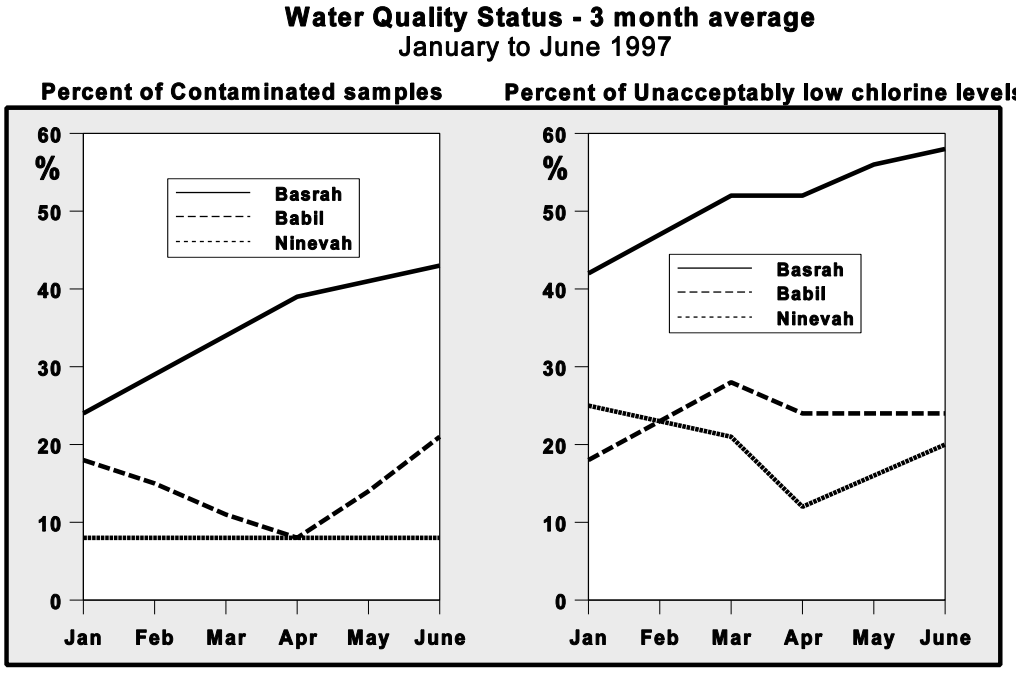
[68] The 1995 Water and Sanitation survey of facilities in the South/Centre supported by UNICEF found 84% were served by a fixed plant, 13% by a compact and 2% by both.

[69] During 1980, expenditure on water and sewage disposal was 16 million ID, this rose to 64 million by 1985, but tended to level off at 79 million by 1990 (Human Development Report, Iraq, 1995 p 93). The percent of total national expenditure dropped from 0.65% in 1980 to 0.26% by 1990, although treated water production tripled over this time.

[70] A recent survey "Coverage of Water and Sanitation Services in Iraq" reported by GEWS, UNICEF and CARE International, Dec 1997 estimates the average current supply to urban areas of the South/Centre (excluding Baghdad) is about 171 litres/per capita/day and for rural areas about 91 litres/pc/day. Adequate per capita coverage is a minimum of 150 litres/day in urban and 80 litres/day in rural areas (WHO), but this does not take into account variation by household and area. For more details, see the end of this section.

Whereas established Iraqi standards[71] stipulate that water should not exceed 1 National Turbidity Unit (NTU), more than 70% of the water supplied to the population has turbidity exceeding 10 NTU. In some places the turbidity even exceeds 25NTU.

Figure 2.10



WHO/IRAQ Monthly Report - November 1997

Water treatment plants lack spare parts, equipment, treatment chemicals, proper maintenance and adequate, qualified staff. Loss of electrical power supply is a crucial factor, where extended power cuts limit efficiency. Further, plants often act solely as pumping stations without any treatment, due to the high demand for water. The distribution network on which most of the population relies, has destroyed, blocked or leaky pipes[72]. Further, there have been no new projects to serve the expected population increase over the past seven years.

Local supplies of chlorine and alum are minimal. The major manufacturing plant for chlorine is unable to produce even one-tenth of the required 500 metric tons per month due to frequent breakdowns. Locally produced alum sulphate is impure, which ruins the water treatment equipment. Importation has not been possible.

The cost of water from escalating private dealerships is unaffordable to most people [73]. State-owned tankers, which catered to the needs of undeserved areas of the country in the past, do not function due to lack of spare parts. People often have no choice but to obtain their water directly from the river,

[71] Iraqi standards of water Quality Control are derived from those set by WHO, which are in turn based on American Standards.

[72] Causing an even further decrease in water pressure .

[73] It is estimated that the monthly cost for water for an average size family is ID3,000 or 60% of the average monthly salary of a government employee. The subsidized official cost for one cubic metre is ID300..

already contaminated by effluent and resulting in major increases in water borne diseases such as typhoid, with reported cases from two thousand in 1989 to about 30,000 in 1996, cholera (zero in 1989 to over a thousand cases yearly) and an increase of diarrhoea incidence in young children by four times the pre-embargo level.

In the Autonomous Region, urban areas rely mainly on a piped water system from 21 treatment plants, while springs (most of which are unprotected) and wells provide the major portion in rural areas. Since 1990, urban areas in the region were affected by similar problems to those of the South/Centre. Following the 1991 war, as a consequence of the uprising, the destruction of villages usually also wrecked the fragile water supply system. In the urban areas, water tankers, sewage pumps and garbage disposal trucks were rendered inoperative. Since then, inter-party conflicts block the routine maintenance of chlorinators outside the larger urban centers.

One-half of the villages in the northern governorates still have no access to a water supply and two-thirds have inadequate sanitation facilities.[74]. During the summer, many villages have no access to even impure water; women and children often have to walk 2-3 km to the nearest source. The construction of long-distance water distribution networks is restricted by the absence of electricity and fuel shortage throughout the region.

In the North, UNICEF has supported a WATSAN programme since April 1991. In partnership with 25 NGOS and local authorities, this programme installs and rehabilitates systems in cities, towns, collective villages and re-settled villages. Contributions from donors average about US$3.5 million yearly. Since 1993, half of this amount was used for rural areas[75]. By the end of 1996, 88% of the 800 water systems in urban and semi-urban areas were reportedly providing safe water to some 2 million people (or two-thirds of the population). The running capacity of each water system varied from 60-90%, and the quantity of water per capita per day ranged between 50 and 200 litres, mainly constrained by network problems and electricity shortage.

The Multiple Indicator Cluster Survey (MICS) in August 1996 is the only household-based survey throughout Iraq reporting on water and sanitation; but is limited by information solely on access to sources and not on their function and adequacy. In the South/Centre, most of the population[76] (82%) have convenient access to a water supply from a network or other source such as a public tap or well, inside the home or within 100 metres. (Table 2.1).

[74] UNICEF/ECHO proposal, 1997

[75] UNICEF, Donor Report for USAID/OFDA Contribution, March 1997

[76]Multiple Cluster Indicators Survey, Central Statistics Organization, Iraq and UNICEF/Iraq. In the analysis, population estimates were based on households, weighted for the average number in each household

Table 2.1 : Water and sanitation access in Iraq - MICS 1996

WATER/SANITATION	IRAQ	South/ Centre	North	South/Centre		North	
				Urban	Rural	Urban	Rural
Water Access	**81.1**	**81.7**	**77.1**	**96.2**	**49.8**	**95.4**	**33.7**
Sanitation access	74.6	77.1	57.7	96.7	33.7	75.1	16.2

Multiple Indicator Cluster Survey (MICS), August 1996

Urban areas are almost fully served with water supply from a nearby network, tap or well, whereas only half of the rural areas have such access.[77]. This result is consistent with those reported from a 1997 area/facility-based survey by GEWS, UNICEF and CARE Australia where 94% in urban areas of the South/Centre (excluding Baghdad city) and 41% in rural areas were served by a suitable water supply. The situation in the North is similar to that of the South/Centre except that access in rural areas is even less. *All the above findings from the MICS do not take into account the quantity or quality of the water.*

The water access by governorate ranged widely from 50% to 99%. Because urban access exceeds 95%, comparisons mainly reflect rural areas (see Figure 2.11).

2.3.2 Sanitation

In the South/Centre, about one-third is served by piped sewage systems with treatment plants (in urban areas only), about one-half use septic tanks and the rest use non-sanitary means for sewage disposal to pit latrines, rivers or open areas[78]

In the 1980's, the Iran-Iraq war interrupted plans to improve the sewage system. Whereas cities on the Tigris and Euphrates had more modern sewage plants, those in the south were less served, in part due to the need for lifting stations to counter the flat terrain and low water table. Since 1990, as with the water sector, sanitation has greatly deteriorated. There are 13 treatment plants that are semi-operational that partially serve 9 of the 15 governorate capitals of southern/central Iraq. The limited funds available for improvement go mainly for the higher priority water supply systems.

The lack of sewage plant function results (in the cities of the south especially), i n over 100 tons of raw sewage disposed daily into the major rivers. Some plants (such as in Thiqar) are completely inoperative. In others, during summer, treated water is blended with raw water directly from the source to increase supply. Decreased water pressure results from breaks and leaks in the water network. In both rural and urban areas domestic pumps are installed directly on the network. The resulting back pressure in the pipelines allows the floating sewage to infiltrate the system.

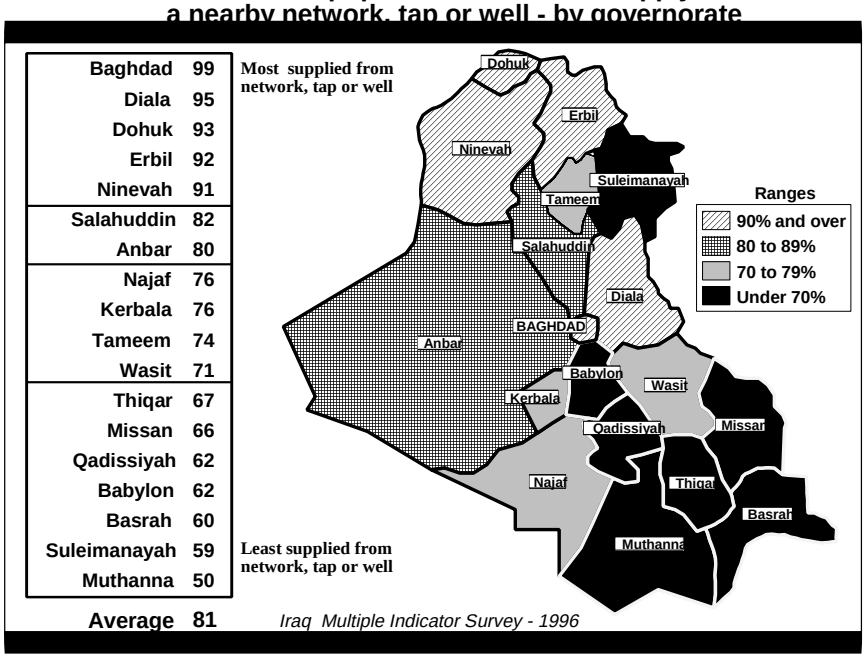
The MICS in 1996 reported in the South/Centre, about three-quarters of the population (77%) have access to a convenient flush to sewage system or flush to septic tank system, inside the home or within 50 metres (*Table 2.1*). If a covered latrine is also included, then as much as 98% satisfied the criteria. Again, like water access, urban areas are almost fully served; in contrast, only one-third of rural areas have access. In the North, the situation is less favourable with three-quarters of urban areas served and only one-in-six people for rural areas. The appropriate means of controlling sewage was not investigated. In addition, information was obtained from direct questioning, with no systematic inspection of facilities.

[77] In the South/Centre, an access of 80% to the treatment networks has been officially reported. The discrepancies between this 80% and the 50% on the surveys may reflect different perceptions of access. The same discrepancies also occur in the North, such as for sanitation access.

[78] Water and Sanitation survey of facilities in the South/Centre, 1995.

Figure 2.11
Percent of population with water supply from a nearby network, tap or well - by governorate

It is useful to compare water access by governorate. Such access is to public (network) and local facilities (well) inside the home or within 100 metres. The range was wide - from 50% in Muthanna to 99% in Baghdad. Access appears less in most governorates to the South as well as Sulamanayah. Because urban access on average exceeds 95%, comparisons mainly reflect rural areas.

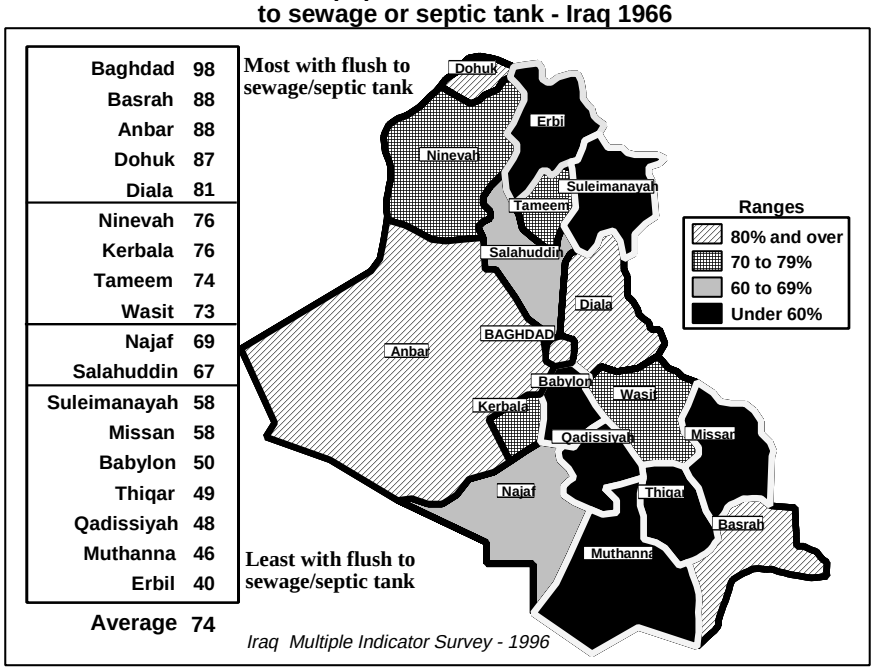


Baghdad	99
Diala	95
Dohuk	93
Erbil	92
Ninevah	91
Salahuddin	82
Anbar	80
Najaf	76
Kerbala	76
Tameem	74
Wasit	71
Thiqar	67
Missan	66
Qadissiyah	62
Babylon	62
Basrah	60
Suleimanayah	59
Muthanna	50
Average	**81**

Iraq Multiple Indicator Survey - 1996

Figure 2.12
Percent of population with sanitation from flush to sewage or septic tank - Iraq 1966

It is also useful to compare sanitation access by governorate. Such access is to sewage systems or the use of a septic tank. Like water access, the range is wide - from 40% in Erbil to 98% in Baghdad. Erbil is of interest in that water access is relatively high. Because urban access on average exceeds 95% in the South/Centre, comparisons mainly reflect rural areas there. This is not the case for the autonomous northern governorates where urban access averages 75%.



Baghdad	98
Basrah	88
Anbar	88
Dohuk	87
Diala	81
Ninevah	76
Kerbala	76
Tameem	74
Wasit	73
Najaf	69
Salahuddin	67
Suleimanayah	58
Missan	58
Babylon	50
Thiqar	49
Qadissiyah	48
Muthanna	46
Erbil	40
Average	**74**

Iraq Multiple Indicator Survey - 1996

Table 2.2 : Water coverage and quantities and Sewage coverage (urban) - by Governorate, 1997

Governorate	Water coverage			Water supply (in served areas)			Sewage coverage
	% of Population Served			Litres/Capita/Day			% of Population
	Urban	Rural	Total	Urban	Rural	Total	Served (urban)
Anbar	91	70	85	155	83	137	100
Babylon	94	36	64	133	58	111	96
Baghdad	100	83	99	218	109	211	80
Basrah	90	61	82	93	58	86	16
Diala	91	45	64	246	159	212	82
Kerbala	92	49	81	136	46	122	100
Maysan	89	13	65	78	104	80	14
Al-Muthanna	93	40	66	122	97	114	88
Najaf	91	55	82	147	70	134	100
Nineveh	97	38	75	147	61	131	100
Qadisiya	95	49	74	134	91	121	100
Salah Al-Deen	66	38	52	243	146	207	99
Thiqar	77	6	42	53	30	51	11
Wasit	93	19	60	96	63	92	23
Totals	**94**	**41**	**78**	**171**	**91**	**158**	**73**

Source: Water and Sanitation Coverage Survey in South/Centre Iraq. UNICEF/CARE, 1997

Served areas - Water from a network (i.e., those covered). Sewage: from a sewage system.

2.3.3 Baseline Assessment and Monitoring of Water/Sanitation Needs at Local Levels

Reliable information is now available for water (urban and rural) and sanitation (urban only) coverage at the Sub-District level throughout the whole of South/Centre Iraq, due to the baseline survey of GEWS/UNICEF/CARE in 1997.[79]

Results are aggregated by Governorate in Table 2.2, where there is a wide variation in all parameters. At the Sub-District level, this is even wider. Hence appropriate targeting is now possible at basic administrative levels for areas of greatest need (based on indicators such as access to and quantity of water, and prevalence of diarrhoea), to include feasibility and extent of community cooperation. Further, the baseline for programmatic monitoring is in place[80]

[79] Data was collected at the Sub-district level, the smallest administrative unit in the country, for all areas (except Baghdad City). Aggregation of this data formed the coverage indicators for governorates and nation. Rural sanitation was not assessed, as they have virtually no proper disposal systems.

In urban areas, the number of beneficiaries connected to the main water supply was estimated by multiplying the number of subscribers by the estimated average number per household.

In rural areas, this was done on a village basis. In all methods, the number of people with no access was calculated by deducting the number of beneficiaries from the population for each given area.

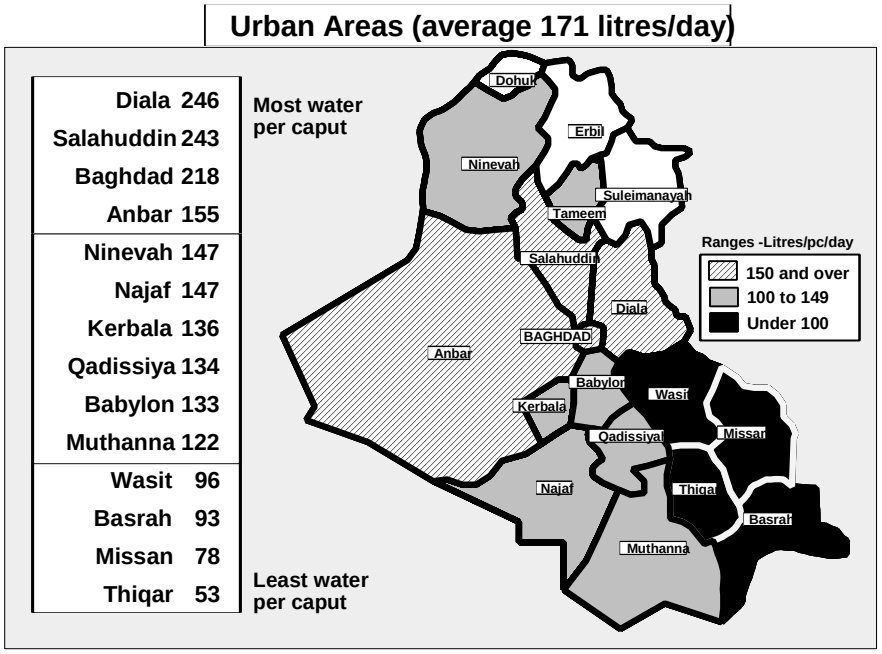
The quantity of water supplied (**limited to served areas**) was estimated by multiplying the design capabilities of the local installations and pipe networks by reasonable efficiency factors (estimated loss from 40 to 65%), such as equipment function and power cuts. For sewage disposal (urban areas), the number of people served was estimated by the number of houses linked to the urban sewage system in the sub-district.

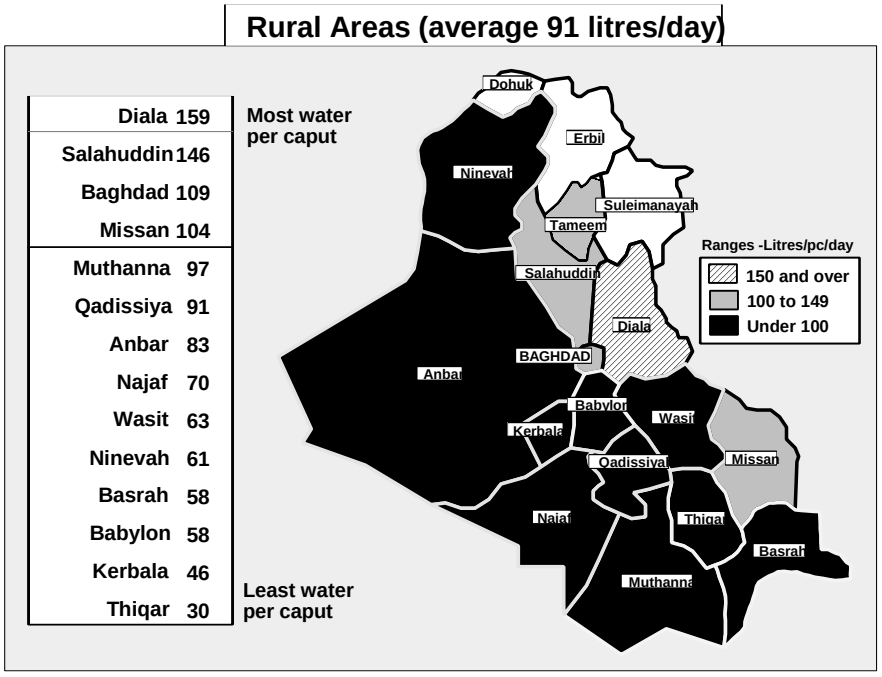
[80] A similar sub-district mapping system has been set up in the Northern governorates for a range of conditions and intervention.

Figure 2.13 shows the distribution by governorate of the quantity of water supplied in served areas, by capita for urban and rural areas. For urban, four of the governorates reach 150 litres/day; about half the rural are less than 80 litres/day.

Figure 2.13

Litres of water supplied per capita per day supplied only to populations covered (served by a network) - by governorate (October, 1997)





Water and Sanitation Coverage Survey in South/Centre Iraq. UNICEF/CARE, 1997

Recent action: The basic strategy adopted in the sector was improving the quality and quantity of clean water. Chlorine is now being provided to the water treatment plants through the Oil for Food programme beginning 1997. Recent testing by WHO at treatment plants (up to February, 1998) show some governorates still have high bacteriological levels. UNICEF regular programme provided spare parts and essential materials for the water supply network to keep the sophisticated water treatment plants in operating condition.

In 1997, the repair and maintenance of the major sedimentation tanks of the Karkh water treatment plant in Baghdad improved the provision of safe drinking water to 3.5 million people. Other water treatment plants have been rehabilitated in Baghdad, Muthana Governorate and Amara Governorate; the total serving a further 0.5 million inhabitants. Another 150 water and sanitation systems serving 4.5 million people underwent simple repairs and maintenance. A computerized database was developed jointly by UNICEF and CARE Australia to monitor the conditions of the plants.

In the North, spare parts were made available to 545 water systems benefitting 2.5 million people, up to 1997.

2.4 Health Services

Article 24 of the CRC/Iraq decrees children's rights to the highest attainable standards of health and to facilities for the prevention, treatment and rehabilitation of illness. Services for children must be complemented with those for mothers. These rights imply appropriate measures to:

1. Diminish infant and child mortality.
2. Ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care
3. Combat disease and malnutrition.
4. Ensure appropriate pre-natal and post-natal health care for mothers.
5. Develop preventive health care, guidance for participants and family planning education and services.

The country's free health care system is administered centrally by the Ministry of Health in Baghdad. It comprises the Directorates of Planning and Health Education, Health Inspection and Monitoring, Preventive Medicine, Environmental Protection, Administration and Legal Affairs, and the General Organization for Marketing Medicine and Medical Equipment. Medicines and supplies are stored in and distributed from a central focus in Baghdad - Kimadia.

Governorates are administered by the Directorate of Health for some 200 General Hospitals, Consultive Medical Centres and Public Health Clinics (serving 200,000+ people), Primary (serving about 40,000) and Secondary Health Centres (for about 10,000) and smaller Units, such as dispensaries.

Prior to the Gulf War, Iraq's health system upheld its CRC commitment. The network of primary, secondary and tertiary facilities were linked between themselves and the community with an extensive fleet of ambulances and service vehicles, and a good communication system. During the 70's, a large number of foreign physicians and nurses were employed. Most of the country's hospitals were built since then, in a modern style. Public hospitals were free and attracted patients through the Arab world.

The ratio of health staff to population (eg one doctor per less than 2,000) and of hospital beds (one per 560) adequately serviced the people. Although curative services were emphasized, with reliance on high technology and specialization, the public health system was expanding. The 1985-1990 National Plan preparation started serious attention to social mobilization campaigns, the mass media, non-health sectors and popular organizations. Primary medical care reached about 97% of the urban population, and 78% of rural residents. Child health indicators of the 1980's reflected the improved health conditions, for example the reduction of infant and under five mortality rates.

The Iraq-Iran war did affect health services, especially in those parts of the country bordering Iran. There was significant damage to institutions, although still able to cope with emergent needs. The functional capacity of the system was greatly diminished by the shortage of water and power, lack of vehicles and an inadequate communication system, shortage of specialized equipment, supplies and parts.

The combined effects of the destructive Gulf war, the subsequent domestic fighting and the economic and the prolonged trade ban have further compromised health care resources and services. Although the sanctions did not directly preclude health commodities, the indirect effects of the trade embargo and reduced government revenues greatly constrained production and importation.

The health system is affected by lack of even basic hospital and health centre equipment and supplies for medical, surgical and diagnostic services. Major surgical operations decreased from 15,125 in 1989 to 4,417 in 1996; laboratory tests from 1.49 million to 0.50 million over the same time. The exodus of certain key staff, such as nurses, due to low salaries has compounded the problems. In 1989, the Ministry of Health spent more than US$500 million for drugs and supplies; the budget is reduced by 90-95%. Although SCR986/1111/1143 is meant to provide US$210 million for each six month period of Phase I and II, only US$80 million (i.e., 20%) had been received as of November 15, 1997.

A recent report adds a numerical dimension to the effect of the economic embargo on the health services.[81] They conclude: " Several leading physicians comment that the conditions in hospitals and the types of pathologies are far worse than when they originally trained in the 1960's; those older recall similar situations in the 30's and 40's..... Health leaders have taken on the overwhelming task of carefully rationing an ever-dwindling supply of medicines... The government has responded by facilitating conditions for private practice... increasing user fees and private services in public facilities, substitution of nursing services with family care, encouraging health workers to innovate... Patients have responded by making greater use of private facilities and/or not using the public services... few other clinical options exist....."

Box 2, on the next page, lists their main findings.

Private, physician-owned hospitals in Iraq have a total of about 2009 beds, some 7-8% of those for public hospitals. The demand has increased since the embargo, but the cost is far beyond most patients, some ID20,000 per stay.

The autonomous northern region is equally affected as the South/Centre. Previously, there was universal access to health services in urban areas, and to most (78%) of the rural population. Of the 381 primary care centers, it is reported that only about 1/3rd now have the capability to provide maternal and child health services.[82] The three major maternity hospitals have a combined capacity of only 450 beds, providing care to just 20% of the estimated 140,000 pregnant women annually. It is estimated that about 2/3rds of all deliveries are home-based, where the services of TBA's are required. The northern governorates increasingly depend on donor funding for essential medical supplies and medicines; however in 1996 this covered only 30-40% of needs.[83]

The situation throughout Iraq continues to be one in which Child's Right to Survival and for the health care decreed by the CRC remains subject to overwhelming risks to life and health generated by the economic hardship.

[81] Richard Garfield, Sarah Zaidi, and Jean Lennock "Medical Care in Iraq Following Six Years of Economic Sanctions." Unpublished report, September, 1996, p.3. The authors visited 11 general, 7 paediatric, 4 specialized and 2 private hospitals; and 4 public health clinics in 7 South/Centre Governorates of Iraq, from April 4-20, 1996.

[82] UNOCHI, Baghdad "Humanitarian Requirements of the Iraqi Governorates of Dohuk, Erbil and Suleimaniyah." Baghdad, 1996, p.8.

[83] UNICEF/Iraq 1996 Annual Report, December 1996.

Box 2: Situation in the Health System - April 1996- (Garfield et al, 1996)

Institutional capacity:

- About one-third of all hospital beds were closed
- Average length of stay declined by more than one-half; many stay just overnight until they realize no treatment is available.
- More than half of all diagnostic and therapeutic equipment was not working
- All hospitals lacked proper illumination, hygiene, water supply or waste disposal
- Basic supplies for cleaning, linen, gloves and syringes were in very short supply or completely absent
- A 95% drop in disposable syringes (each costing ID150), resulting in epidemics of viral hepatitis, muscle abscesses and other infections, due to inadequate boiling or inoperative sterilizers

Environment

- Only one of the 24 hospitals had sheets for some patients
- Only one had a working central air conditioning
- The monthly budget for cleaning (ID1500 = $2) is totally inadequate; the absence of soap creates a hazard for infection and parasites, such as amoebiasis
- Cleaning staff are few (in one hospital reduced from 20 to 2)
- Most hospitals had no repair or maintenance of their plumbing systems for years

Surgical care

- The number and resources for operations have reduced greatly (in Mosul, for example from 15 to 2 weekly).
- Lack of basic materials (e.g. for suturing) has forced adaptations, such as no internal closure for some
- abdominal surgery
- Anaesthetics are in short supply and those available are of poor quality
- Post-operative care and pain management in some hospitals is limited to aspirin
- Surgical appliances are in very short supply (e.g. plaster and plates for fractures, catheters, naso-gastric
- tubes for infants)
- Critic shortage of blood bags (market cost ID30,000) resulting in preventable deaths due to haemorrhage

Emergency medicine

- Preventable deaths from conditions such as asthma, fits or poisoning resulting due to lack of supplies; and an increase of life-threatening conditions such as heart attacks in hypertensives, of amputations/coma in diabetics, in severity of untreated burns.
- Those with chronic diseases must vie with those having acute conditions, risking serious complications.

Maternity care

- Decrease in maternity visits to public hospitals by about one-half.
- Those attending are more likely to have risk factors, such as poor nutrition, lack of adequate ante-natal care and conditions such as hypertension
- This high risk group has contributed to an increase in neo-natal mortality, in some hospitals this has doubled

Support services

- Only 10-20% of that required for X-ray film
- Previously record keeping was computerized; now all is done on paper, in grossly limited supply
- Ambulances are in short supply. In Baghdad, 21 are operating (compared to 350 in 1990). The major problem is shortage of tyres.

Health personnel

- Many young graduates from the 10 medical schools have left the country due to lack of opportunity for remunerative private practice
- Experienced nursing staff has reduced by more than one-half in many hospitals, due to financial difficulties
- In many wards, there is only one nurse per shift

Health centre care

- Shortage of antibiotics, pain and emergency medicines limit the number of patients treated and those treated, incomplete courses.
- Dental care limited to emergency extractions
- In the centre assessee, only half the prescribed medicines were available
- Afternoon 'private' session visits, allowed by the government since 1994, cost ID50 for a generalist and ID75 for a specialist, with the physician keeping 75% of this added income. This is much less than earnt by a 'regular' private practitioner

Rural Hospitals

- Small and rural hospitals are relatively better off than major ones, being less sensitive to the lack of heating, cooling and power
- The major new limitation is the lack of ambulances for major surgical, emergency and specialist care
- Post-operative infection rate for clean wounds rose from 5% to 25% as well as the post-partum infections

2.5 Assessment of Health and Nutrition

2.5.1 Child Health

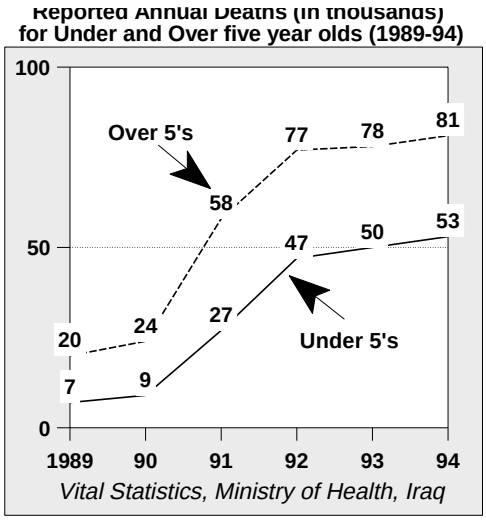
Many factors affecting child heath are similar to those presented for nutrition (pp 39-44) - child and household food security, exposure and resistance to disease, care, health services, water/sanitation and basic factors such as economic status and education.

2.5.1.1 Mortality

The increase in mortality reported in public hospitals for children under five years of age (an excess of some 40,000 deaths yearly compared with 1989) is mainly due to diarrhea, pneumonia and malnutrition. In those over five years of age, the increase (an excess of some 50,000 deaths yearly compared with 1989) is associated with heart disease, hypertension, diabetes, cancer, liver or kidney diseases (**Box 3**). The different patterns between under- and over-fives require different foci of health care with their specific priorities when resources are scarce.

Box 3: Comparison of deaths between Under and Over fives/adults - Rates/1000

Vital Statistics of the Ministry of Health indicate that the mortality of children over five years of age and adults has increased since 1990 in a similar order of magnitude than that of under fives. However as U5s represent only one-sixth of the population of over 5s, the U5 rates are much higher than those older. Even so, it reflects the extent to which adults are affected, affecting their own constraints.



With the substantial increase in mortality, under-registration of deaths is a growing problem. For infants, reporting a death would entail cancellation of the due ration for that child.

A comparison of trends of Under Fives' Mortality rates (per 1000 live births) reported from selected Middle East countries (from 1960 to 1995), show a consistent and often dramatic reduction in all countries, apart from Iraq. From 1988 to 1995, there is a marked resurgence in the magnitude of mortality for Iraq in contrast to reduction in other countries. (Figure 2.14)

This is also demonstrated by a change in the direction of the global rank for each country from 1989 to 1996, where number 1 rank is the highest U5 mortality rate. Whereas Iraq in 1989 ranked 61st out of 121 countries reporting (i.e. at the mid-point of the scale), by 1996 Iraq ranked 39th of 191 countries (i.e. only about one-quarter of all countries in the world had a higher rate). This result can be compared with neighbouring countries, where in almost all cases, there is a marked relative improvement in ranking (Figure 2.15).

Figure 2.14

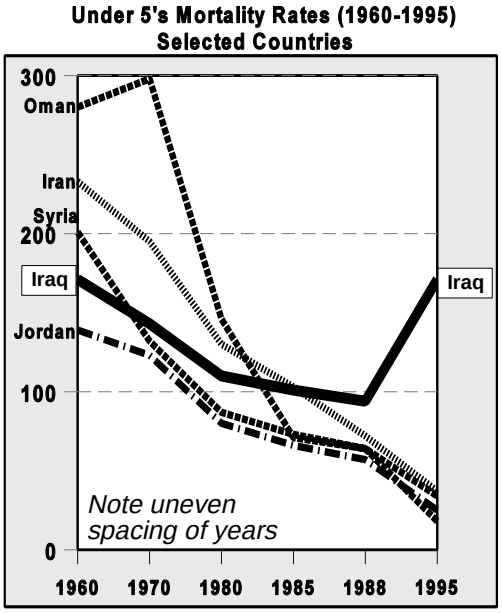
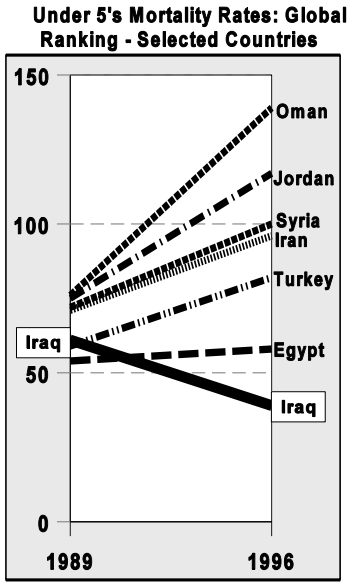


Figure 2.15



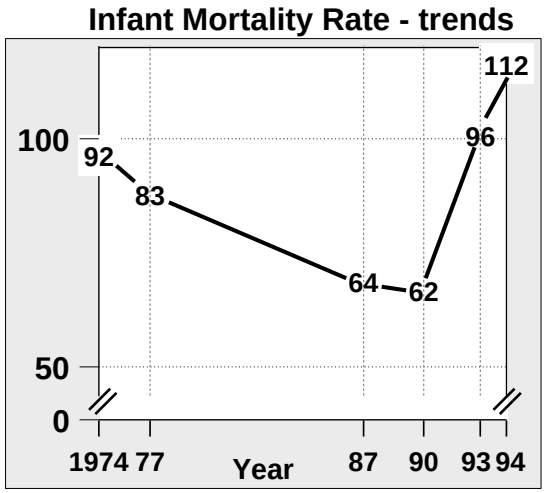
Sources: State of the World's Children 1990, 1998;
Statistics in UNICEF-assisted countries -1990

Trends in Infant Mortality for Iraq are shown in Box 4 below.

Box 4 Infant Mortality

The Infant Mortality Rate (IMR) is a key indicator for the implementation of CRC/Child Survival and one of the three components of the Human Development Index used by UNDP to rank countries. Different methods of estimation and the IMR sensitivities complicates comparison of time trends. Hence a single source which includes the 1977 and 1987 census estimates is used here.

The pre-sanction decline in IMR and its later rebound is consistent with other sources of information, such as Vital Statistics from the Ministry of Health. The extent of the change is debated.



Deaths in infants per 1,000 live births

Iraq Human Development Report - 1995 (p 19)
Iraqi Economists Association/UNDP, Baghdad

Mortality rates in Iraqi young children relevant to recent trends have been estimated from various

studies.[84] A common conclusion, summarized by WHO/Iraq in their 1996 report, was that the IMR (Infant Mortality Rate) and U5MR (Under 5 Mortality Rate) had increased substantially since 1990. Further, the trends are consistent with other sources, such as vital statistics and comparisons with neighbouring countries.

Several studies have documented the decline of child health since 1990.[85] Children as "hidden casualties of war" are denied their rights as expressed in the CRC. This increase in infant/child mortality has been associated with increased illness unattended by adequate health care, deteriorating living standards and compromised water/sanitation.

The current poor health situation is conducive to diarrheal episodes and acute respiratory infections, both leading causes of infant and child mortality and morbidity.

[84] **Ministry of Health/ ESCWA/ UNICEF/ WHO Maternal and Child Mortality Survey, 1990** - the IMR result using direct estimates was 25/1000 live births; for indirect estimates the IMR was 41/1000

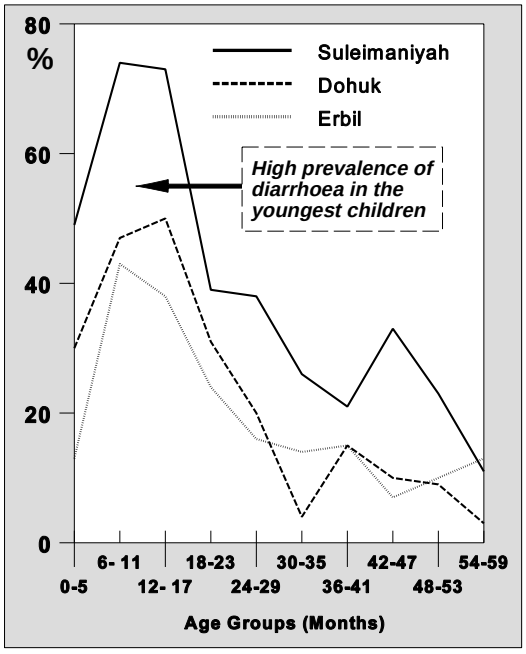
Harvard Study Team "Special Report: The Effect of the Gulf Crisis on the Children of Iraq." New England Journal of Medicine, 1991, Vol. 325:977-80. This household survey conducted by an International Study Team in September 1991 covered the entire country, except for 2 of the 18 governorates. A sub-sample of 2,676 children under five years was assessed for nutritional status.
The IMR rose from 32 before sanctions (1985-1990) to 93 afterwards. U5MR increased 3-fold from 43 to 129. This rise in mortality indicated excess deaths of 46,897 children under five years of age during the first eight months of 1991. There were no statistically significant gender differences.

Evaluation of Food and Nutrition Situation in Iraq. FAO, Rome, 1995 TCP/IRQ/4552 (data from Baghdad) This survey used recall to a pre-sanction reference period 1989-90 (for infant mortality) and 1985-90 (for under 5's mortality) and post-sanction for the 12 months preceding the survey (for infants) and 5 years preceding for under 5's. Results showed the IMR doubled and the U5MR increased almost 5 times. The survey was repeated in June 1996 and again in June 1997, but the results for mortality in either year were not reported.

[85] See, for example,
Alberto Arscherio, Robert Chase, Tim Cote et al "Special Article: Effect of the Gulf War on Infant and child Mortality in Iraq." The New England Journal of Medicine Vol 327(13), p.931-936, 1992;
"International Notes: Public Health Consequences of Acute Displacement of Iraqi Citizens-March-May 1991." Morbidity and Mortality Weekly Review Vol 40(26), p.443-446;
Physicians for Human rights "The Children of Iraq on the Brink of Disaster." Briefing Memorandum/revised. Somerville, MA, 1991.
Schaller and E. Nightingale, "Children and Childhoods: Hidden Casualties of War and Civil Unrest" Journal of the American Medical Association Vol. 268: 642-44, 1992.

Diarrhoea and ARI: The 1996 MICS for the northern governorates reports over one-quarter (28%) of all children under five years of age had diarrhoea during the two weeks prior to the time of the survey. The prevalence of diarrhoea in each governorate was much higher among children of 6-18 months of age (ranging from 40-70%), compared to those at other ages - *Figure 2.16*. This result is consistent with higher rates of acute malnutrition in the same age group.

Figure 2.16:
Prevalence of Diarrhoea by Governorate and Age in Northern Governorates MICS 1996



The high prevalence of diarrhoea (20-50%) among children aged 0-5 months reflects inadequate protection from contaminated fluids and food compounded by bottle use at a time when breast feeding alone should be provided.

For the South/Centre governorates[86] a recent survey by MOH/UNICEF/WHO shows an almost four-fold increase in the number of annual diarrhoeal episodes per child from an average of 3.8 for 1990 to 14.4 for 1994 [87].

Although no survey data are available for the incidence of acute respiratory infections (ARI), statistics from the MOH show an increase of registered cases for ARI and pneumonia of some 50%. More important, the case fatality rates[88] for diarrhoeal episodes, ARI and pneumonia has increased from 5 to 10 times since 1990 (*see also page 24 relating to infections and mortality*). This is probably the result of a number of factors, including decreased resistance due to malnutrition, delayed or absent treatment due to lack of available health care and perhaps changes in methods of reporting.

The MOH programme for Control of Diarrhoeal Diseases or CDD, gained momentum from the mid-80's. The use of Oral Rehydration Therapy (ORT) increased from 9% in 1985 to 61% in 1987, with an even greater increase in the use of home prepared fluids. As a result, diarrhoea related deaths among U5 children fell from 8.5 per 1000 live births in 1985 to 1.7/1000 live births in 1987. The greatest decline was among infants and rural children. The public sector production of rehydration salt, marketed locally as "Dextroly", reached 15 million packets per year in 1989 covering the total local demand. Most of the population had access to the salt since it was freely distributed through over 900 ORT corners established in the different health institutions. The CDD programme was supported by effective social mobilization, education and communication activities where the general Federation of Iraqi Women (GFIW) together with primary school teachers, pharmacists, paramedicals and religious leaders all contributed effectively in these activities.

[86] Corresponding information on diarrhoeal prevalence and its handling by mothers is absent from the MICS analysis for South/Central Iraq, although the data is available.

[87] KAP study on ORT and drug use for diarrhoea (Baghdad, Basrah Qadisiyah and Nineveh. MOH, April 1994.

[88] Case Fatality Rate - The percent cases with the condition who die from it (i.e., CFR for pneumonia = Number of deaths due to pneumonia X 100 ÷ Number of cases with pneumonia).

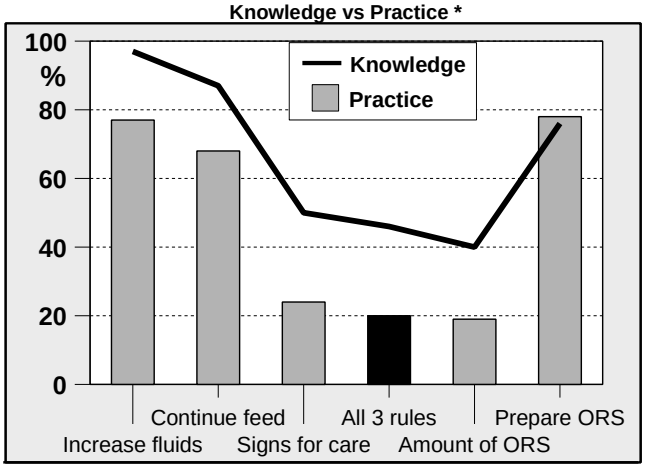
This programme was severely interrupted by the Gulf War through the effect on both the production of the Dextrolyte and the demise of the ORT corners. Combined with the lack of clean drinking water and adequate sanitation, this caused a resurgence of diarrhoea-related mortality.

To reactivate the programme, the MOH conducted CDD campaigns in 1993 and 1994 with UNICEF and WHO support. Imported ORT, improvement of food hygiene, training of various cadres of health workers and NGOs and rehabilitation of the ORT corners followed. In 1994, MOH issued the National Policy on Drugs and Antibiotic Usage for Diarrhoea, as per WHO regulations to prohibit the production and prescription of potentially harmful drugs for diarrhoea treatment in children.

A KAP study by the MOH, in Baghdad, Qadisiyah, Nineveh and Basrah of 3000 mothers revealed progress in the use of ORS (Oral Rehydration Salt, used in home-prepared solution) - from 57% in 1990 to 70% in 1994;and ORT from 71% in 1990 to 78% in 1994. In the 1996 MICS however, about one-half of mothers provided appropriate fluids and solutions, and one-third provided continued or increased feeding for their child with diarrhoea. [89]. A similar problem was found in a more recent survey (October 1997) in the Northern Governorates

Two major Health Facility Surveys in the South/Centre during 1997 - Management of Diarrhoea, and Maternal Child Health Services underlie the intent of the Ministry of Health to better understand health workers knowledge and practices for improved programmes. In the Diarrhoea Management survey, several problems were revealed in assessment, knowledge and practices.[90] One aspect was that, although ORS is readily available, it was not adequately used due to lack of training and a skepticism of both doctors and mothers about its value, especially when compared with the demand for drugs. The gaps between knowledge and practices with regards to home care and use of ORS shows weaknesses in explaining to the mother the signs for care and the amount of ORS to be used, even though the method of preparation was usually correct (*Figure 2.17*).

Figure 2.17:
Health Workers' Advice on Home Care and ORS
Knowledge vs Practice *



*% of workers who knew about the advice vs. % who practiced it

Health Facility Survey on Management of Diarrhoea in Iraq, August 1997- MOH/WHO/UNICEF

[89] MICS - Northern Governorates, 1996

[90] **The Health Facility Survey on Management of Diarrhoea** was conducted in July/August, 1997 in 26 hospitals and 33 PHC's of six governorates. It consisted of observation of health workers' management of 294 children under five years with diarrhoea, re-examination by surveyors, and exit interviews with caretakers of the same children; interviews of 117 staff; assessment of supplies; review of 1090 case records; and qualitative data based on the observations and discussions with health staff. One-third of the children were dehydrated and about one-half malnourished (underweight-for-age).

Some key findings: Despite the regular availability of ORS in most facilities, only one child in eight was correctly managed (combining assessment, rehydration and giving correct advice on home care). Most malnourished children did not receive adequate care in part due to lack of assessment; most dehydrated cases were not rehydrated due to lack of awareness; those with persistent diarrhoea or dysentery were not managed properly, even though most were identified correctly.

ARI: The control of ARI programme was reinstated in 1991. It addressed three main problems: poor application of WHO standard case management by health workers; shortage of drugs: and inadequate mothers' knowledge on home care and early identification of danger signs. The MOH (with UNICEF support), increased training of medical and paramedical staff and undertook a nationwide advocacy campaign to raise the awareness of mothers.

In 1994, the MOH conducted a KAP study at the national level (the three northern governorates excluded). This revealed that the average number of ARI episodes in Under5's per year was 5.7, with the highest in Baghdad (7.8) and the lowest in Thiqar Governorate (2.2). About one-quarter of the children had ARI at the time of the survey. Of these, one-half were treated with antibiotics, one-half with cough syrup and one-in-eight treated with home remedies. While 40% of mothers consider difficult breathing as an important sign for referral, only one-quarter recognized rapid respiration as a danger sign.

Further efforts related to ARI since 1994 are provision of essential drugs and pneumonia kits, promoting attitudinal change among practitioners and communication campaigns for mothers. However, in the 1996 MICS survey, still only one-third of mothers knew the danger signs (rapid or difficult breathing) for their child with ARI. A more recent survey (Oct 1997) in the Northern Governorates revealed the same problem.

The risk to Child Survival is compounded by inadequate health professional handling of children with diarrhoea or ARI and lack of proper communication to mothers about adequate care.

2.5.1.2 Communicable Diseases (Vaccine-preventable)

Since 1990, Iraq's immunization services were interrupted. The Expanded Programme on Immunization (EPI) coverage was affected, with disruption of vaccine supply, of the cold chain and in the health service upheaval in general. This compromised protection against preventable childhood diseases and their incidence rose steeply in 1991 and in some - measles and whooping cough - continued rising in 1992. Whereas only 10 laboratory confirmed cases of polio were reported in 1989 (with Oral Polio Vaccine coverage registered at 90%), this rose to 186 by 1991; neonatal tetanus rose from 42 to 936, diphtheria from 96 to 511 over the same time period *(Figure 2.18*). The decline in most conditions is a reflection on successful EPI efforts. Tuberculosis (occurrence shown for adults plus children) is an exception, in part due to the difficulty in treating this chronic disease.

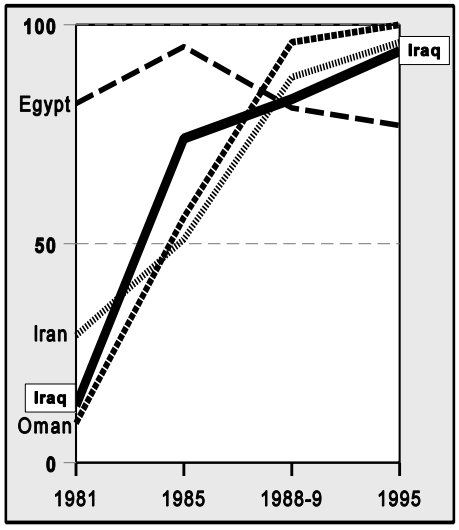
Immunization coverage

After the MOH's revitalization of the Polio Eradication Programme in 1992-1993, polio cases reduced to 53 in 1993. More recent efforts towards Eradication include the organized campaigns of Polio National Immunization Days (PNID) which began in 1995, and repeated annually[90].

The efforts of the MOH extend to several infectious diseases among children, the incidence of which declined significantly after 1992. This change is attributed to the collective efforts of Iraq's health authorities, UNICEF and other U.N. agencies. Coordination was crucial in rehabilitating the cold chain of the Expanded Programme of Immunization (EPI) and ensuring the availability of vaccines. Consistent with the Mid-Decade Goals, this resulted in coverage exceeding 90% for the main vaccine preventable diseases in all governorates of Iraq by 1996.[91]

Using DPT coverage as an example, trends for immunization in the whole of Iraq very compare favourably with neighbouring countries (Figure 2.19)

Figure 2.19
DPT Coverage Rates (1981-1995)
Selected Countries



Sources: State of the World's Children 1990, 1998; Statistics in UNICEF-assisted countries -1990

In November 1994, the final report of The Ministry of Health on the National EPI programme indicated the following results for EPI coverage of a sample of 3,150 children (12-23) months of age, 3,150 mothers who have children (0-11) months of age and 6,750 women in child bearing age:

Health card retention rate						79.5%
BCG coverage with positive scar					83.8%	
Regardless of scar						96.2%
Measles coverage						63.3%
DPT/OPV	I	82.3%	II	76.1%	III	70.1%
TT for mothers with children 0-11 months of age:						
	First dose	67.3%	Second	62.3%	Third	35.1%
TT coverage for women in child bearing age :						
	First dose	56.4%	Second	44.1%	Third	25.3%
Newborn protected from NNT at birth						58.7%

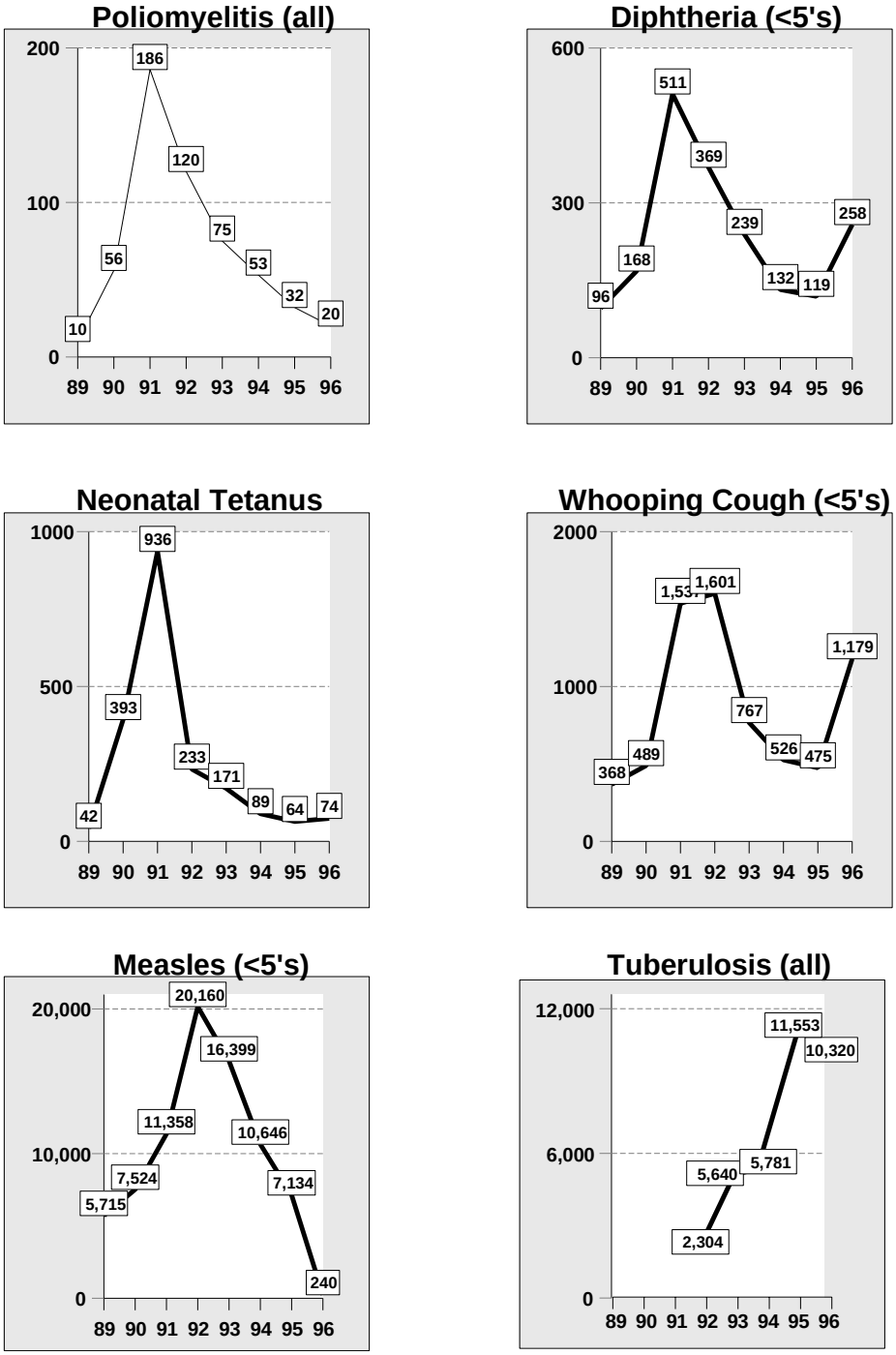
[90] Salah-Aldin Ahmad Raheem and Nawar Majied Aziz "Review of National Polio Immunization Days, Iraq-1997." Ministry of Health, Republic of Iraq, 1997.

[91] State of the World's Children of 1997, UNICEF.

Figure 2.18

Trends in Immunizable Preventive Diseases

Iraq (South/Centre) 1989 to 1996



Reported cases by year*: Statistical Department, MOH*

Increasing efforts are being made to address the issue of insufficient coverage, for polio, as well as a comprehensive measles campaign in late 1995, and campaigns for tetanus toxoid in high risk areas. In 1998, there has been a resurgence of measles, with a relatively larger number of people over five years affected.

A high EPI coverage has been particularly difficult for the northern governorates due to inter-factional fighting and displacement of the population. The Directorate of Health reports between January and June 1996, above 75% measles immunization coverage among children under one year was achieved only in ten of seventy-four sub-districts, coverage of 50-75% in nine sub-districts, with the remaining five districts at a level below 50%. The DPT immunization rates were marginally better than those reported for measles.[92]

Results for the MICS (August 1996)[93] showed for governorates of South/Central Iraq that immunization coverage reported from children aged 12-23 months was very high for BCG (98%)[94] and intermediate for measles (80%) and DPT3/OPV3 (73-74%).[95] For the northern governorates immunization coverage was also very high for BCG (90%), and intermediate for measles (79%) and DPT3/OPV3 (72%). These results show a high level of immunization coverage which closely approximates that set for the Mid-Decade Goals of Iraq's NPA. Examples for BCG and measles coverage by governorate are shown in Figure 2.20 on the next page.

The immunization coverage for tetanus toxoid vaccination was 42% (in the Northern governorates) for mothers during their last pregnancy and 44% in the South/Centre.

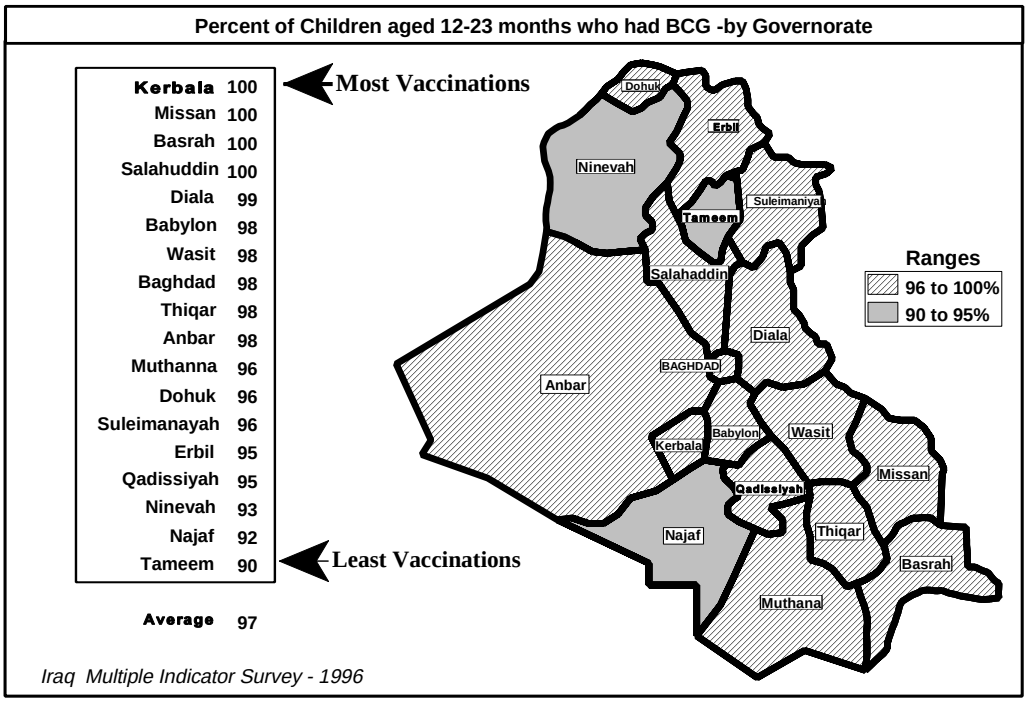
[92] During 1997, coverage in the north has improved as shown by official records and preliminary results from a recent EPI cluster survey.

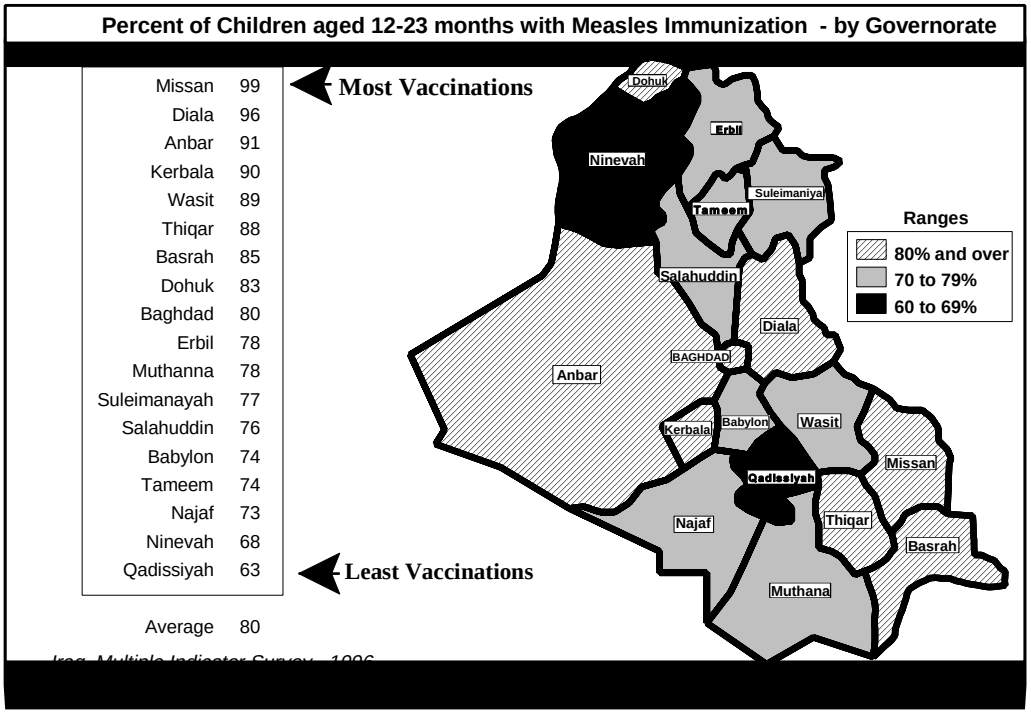
[93] Data collection for this survey took place over a period of 24 days (August 10-September 5) in the south/center governorates and initially in the northern Autonomous region. But because of the fighting in the latter areas there was a temporary suspension of fieldwork. This was resumed in September where it was completed in Erbil on September 19 and in Suleimaniyah on September 30.

[94] In both the South/Centre and North, evidence of BCG must be provided for registration of ID in infants and the added milk formula ration.

[95] The results for DPT/OPV3 are probably under-estimates, due to methodological problems in the survey, e.g., under-reporting by mothers/respondents about the recent introduction of polio vaccine combined with BCG at birth and that received at the Polio National Immunization Days conducted during 1995 and 1996

Figure 2.20: BCG and measles vaccination coverage - Iraq 1996





Trends in the reporting of selected infectious and transmissible diseases (meningitis, malaria, kalazar, brucellosis, viral hepatitis and giardiasis) from 1989 to 1996 are shown in Figure 2.21[96]

Viral Hepatitis

One vaccine-preventable disease with an incidence which continues to climb is Viral Hepatitis. The vast majority are probably Type A, which is generally water borne and results in jaundice and liver dysfunction. The incidence in 1989 was 1,816 reported cases, rising to 16,801 by 1993 and after a dip, rose to 29,803 in 1996. Due to a lack of laboratory reagents to detect sub-clinical cases, it is likely the results are under-estimates. Further, the reports are for all ages, thus it is unclear what major age groups are affected.

Enteric Infections

Inadequate water and sanitation, overcrowding and constraints for personal hygiene has led to steep rises in cholera and typhoid fever . No cholera was reported in 1989 nor 1990; in 1991, 1217 cases were reported, remaining at a similar level yearly through 1994. There were about 1,700 cases of typhoid in 1989 and 1990. This increased 10 times by 1991 and 15 times by 1994. In that year one person in about 700 had typhoid (or three people on average for each of the 10,000 villages in Iraq).
The distribution of typhoid by governorate during October 1997, shows the variation throughout Iraq for that particular month *(Figure 2.22)*. Results must also be interpreted according to completeness in reporting.

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Other diseases

Trends for **meningitis** show an increase in reported cases from 1190 (1,810 cases) to 1991 (5,792), then a consistent decrease up to 1996 (Figure 2.21). The reason for this is not clear.

KalaAzar (or Leishmaniasis) is a parasite which is transmitted by a sandfly, resulting in severe anaemia and liver disease. It also has a skin variety. Shortage of proper pesticides and spraying equipment and the increase in rodents and stray dogs (as reservoir hosts) are responsible for the continued higher incidence from 1991 to 1996. Shortage of drugs precludes adequate treatment.

Brucellosis results from exposure to infected milk from cows. It's rise is due in part to lack of proper sterilization of the udder, especially during milking, and to lack of control of the disease in cows.

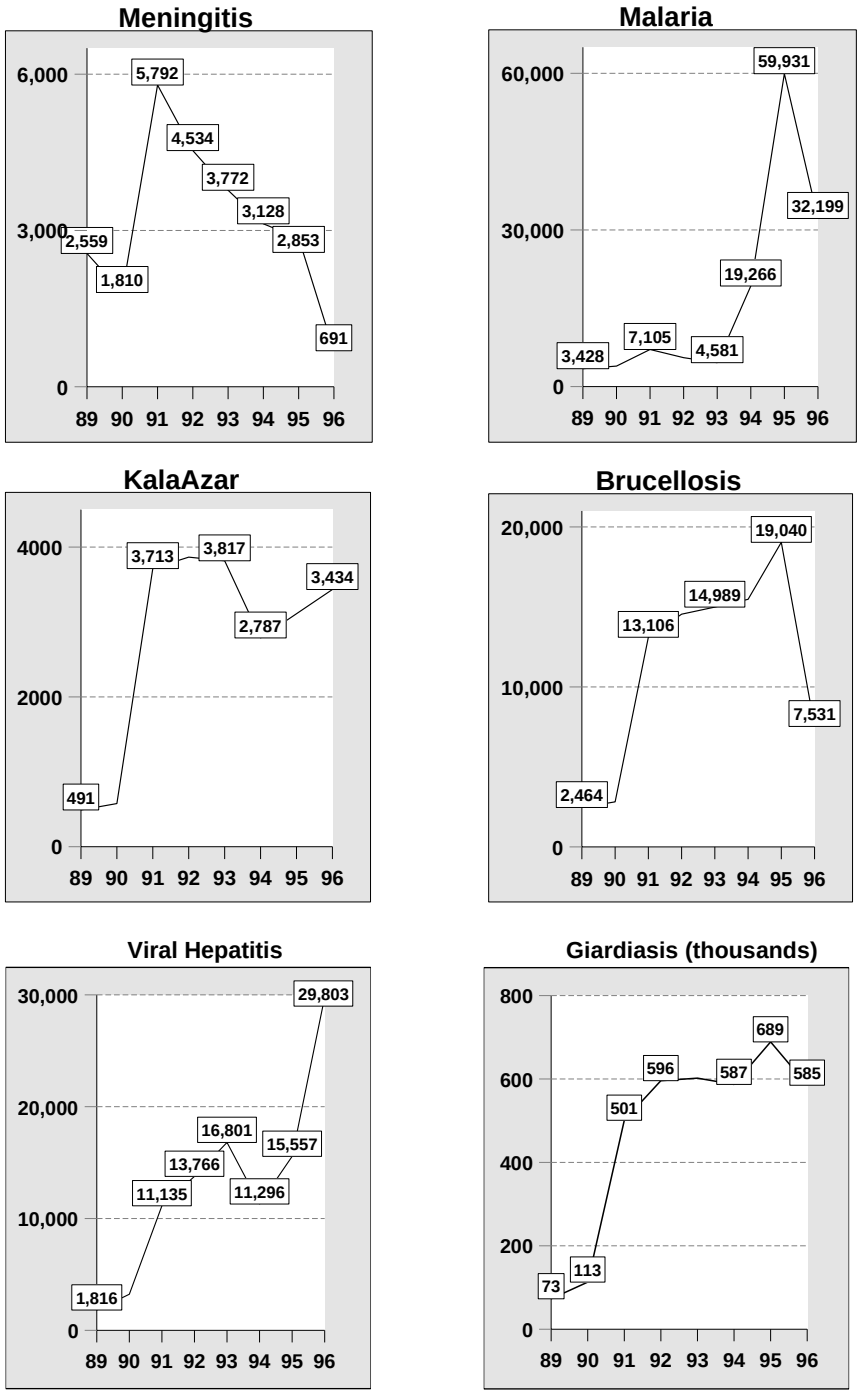
Giardia is an intestinal parasite which causes chronic diarrhoea, especially in children, when the worm load is high. This results in malabsorption of food and nutrients, with resulting malnutrition. It's incidence has risen tenfold since 1989 and continues high. If it is assumed most of the cases are children under 5 years of age, then up to 20% (600,000 of 3 million) have giardia; probably more, as many will not be diagnosed microscopically. The incidence of **Amoebiasis** has also greatly increased. It causes severe diarrhoea and may result in abscesses in the liver and elsewhere. Incidence rates for other intestinal parasites detrimental to children, such as **roundworm** and **hookworm** (a potent cause of anaemia), are unavailable but are likely to be high.

Malaria deserves special mention. Almost eradicated prior to the sanctions, malaria has increased up 10-20 times since 1989, including serious epidemics in certain areas of the country. It is not limited to the north (see Figure 2.22 on page 54). This is due to a combination of water stagnation (e.g. near human habitation), lack of insecticides for vector control and scarcity of drugs for treatment. Malaria, potentially fatal, is an important cause of anaemia in children and mothers; it also results in low birth weight of the newborn due to placental involvement.

[96] See: The Health Conditions of the Population in Iraq since the Gulf Crisis. WHO. March 1996 WHO/EHA/96.1

Figure 2.21

Trends in selected diseases
Iraq (South/Centre) 1989 to 1996



Reported cases by year (all ages)
Source: Statistical Department, MOH

2.5.2 Maternal Health and Safe Motherhood

Maternal health and nutrition is relevant to the CRC and CEDAW for both survival and welfare. A mother is especially vulnerable in her multiple roles as care-giver, household and wife duties and at times, farmer and income earner. Increased pressure on her resources occurred in the Iraq-Iran war and again since the embargo. Of concern is her increased food and nutrient requirements during pregnancy and lactation. Of special risk are widows and the very poor, whose problems are often compounded by multiple young children.

The health service delivery problems presented earlier in this chapter affect women and in particular in relation to the risk of morbidity and mortality associated with childbirth. Lack of resources for care and anaesthesia makes childbirth, especially if complicated, very hazardous and increases the incidence of post-partum bleeding and sepsis. Further, problems with emergency care and absence of functioning ambulances are likely to increase maternal mortality since last estimated at 117/100,000 births in 1989. No recent data is available.

Under-nutrition of mothers is reflected by newborn low birth weight (LBW).. Up to 1990, the 5% prevalence of LBW and average birth weight of 3.4 kg were similar to industrialized countries. Since then, the MOH reports a marked increase to 22% in 1995[97]. A recent survey in Baghdad revealed that 16% of young mothers had a Body Mass Index of less than 18.5, indicating chronic energy malnutrition[98]. Anaemia in surveys is consistently found in 60% or more of pregnant women attending the PHC. Anaemia affects health and physical capacity, submitting a further drain on the mother's scarce resources. When severe, it is a potentially fatal condition associated with childbirth, both for the mother and her newborn. Anaemia is difficult to control under the current system of iron/folate supplementation at PHC's.. Malaria is of special concern, not only in terms of the mother's health and anaemia, but also as a cause of low birth weight.

Tuberculosis (TB) is increasing, especially in women. WHO reports that registered TB cases rose in the 90's by almost five times: from 2304 registered cases in 1992 to 10,030 in 1996. In 1992, TB in women numbered about one-half that of men; by 1996 the sex incidence was roughly equal. In other words, whereas TB in men has increased three times, that for women has increased almost eight times since 1992.

Antenatal, birthing and postnatal care of women is of special importance both to mother and child. Since 1991, hospital delivery care and its adequacy has deteriorated, although mothers would still prefer to attend the hospital for delivery, because of the trained staff based on a recent MOH survey.[99] The same survey reported about 50% of mothers deliver at home, mostly at the hands of a midwife (35%). A smaller proportion (26%) are assisted by trained TBA's, followed by health cadres (20%) and physicians in hospitals[100].

Over 90% of the birth attendants were trained, reflecting the adequacy of Iraq's earlier maternal

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[97] The GOI Initial CRC Report, 1996.

[98] WFP/FAO Assessment Team Report, June 1997

[99] Survey of Family Planning, Delivery Practices and Birth Attendants in Iraq (MOH, WHO, Iraqi Family Planning Association, UNICEF) This facility-based and household survey was conducted by the TBA Programme of the Ministry of Health in December 1996 to provide information to improve the design and implementation of these programmes such as Reproductive Health and Family Planning, also the Safe Motherhood strategy and concerns. The survey had three major components: family planning services for married women of child bearing age (15-49 years); antenatal and home delivery services for married women who had delivered a child within the past two years or were currently pregnant; and knowledge/practices of birth attendants who delivered their children at home

[100]In the Autonomous region, coverage by ante-natal care and TBA services was 48% in 1996, far less than in the South/Centre.

health programs. Knowledge and practices of most of the birth attendants (midwives or trained TBAs) appeared adequate, apart from lack of proper attention to the cord and non-referral of key problems during delivery, failure to visit the mother after delivery and incomplete advice to the mother. Key items in birth kits were commonly missing.

During antenatal visits, advice from PHC staff, such as for nutrition seems rare. The level of TT during pregnancy of 70% and reaching 64% lifetime for at least 3 doses appears consistent with other reporting sources. Adequate provision of iron tablets (only one-quarter of women) is far below the need.

Potential sources such as the media, birth attendants and local agencies seem underutilized to influence the women's decision to seek family planning or antenatal care. Further, advice from birth attendants on child care and breast feeding is rarely given.

About one in eight deliveries are complicated. The most common problems - bleeding and prolonged labour. One-third of all complications were referred.

The survey further found that about 1/3rd of currently married women use family planning, most beginning within the past two years and 3/4ths know about contraceptive loops and pills. These were the major methods used beside breast feeding. The most common reasons for not using family planning were that husbands refuse to use any and the desire for more children. Recommendations related to need for advocacy; family planning programme expansion to PHC's; improved training; supervision and monitoring and to strengthen communication and counseling.

Another recent survey by the Ministry of Health, South/Centre in 1997 provides results which overlap with and confirm that just presented[101]. It also provides valuable information about women's satisfaction of the services.

Pertinent findings: On observation, about 2/3rds of the PHCs had sufficient basic supplies and 1/3rd sufficient medicines. Only 1/4th of the staff were satisfied with the available resources. Of those dissatisfied, lack of drugs was the major problem.

The staff weighed some 3/4ths of the mothers, done correctly about 2/3rds of the time. Plotting of the child's weight on the growth chart was done correctly in about half of the observations. Most of the 51 medical staff (86%) tested blood pressure, but only one-half checked for anaemia and one-third for oedema. Of the 9% of registered mothers referred, few (12%) had feedback.

Only 20% of the staff were aware of the value of breast feeding for family planning; while most (81%) knew about the link between maternal malnutrition and low birth weight, but few (17%) responded about the need for adequate birth spacing.

Most (83%) of the mothers were satisfied with the services provided. Anaemia prevalence was high (61%) in pregnant women Although 90% received iron/folate, only one-half had sufficient amounts. Most (87%) were instructed on its use.

Discussant groups of pregnant mothers and birth attendants revealed that most mothers are aware of the major contraceptive methods (including breast feeding) and the need for birth spacing over 2 years. Many have no opportunity to rest nor buy nourishing food. They prefer the hospital for delivery, identify the most common illnesses of infants (excluding malnutrition) and are aware of methods of caring for their newborn. The survey report recommends the need for training, especially to identify pregnant mothers with risk factors; for improved education in curricula and improve awareness for mothers and staff.

[101] The Rapid Evaluation Methodology (REM) in the Mother and Child Health and Family Health Programme, was conducted in six governorates of the Centre/South in February/March 3, 1997 in 43 PHC's. Surveyors interviewed and observed a total of 574 staff; conducted exit interviews of 600 pregnant mothers and audited of selected equipment/supplies and requirements

2.5.3 Health Programs: Re-Defining Health Development and Meeting Decade Goals

The economic crisis has by necessity influenced the prevailing drug dependent, high technology, curative-oriented health development model[102]. A positive aspect is the greater focus on prevention, which is increasingly perceived as an efficient approach to addressing child and women's rights and the health goals of the NPA. Constraints still abound, such as personnel, supplies and equipment, communication and transport. However, there is strong positive evidence that the GOI clearly promotes excellent quality preventive health and nutrition services, coupled with the willingness to improve the performance of the health cadre and developing the services throughout the existing structure. .

The MOH has developed several plans (eg National Plan of Action for the Preventive Health Department, the National EPI Plan, the National Plan for Nutrition) conferences (eg Midwifery and safe delivery, Nutrition and Health Education Conferences) with regular central and local workshops; all strengthening the coordination between the centre and directorate staff. Several focused surveys and studies on PHC facilities, quality of health care and client satisfaction, and KAP of caretakers has provided a valuable basis for effective implementation.

The Ministry has revitalized several programmes, such as EPI, control of ARI, CDD, MCH care and addressing malnutrition. There is an evolving perception of the relationship between health and nutrition as a dominant factor in young child mortality[103]. Further, linkage across projects is developing. One example is the Integrated Management of Childhood Illnesses (IMCI) initiative, adopted by the Ministry of Health, with UNICEF/WHO cooperation. This combines common strategies and programme elements (eg training, supervision and service delivery) for ARI, CDD, breastfeeding promotion, measles immunization and malaria treatment/control). The Mother-Baby package reinforces the connection between family planning, care of pregnancy, delivery and post-partum, including the neonate. Linked strategies which combine methods of delivery (eg EPI and vitamin A distribution) are being implemented.

The care element in the health-nutrition dyad is gradually being integrated - for improved practices at the service, community and household levels. However, inappropriate practices continue. Although breastfeeding prevalence has increased since the embargo, that of exclusivity in the first 6 months and provision of appropriate foods after then is often lacking. The MICS reports that only about one-third of mothers interviewed state the two major warning signs associated with serious respiratory infections (rapid and difficult breathing). Doctors maintain a lingering reliance on drugs for diarrhoea, despite the recent MOH policy on restricting these. ORT is almost universally available, but its is underutilized. However, there is more awareness of appropriate practices for the management of diarrhoea (ORS or ORT, fluids, and feeding) and its priority in programmes.

The Ministry of Health will continue to pursue the goals for the year 2000 to reach the following: eradication of Polio, elimination of TT, and control of measles; reduction of children under five mortality and morbidity due to diarrhea, ARI and pneumonia; reduction of maternal mortality especially at giving birth due to incorrect practices; expand utilization of family planning services; promotion of breast-feeding, strengthening nutrition rehabilitation project and reduction of malnutrition especially among children under five; promote school health, prevent and control communicable diseases and promote environmental and personal hygiene

[102] The interpretation of Health For All is limited to equitable distribution of health infrastructure, staff and medical supplies without the community participation thrust of Primary Health Care.

[103] WHO reports that malnutrition is responsible for at least half the deaths in young children, especially related to diarrhoea and ARI.

. Decentralization, involvement of local government, effective leadership, supervision and coordination are evolving, at different paces according to the type of project and its support. as well as active, willing and informed community participation are integral elements of achieving goals and objectives and adoption of new initiatives

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Beyond disease specific campaigns, the recent creation of Community Child Care Units (CCCU's) is a move towards decentralization and health promotion as social development, integral to the spirit of the CRC. Further, the involvement of officials at the level of administrative units below that of national structures in 1994-1995 helped to monitor the realization of Mid-Decade goals.

The influence of Local People Councils (LPC) has been enhanced within the national structure since 1996. These councils, with local chapters of the General Federation of Iraqi Women (GFIW), the General Federation of Iraqi Youth (GFIY), the Farmers' Union and the Trade Unions have the potential to mobilize local popular support and involve the community in activities conducive to children's well-being. They need material and specialized support. Due to budget constraints, the continuing support for health education and promotion programs in rural areas stopped. Those developed by the GFIW which once covered about one-quarter of rural areas, were terminated in 1996, confining their activities to urban areas.

Shortage of drugs, medical supplies and equipment will be addressed through the implementation of the Oil-for-Food programme. More than US$ 630,000,000 is allocated for the Phases I, II and III. An additional US$ 200,000,000 is expected if the supplementary distribution plan is finalized.

However, recent studies and surveys carried out by GOI, supported by UNICEF and WHO, revealed the sizeable gap in the knowledge and practices of service providers reflecting the depleted health infrastructure status. The same surveys indicated poor registration/recording/reporting and data use with inadequate supervision activities attributed mainly to transport difficulties as well as shortage of properly trained supervisors. Hence, upgrading technical skills and knowledge of service providers and child care takers is a priority. Further, an efficient monitoring and data collection system is required, to identify pockets of low immunization coverage and high disease and malnutrition prevalence for a better targeted programme implementation and ensure optimal utilization of resources. Such information use must also extent to the community through the CCCU's.

2.5.4 Malnutrition

Prior to 1990, severe clinical malnutrition was rarely seen in Iraq and studies suggested a low prevalence of underweight even in poorer areas[104]. There was probably regional variations in nutritional status. For example, the rural population is generally worse off economically with higher literacy rates than the urban, and certain governorates, such as Basrah are traditionally food-deficient. But none of the pre-1990 nutrition assessment studies showed malnutrition of the severity reported later.[105]

The current situation: The most recent household survey throughout Iraq to assess the nutritional status of young children was the 1996 Multiple Indicator Cluster Survey (MICS) done by Iraq's Central Statistical Organization, in collaboration with UNICEF.[106] Combining the results for each report (taking into account the different populations), the prevalence of underweight was 22.9%; of chronic malnutrition (stunting) 31.3% and acute malnutrition (wasting) was 10.1% (Table 2.3).- *for an explanation of these terms see Box 5*. These levels indicate that Iraq has a serious problem of malnutrition in young children, equivalent to that encountered in very needy countries of the world. Such levels reflect not only the current danger to Child Survival and Development of the Children of Iraq, but also the adverse impact on future generations due to the lifetime consequences.

Table 2.3 : Prevalence % of Malnutrition (moderate/severe) - MICS 1996

MALNUTRITION	IRAQ	South/ Centre	North
Underweight	**22.9**	23.4	19.3
Chronic (Stunting)	**31.3**	32.0	26.3
Acute (Wasting)	**10.1**	11.0	3.8

[104] For example, Beradi, 1989 from a cross-sectional survey of 4153 children aged 0-8 years in Central Iraq reported results similar to the international reference data - i.e. to industrial countries, with even a tendency to obesity (reported in Nutritional Status Assessment Mission to Iraq, p 21 - FAO. November, 1993)

[105] Noriko Sato, Omar Obeid and Thierry Brun, "Malnutrition in Southern Iraq." Letter to the Editor, The Lancet Vol 338, 1991, p.1202.

[106] **The purpose of the MICS** was to assess the progress towards the Mid-Decade goals of the National Plan of Action for children, drafted by the GOI after the World Summit for Children. The MICS covers health, nutrition, education, and the water and sanitation sector. **Another purpose of the survey** was to have baseline data against which the impact of the implementation of SCR 986/1111 could be assessed. It was conducted throughout Iraq's 18 governorates during August and September 1996. The household sample yielded 1,799 children under five years in the Northern Governorates and 6,392 in the South/Centre for assessment, including that for nutritional status.

The report for the Northern Governorates was released in May, 1997; that for the South/Centre not until October, 1997 soon after permission was obtained from the GOI.

Box 5

Nutritional Implications for the Anthropometric Indicators

Chronic malnutrition *(or stunting) results in poor physical child growth, often accompanied by sub-standard capacity for development and education. It reflects the cumulated detrimental effect on child growth by adverse economic conditions, poor health, feeding and care. Chronic malnutrition is difficult to reverse after the child reaches 2-3 years of age. Often stunted children grow up to be stunted adults, with a continuation of the same detrimental process on their children.*

Acute malnutrition *(or wasting) reflects more recent onset adversities, such as diarrhoea and acute respiratory infections compounded by inadequate feeding. It is most easily reversed, but often recurs due to repetition of this cycle. This type of malnutrition is the most readily recognized by mothers, due to a child appearing thin.*

Underweight *implies a composite of chronic and acute malnutrition - either or both of these can result in underweight. It is the most widely understood indicator for nutritional status and is used in UNICEF's Progress of Nations report to monitor nutrition.*

Whereas chronic malnutrition and underweight are measured by a low height and weight for age respectively, acute malnutrition is assessed by a low weight for height.

Results for Iraq will mainly reflect those of the South/Centre population due to its much larger population than that of the Autonomous Northern Region. Also, it would appear that the rates for underweight and chronic malnutrition are a little greater in the South/Centre compared with the North and that of acute malnutrition much greater (11.0 vs 3.8%). This suggests at the time of the survey there was still a progressive deterioration in nutritional status in the South/Centre.

Urban/rural comparisons: Due to the dominance of the population in the South/Centre compared with the North, these and further results will be presented separately for each. There was no difference in malnutrition rates between urban and rural areas for the South/Centre. In the North[107], there were distinct and statistically significant differences in underweight and stunting prevalence.

Table 2.4: Prevalence % of Malnutrition (moderate/severe) by Urban/rural - MICS 1996

	South/Centre		North	
MALNUTRITION	**Urban**	**Rural**	**Urban**	**Rural**
Underweight	23.1	24.1	17.3	23.1
Chronic (Stunting)	31.7	32.7	24.8	29.5
Acute (Wasting)	10.2	11.7	3.4	4.8

[107] Lack of an urban/rural difference for the South/Centre was also reported in two later nutritional status surveys based in PHC's throughout all 15 governorates; the same results applied for lack of any sex difference.

There were no significant differences by sex (Table 2.5)

Table 2.5 : Prevalence % of Malnutrition (moderate/severe) by Sex - MICS 1996

	South/Centre		North	
MALNUTRITION	**Male**	**Female**	**Male**	**Female**
Underweight	23.5	23.3	20.3	18.1
Chronic (Stunting)	30.8	33.2	26.9	25.7
Acute (Wasting)	11.7	10.3	4.3	3.4

In order to consider the variation within Iraq, malnutrition results for governorates are presented in the following maps and tables:

For Underweight, the highest prevalence is in the south, the lowest in a belt north and east of Baghdad. *(Figure 2.23)*

Figure 2.23
Prevalence of Underweight (or General Malnutrition) by Governorate - Iraq 1996

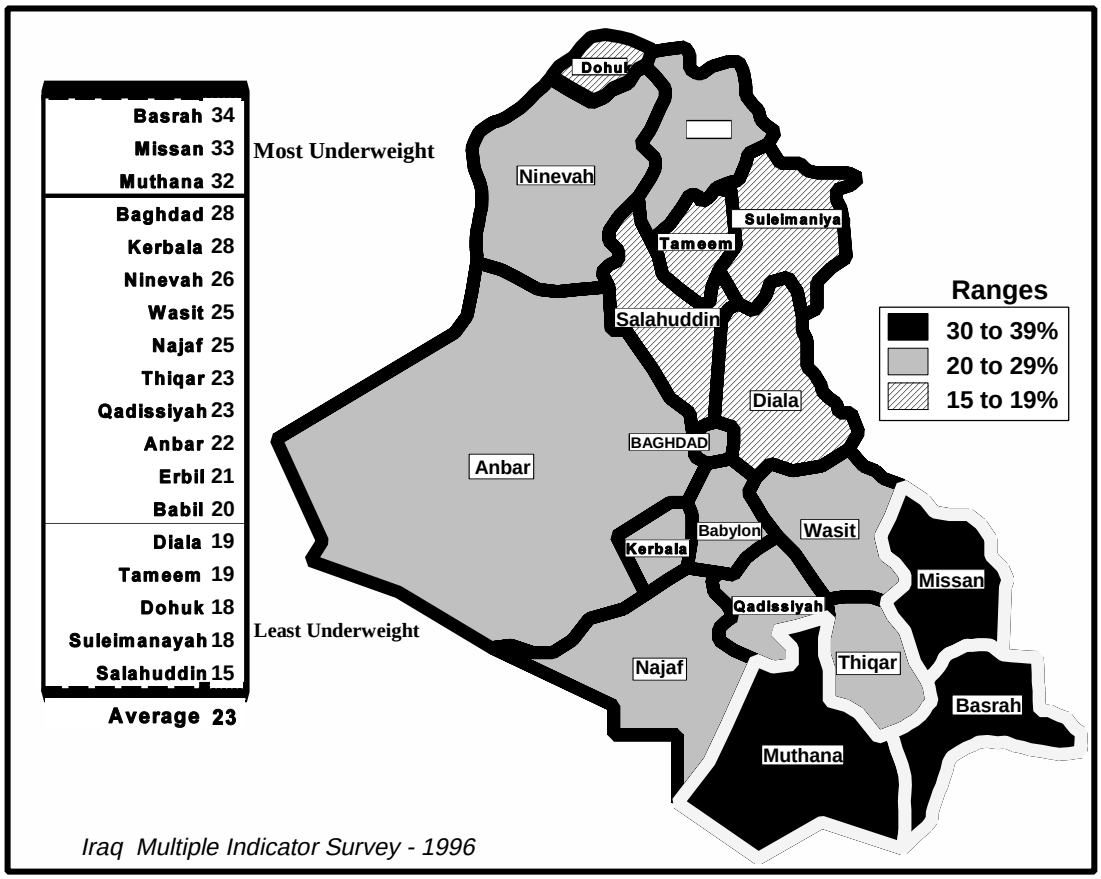


Figure 2.24

Prevalence of Stunting (Chronic Malnutrition) by Governorate - Iraq 1996

With regards to Chronic Malnutrition, a similar pattern to underweight is apparent. The very high result for Missan governorate may be in part related to its especially severe experiences during the two wars. From which it has not yet recovered. Interpretation of the results should take into account the internal migration of hundreds of thousands from the south to governorates such as Najaf and Kerbala. *(Figure 2.24)*

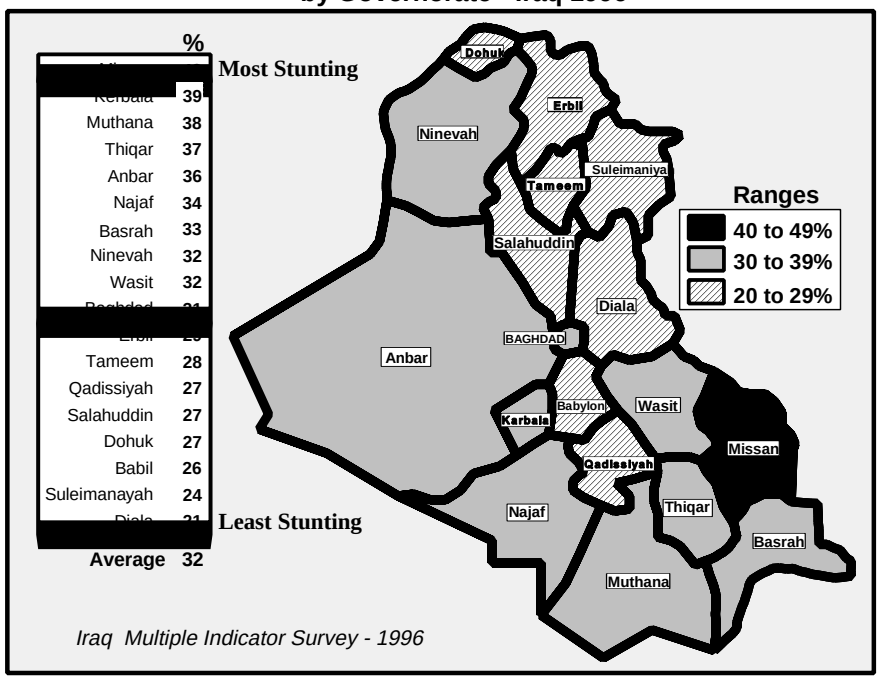
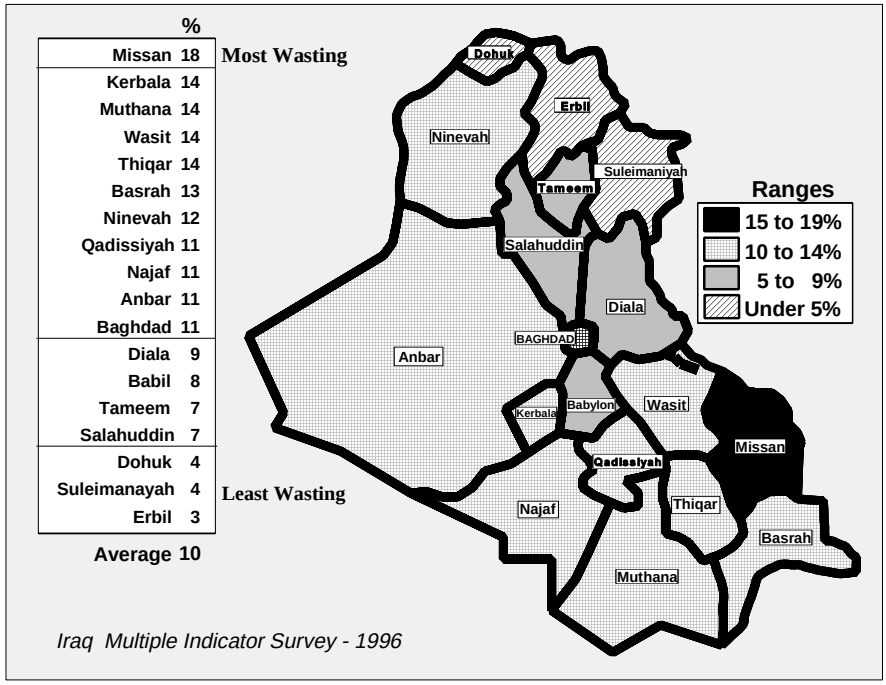


Figure 2.25

Prevalence of Wasting (Acute Malnutrition) by Governorate - 1996

Wasting prevalence shows the most striking variations by governorate. It ranges from under 5% in the Northern Region to 5-9% in parts of Central Iraq (excluding Baghdad) and its immediate governorates to the north. Again, Missan (18%) fares the worst. *(Figure 2.25)*



Malnutrition and age: The pattern of malnutrition as the child ages shows a steep rise in general (underweight) and chronic malnutrition up to 2 years of age and then tends to level off *(Figures 2.26, 2.27)*. The typical pattern of steep rise in wasting prevalence from 6 to 24 months (due to high exposure to infections and inadequate feeding) is shown for the Northern Governorates. The prevalence of wasting is so low after 2 years of age (1% or less) that the underweight dips also after 2 years[108]. The high prevalence of wasting in children aged 0-5 months for the South/Centre especially, is suggestive of seriously compromised breast feeding.

Figure 2.26
Malnutrition by Age
South/Centre governorates

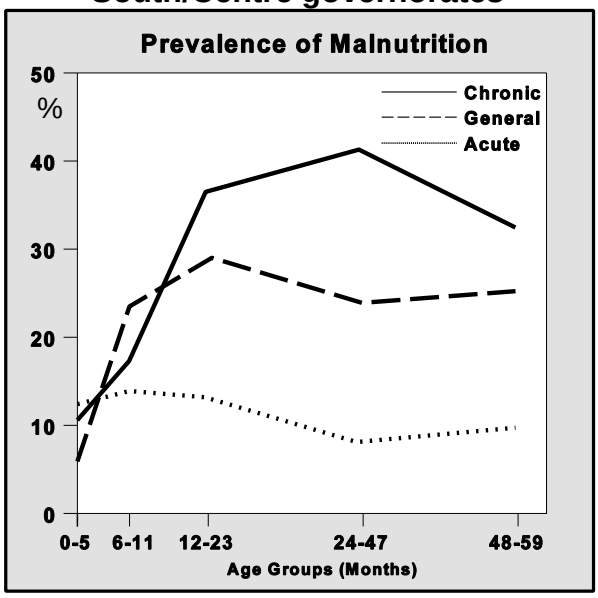
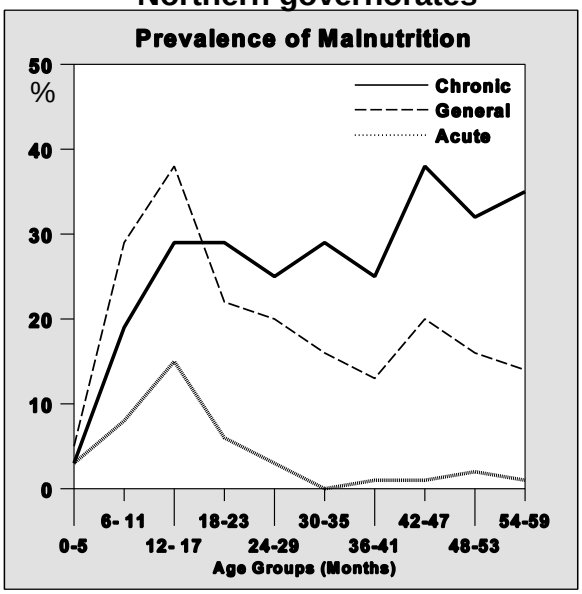


Figure 2.27
Malnutrition by Age
Northern governorates



Source for each: MICS (1996)

[108] For some reason, the timing of the survey (in August/September) may have differentially affected the North less than the South/Central with regards to wasting and underweight; i.e. produced a lesser prevalence from 2 years of age, when rates for younger children were about the same for the two regions. This does not affect stunting, where the patterns for each region are similar.

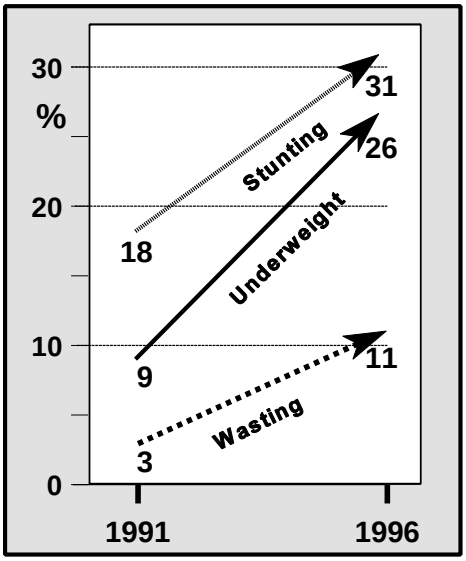
Two key questions need addressing. What was the extent of the nutrition change prior to 1990 up to 1996 and what has been the situation since August 1996 when the MICS was done, with special reference to the period of the Oil-for-Food inputs.

Trends from pre-1990

The first comprehensive nutritional status survey in Iraq was done in August/September 1991, just one year after the embargo began, conducted by an International Study Team[109]. The sub-sample of 2,676 children aged under five allowed a description of total urban/rural, sex and age groups; selected regions but not governorates. Results showed that 11.9% were underweight, 21.8% stunted, and 3.4% wasted[110].

Figure 2.28

Changes in Prevalence of Undernutrition from 1991 to 1996 - South/Centre Iraq



Prevalence - less than -2 SD reference in children under five years of age
Household surveys - August 1991, 1996

Trends: Comparison of the results for the August 1991 survey by the International Team with that of the Multiple Indicator Cluster Survey is valid as each was a random household sample of similar population groups and the methods of measurement and analysis for nutritional status were the same. There has been a serious increase in prevalence rates in the South/Centre since that time - stunting 18% increased to 31%; underweight 9% to 26%, and wasting 3% to 11% (1991 results listed first)[111]. The most striking increase has been with wasting (over 200%) - *Figure 2.28*

Recently, a method to interpret the severity in the extent of malnutrition in young children has been proposed, according to prevalence rates[112]. In countries with low prevalence, malnutrition would not be considered an important problem, those with medium prevalence would have a problem of malnutrition and with high prevalence a serious problem.

Based on these criteria, Iraq has moved from a country in 1991 having a low prevalence of all three indicators (wasting, stunting and underweight), with malnutrition not an important problem, to high prevalence rates in 1996, matching the serious extent encountered in the very needy countries of the world. It should be noted that the 1991 survey was done one year after the start of the sanctions, when the adverse effects on nutrition had already begun.

[109] Harvard Study Team "Special Report: The Effect of the Gulf Crisis on the Children of Iraq." New England Journal of Medicine, 1991, Vol. 325:977-80.

[110] The report suggested that survival bias (due to the large number of child who died, who were likely to be wasted) may have been partly due to the low prevalence of wasting.

Other pertinent findings: A strong relationship between maternal education and underweight and stunting (but not wasting); a similar strong correlation between diarrhoea and malnutrition for all indicators; no major urban/rural nor sex differences in malnutrition

[111] The corresponding changes for the whole of Iraq (including Northern Governorates) are: for stunting 22% to 31%, underweight 12% to 23% and wasting 3% to 10%, from 1991 to 1996.

[112] Quoted in K. Sullivan trip report, Baghdad (January 1997)

Further, there are important differences for regional changes in Iraq between 1991 and 1996. Results show a marked increase in prevalence in all regions of the South/Centre. Whereas the North started with a high prevalence of stunting (30%) and has remained high; the other regions have increased greatly in extent. (*Figure 2.29 on page 65*). Stunting is the preferred indicator for longer-term changes as it is the most stable.

Other more limited surveys in the South/Centre, primarily Baghdad, have confirmed the deteriorating nutritional status among children. For example, in June 1995, FAO reported 28% of children under five were stunted, 29% underweight and 12% wasted, based on a survey conducted with the Nutrition Research Institute, Ministry of Health.[113]

The lack of dramatic increases in nutritional status for the North (compared with the South/Centre) does not indicate the need is less. The levels of stunting are almost the same, that of underweight depends greatly on wasting, which can fluctuate rapidly[114].

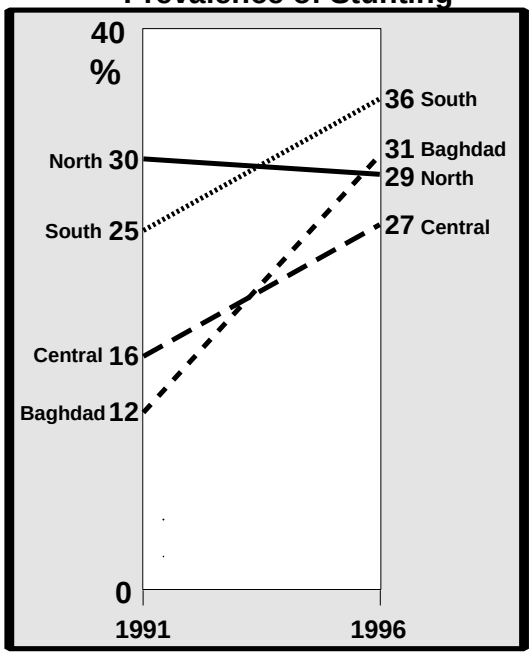
[113] The household survey was conducted in the poorer areas of Baghdad which had been covered by the 1991 International Study Team's survey; with a sample size of 594 children from 25 clusters. Malnutrition rates had increased from 2-4 times that in 1991.

[114] Stunting, initially registered at 29.5% remains at the comparable level of 26.3% documented in the 1996 MICS. Corresponding figures for underweight are 19.1% compared to 19.3%, and for wasting 4.5% vs 4.8%. The higher levels in stunting during 1991 may reflect more the severity of the situation in the North at the time.
It is important also to emphasize that during the five year interval between 1991 and 1996, variations are likely to occur. Further, a low total prevalence does not preclude pockets of high malnutrition rates.

Figure 2.29

Changes in Nutrition Status - Iraq (1991 to 1996)

Prevalence of Stunting



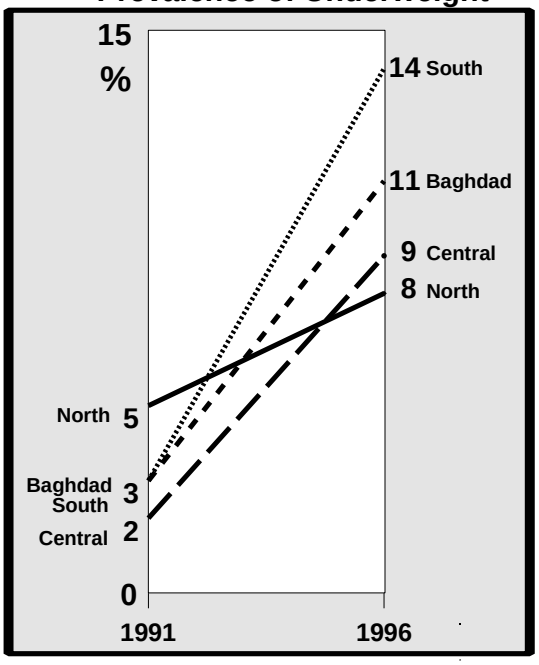
In September 1991 (about one year after the start of sanctions) a random sample of 2676 Iraqi children under 5 years were measured for nutritional status. In September 1996 (five years later) a repeat random survey was conducted on 8,191 Iraqi children using the same procedures and analytic criteria (WHO reference data).

The change in nutrition is based on the 1991 designated areas of the country: Baghdad (urban and rural); Central (Anbar, Babil, Diala and Salahuddin); South (Basrah, Kerbala, Missan, Muthana, Najaf and Qadissiyah); North (Erbil, Dohuk, Ninevah, Suleimaniyah and Tameem). Wasit and Thiqar governorates could not be included as they were not surveyed in 1991.

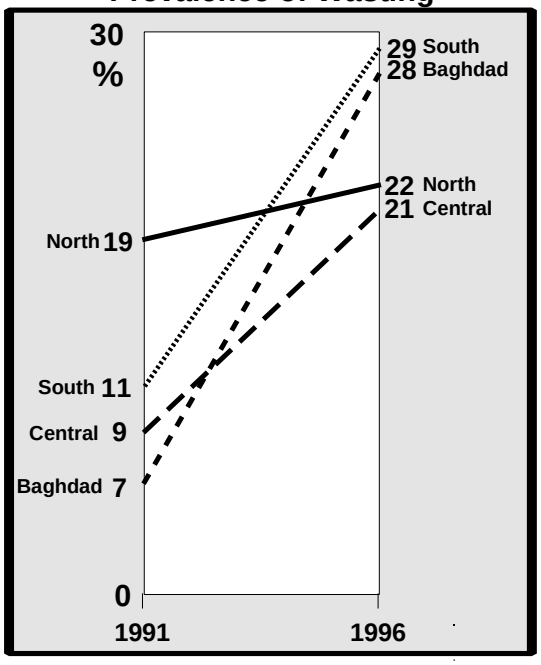
Stunting is the most stable indicator over time. Results show a marked increase of prevalence in the South, Central and Baghdad with no change in the North group.

Similar trends are noted for Underweight. For wasting, an indicator of acute malnutrition, there was an increase in all groups.

Prevalence of Underweight



Prevalence of Wasting



AJZ

Trends from 1996 to 1997

Surveys were undertaken throughout the South/Centre during 1997 by the Nutrition Research Institute/MOH supported by UNICEF, with WFP as additional observers. The first (in April), was for a further baseline to the MICS, closer to the onset of SCR986 ("oil for food") implementation. The second (in October), was to determine if there was any significant change in nutritional status of young children after implementation.

In April 1997, a survey was conducted in 87 Primary Health Centres throughout the 15 governorates of Iraq during the three Polio National Immunization Days, when 15,466 children under five years of age were measured.[115] The result of 24.7% underweight, 27.5% stunting and 8.9% wasting in under fives was similar to the MICS' findings in August 1996, confirmed the continuing nutritional problems in Iraq. The same lack of change was found for infants. (Table 2.3, page 58)

From October 27 to November 2, 1997, the same 87 Primary Health Centres were re-surveyed, where 3,153 infants attending routine immunization sessions were measured for weight and length[116]. Results indicate that underweight in 14.6% of infants, chronic malnutrition in slightly less (12.2%) and acute malnutrition in 7.5%.

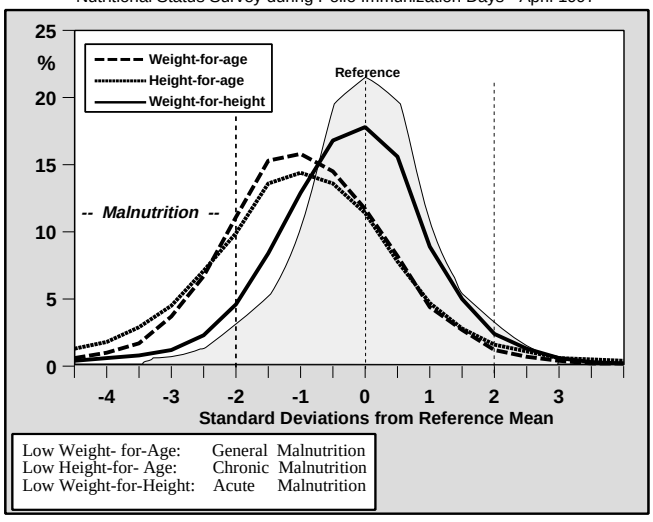
Results for infant general and chronic malnutrition are at least 10% less than would be expected for children aged under five years, based on data analysis comparing the two age groups from the two prior surveys (August 1996 and April 1997) in the South/Centre governorates (see also Table 2.6 for differences). This is because the process for these types of malnutrition is cumulative over time; i.e., increases with the child's age. On the other hand the prevalence of wasting tends to peak at 6-23 months of age and then declines, so the results for infants (which includes those aged 6-11 months) tends to be of similar magnitude as that for the under fives.

In the South/Centre April 1997 survey, malnutrition is so pervasive that every governorate in South/Central Iraq had a prevalence of chronic malnutrition of at least 20%, as was reported in the MICS, 1996. Further, not only were the prevalence rates high, but there was a shift in the whole population towards poorer nutrition. Even those with prior assumed much better status have become worse, although not yet severe enough to be classified as malnourished (Figure 2.30).

Figure 2.30

Distribution of Nutritional Status - Total Sample

Nutritional Status Survey during Polio Immunization Days - April 1997



[115] Nutritional status survey at Primary Health Centres during Polio National Immunization Days (PNID) in Iraq. April 12-14, 1997 MOH/UNICEF/WFP

[116] Nutritional status survey of Infants in Iraq attending immunization sessions. November, 1997. MOH/UNICEF The survey was careful to select only those children with current documented appointments for immunizations (BCG, Polio, DPT, OPV and Measles) and to exclude any mothers whose children came for screening for food..

Table 2.6 : Comparison of Malnutrition Prevalence percentage in Infants and Under-fives for recent surveys in South/Centre Iraq

Malnutrition type	Indicator	Age	Aug 96*	April 97**	Oct 97***	Mar 98****
General (Underweight)	Weight-for-Age	Under 5's	23.4	24.7	_____	22.8
		Infants	14.1	14.7	14.6	13.2
Chronic (Stunting)	Height-for-Age	Under 5's	32.0	27.5	_____	26.7
		Infants	13.7	15.3	12.2	16.2
Acute (Wasting)	Weight-for-Height	Under 5's	11.0	8.9	_____	9.1
		Infants	13.1	9.0	7.5	8.3

All results in percentages

* *Aug 96 - Multiple Indicator Cluster Survey (household)*

** *Apr 97 - Survey of Under fives with Polio Immunization days PHC*'s

*** *Oct 97 - Survey of Infants with Regular Immunization at the same PHC*'s

**** *Mar 98 - Survey of Under fives with Polio Immunization Days at the same PHC*'s

A comparison between results for the two PHC-based April and October 1997 surveys shows the level of underweight in infants has remained the same (14.7% in April vs. 14.6% in October). There are minor differences in acute malnutrition prevalence (from 9.0% to 7.5%) and in that for chronic malnutrition (from 15.3 to 12.2%). Results from a repeat survey in March 1998 indicates there is still no detectable real change in malnutrition rates of under fives and infants.

A nutritional status survey of 15,804 children under five years of age was conducted in 87 Primary Health Centres (PHC's) throughout the 15 South/Centre governorates in Iraq during (PNID) from March 14-16, 1998. This was done by the Nutrition Research Institute, MOH, supported by UNICEF and WFP. The methods and sampling procedures were the same as during the April 1997 survey, with the same PHC's visited. Results indicate that the prevalence of stunting (chronic malnutrition) in children under five years of age was 26.7%, of underweight was 22.8% and wasting (acute malnutrition) was 9.1%.

In the Northern Governorates a recent survey sheds more light on changes since 1996.

The random sample household survey was conducted by the Regional Ministry of Health and Social Welfare with UNICEF support from November 17th to December 8th 1997. A total of 90 clusters (30 per governorate) were included, each with 25 households. The survey included assessment of nutritional status of 2,328 children aged 0 to 5 years, using weight and height measures.

Results show that the nutritional status of children under five years of age continues to be serious, especially stunting (chronic malnutrition). At a level of 30.3%, this compares with the poorest countries of the world. Underweight prevalence at 15.9% appears less of a problem, and that of acute malnutrition (wasting) is relatively low at 3.1%. The highest prevalence of underweight and wasting is for children aged 6 to 24 months. Rural areas appeared to have more chronic malnutrition as compared with urban (35.5 vs 23.7%).

Since August 1996 when the Multiple Cluster Indicator Household Survey was conducted, there has been no reduction in stunting prevalence; indeed there may be a slight increase (26.3 to 30.3%). Underweight prevalence seems to have reduced from 19.3 to 15.9%, with wasting a marginal decrease from 3.8% to 3.1%. The two surveys had the same methods and each used the WHO definition of malnutrition (<-2 SD of reference).

Although no strictly an evaluation of SCR986, due in part to lack of a survey in mid-1997, it is likely that attention to acute health problems (and perhaps added foods for children) has made a difference, but the basic infra-structural problems remain reflecting chronic malnutrition. Also chronic takes longer to reverse than acute, hence a survey in the near future may indicate some decrease in this problem.

2.5.2.1 Micro-Nutrient Deficiencies

Micro-nutrients refer to those nutrients which although required in small amounts have a profound influence on the health and survival of the young child. Those especially relevant to Iraq are Iodine, Vitamin A, Iron and Vitamin D.

Iodine Deficiency Disorder

Iodine Deficiency Disorder (IDD) results in a spectrum of afflictions ranging from stillbirth, reduction of intelligence (IQ) to mental retardation and deafness. The deficiency also affects animal rearing and growth resulting in further economic deprivation for nations, producers and consumers.

IDD is probably not new to Iraq, where leaching of iodine from the soil occurs especially in the mountains and foothills. However, the awareness to the deficiency is new, as in most Middle East countries. One study conducted in 1993 in the northern governorates of Dohuk and Erbil showed high incidence of goitre in primary school children (results to be included). In some districts such as Zakho, over one-half of the children had goitre. A further study in 1994 concluded "IDD is no longer limited to the Northern governorates; it exists even in the governorate of Basrah, a port in the southern part of the country where goiter had not been familiar in the past".[117] The price of once abundant fish, an important source of iodine which used to be considered poor people's food, became unaffordable to most.

It is critical to prevent the problem before it starts to develop in the foetus[118], hence iodized salt is the only effective long term strategy. UNICEF, in cooperation with the MOH and Ministry of Trade, advocated for iodized salt into the ration system and supported its production in seven salt plants. UNICEF-promoted social marketing includes mass media messages and posters on public transportation vehicles.

The MICS survey in late 1996 reported on the very limited distribution of iodized salt, if at all, especially throughout the South/Centre governorates. Only one in ten households had at least the minimal recommended 25ppm of iodine in their salt on testing, an unacceptable result *(Figure 2.32 Iodine, page 70)*. The SCR986 ration for 1997 is meant to include the provision of iodized salt. However, because of erratic deliveries, the situation is still not much better, based on recent reports from the NRI/MOH.

In the North, the population is more sensitized to iodine deficiency and iodized salt is available through plants and across borders. Hence results for the MICS showed a much higher percent of households using iodized salt than in the South/Centre.

[117] Study presented by Dr Amal Swaidan at the 1994 IDD National Workshop, Baghdad.

[118] Making this foetal and new born right as well as a child right to survival and development

Figure 2.31 VitaminA:
Percent of Children 0-23 months who received Vitamin A - by Governorate

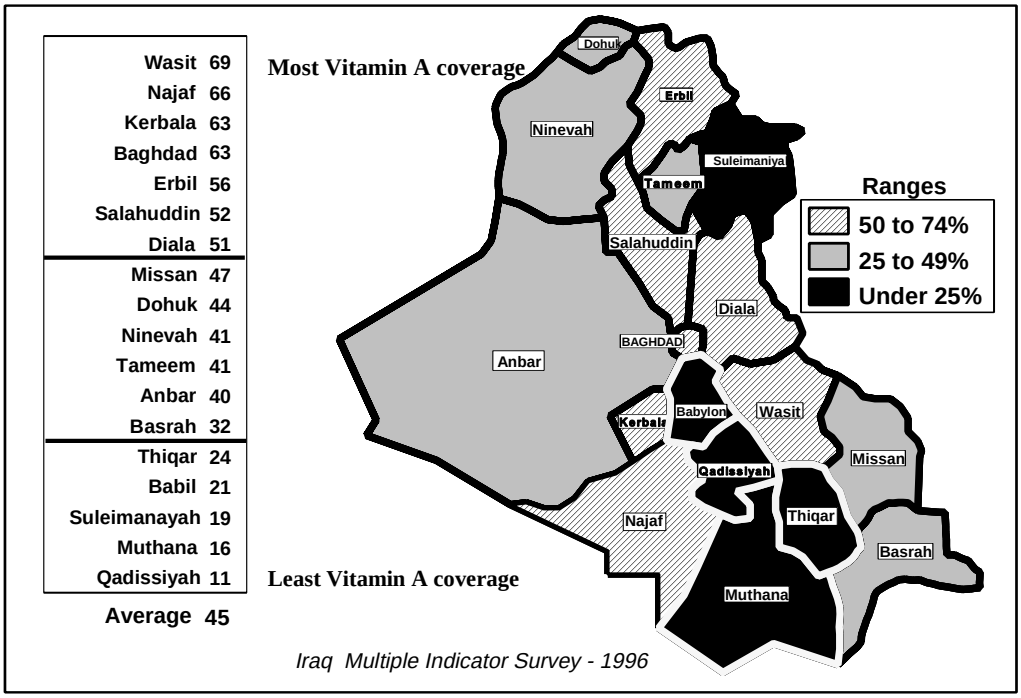
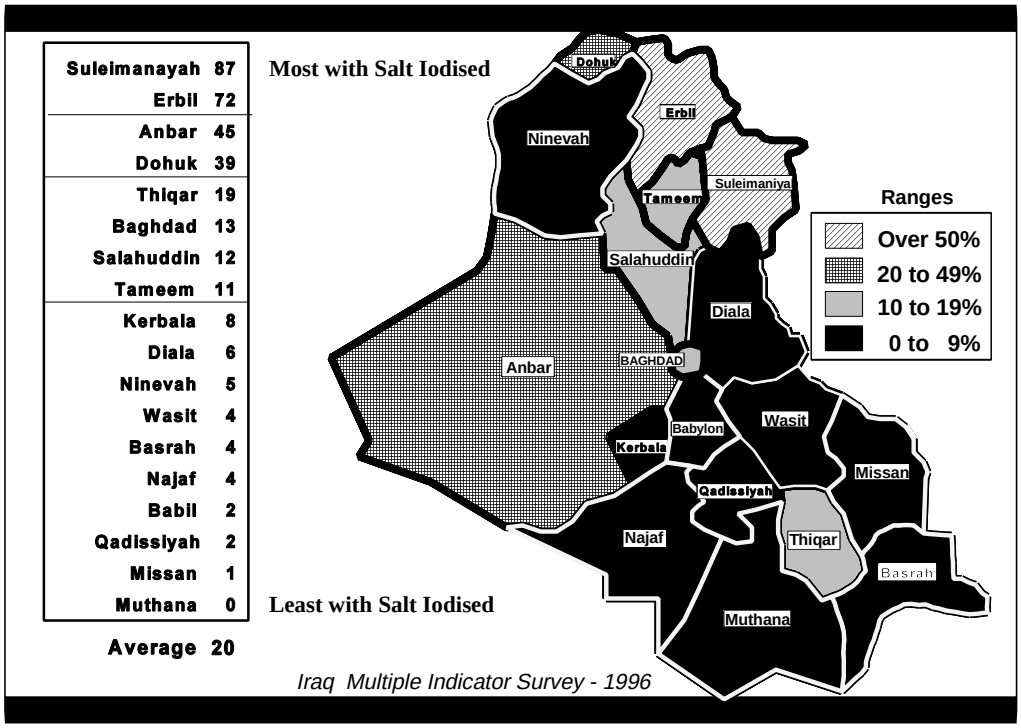


Figure 2.32 Iodine:
Percent of Households with Iodized Salt >25ppm - by Governorate



Vitamin A deficiency

In 1988, WHO classified Iraq as a country where Vitamin A deficiency was not a public health problem. This has now changed.

Results from the 1994 Vitamin A assessment survey of 9000 children under five years of age in governorates of the Northern and South Central part of Iraq, supported by UNICEF, brought attention to the problem of Vitamin A deficiency [119]. The prevalence of night blindness was 1.6%, surpassing WHO's level of 1% to indicate a moderate public health problem.

The deficiency is due to the lack of dairy products, meat and eggs in the diet; the ration distributed previously by the government; and more recently through the "oil for food". The prices of the needed foods is well beyond the reach of Iraqis, especially those most affected by economic hardship.

Recognizing the problem, the MOH supported by UNICEF introduced a supplementation program in late 1995 which focused on new mothers, and children of 9 and 18 months of age linked with measles immunization and the booster dose for DPT. The MICS survey showed that this programme was beginning to reach needy children (*Figure 2.31 Vitamin A, page 70*). However, the most effective feasible prevention is to improve the quality of the rations, with special reference to Vitamin A fortification of vegetable oil.

Vitamin A deficiency is especially important due to its proven link to morbidity and mortality, with relevance to Child Rights and Development[120]. It increases the child's susceptibility to diarrhoea and respiratory infections, already rampant due to poor water quality and sanitation. Studies in several countries show that effective vitamin A distribution can reduce the mortality of young children by up to 30%, especially those with high rates of malnutrition.

Iron deficiency Anaemia

Anaemia due to iron deficiency is the most common nutritional disorder in Iraq, affecting more than one-half of pregnant mothers and probably a similar percent of young children. It is an important cause of maternal mortality and young child morbidity. Further, it can result in irreversible cognitive development in young children and limit education potential at schooling. It's effect on the economy is to reduce the work and labour efficiency.

It is due to non-replacement of iron loss during menstruation and pregnancy, depletion by illness (including malaria) and worms, with lack of adequate dietary replacement. In the diet, animal protein is especially important (even in relatively small amounts) to improve the utilization of iron from usual sources, such as cereals and leafy vegetables. Again, their expense and lack of inclusion in the rations precludes effective solutions to this pervasive problem.

[119] There was no gender difference in the incidence of Vitamin A deficiency. A prior study in 1991 also reported about the problem in the South - Vitamin A deficiency and Malnutrition in Southern Iraq HKI/SCF/UNICEF, May 1991.

[120] It is also the leading global cause of blindness in young children .

The supplementation of iron and folate for three months during pregnancy done in the PHC's has alimited effect, mainly due to lack of compliance both in Iraq[121] and in other countries. Apart from an improved diet, an effective alternative is fortification of iron in food (commonly wheat flour).

Vitamin D Deficiency

This causes rickets (an affliction of bone development and growth) in young children and is due to lack of Vitamin D in the diet or its precursors which are converted into the vitamin through exposure to sunlight. This lack of exposure for infants is a part of many cultures, including that of the Arab world. In the past, the diet for both the mother and child mainly through dairy products, was sufficient to prevent the deficiency. This has now changed.

Reports of Vitamin D deficiency are now appearing and are expected to increase with evolving recognition. Vitamin D ergocalciferol tablets for affected children and drops for infants, are provided by UNICEF and distributed through health centres. However, the only effective solution is improvement in the diet for mothers and young children as changing traditional ways is difficult.

2.5.2.4 Breast feeding

Breast feeding is a natural and crucial assurance to promote child survival rights and needs and to prevent malnutrition. The Koran decrees that Breast feeding be continued through the child's second year of life.

The prevalence of Breast feeding during 1988 to 1990 was about 60% in the first 3 months and 45% in the first year[122]. Although no data are available, it is likely that the extent of Breast feeding was higher in the past, before the economic boom. The first reported household survey since 1991 was in Baghdad during 1993 which reported that 61% of 253 children under one year of age were still breast-fed.

Another household survey in 1994 by MOH/GFIW covered 2650 families from 6 governorates showed that "total dependence" on breast feeding was 71% (85.5% in rural and 65.2% in urban areas), but the age for which this applies is not clearly indicated. Breast feeding was 71-75% in mothers with no education or primary/intermediate levels, 64% in secondary schoolers and 52%-58% in the more highly educated. Those few with Masters and Ph.D. degrees had rates from 73% and above, suggesting the elite had reverted to "traditional ways" in conformity with the trend in industrialized countries.

Multi-sectoral programming assumes that maternal education is conducive to health practices which protect/enhance child survival/well-being. This is not the case with breast-feeding and underscores the continued need for Health Education.

The MOH uses mass media to raise awareness about the importance of breast feeding, including exclusivity in the first six months of life and promotion of "Baby Friendly Hospitals". The social constraint to be countered is false perceptions of "progress" in modernizing societies of the non-western world, of which Iraq is one which emulate adverse practices and imports by western societies (including the misuse

[121] The TBA survey by the MOH/WHO/UNICEF in late 1996 showed that one-quarter of pregnant women who attended the PHC's received a full course of iron/folate, but whether they ingested this adequately is not known. The MCH Health Facility survey conducted by MOH/WHO/UNICEF in August 1997 had similar results, even though the tablets were readily available at the centres.

[122] The State of Iraqi Children. 1991. Ministry of Health, Iraq
The data for 1991 are unclear - a further reduction of about 5% in the 3 month and one year groups. The apparent increase in the 6 months group of 15% is based on comparison with the 1990 data, with that of 1998 and 1989 there is a continued reduction.

of infant formula)[123]. The positive aspects of possible return to a Breast feeding-oriented culture by the elite in Iraq may be useful for role models in media messages[124].

The MICS in 1996 reported that almost all mothers (95% in the South/Centre and 99% in the North) at least started breastfeeding their last child[125] - *Table 2.7.* Just over one-half (62%) of the mothers breastfed their child from 12-15 months (reflecting infancy) and one-quarter (24%) from 20-23 months (reflecting up to the end of two years of age).[126] Bottle feeding is common (21%) during infancy, even in those breastfed. About three-quarters of children (72%) 6-9 months received solid or semi-solid foods.

It appears that young children in the North had a shorter duration of breastfeeding, a greater extent of bottle use and probably, a much lesser degree of complementary feeding - all factors related to appropriate feeding practices and child care.

Table 2.7 : Prevalence Percent of Feeding Indicators - MICS 1996

BREASTFEEDING	IRAQ	South/Centre	North
Ever Breastfed	**95.5**	94.9	99.3
Breastfed 0-11 months	**-------**	-------	68.5
Breastfed 12-15 months	**62.0**	64.2	47.4
Breastfed 20-23 months	**23.9**	24.9	17.3
BOTTLE FEEDING- 0-	**21.0**	19.7	29.4
ADDED FOODS 6-9 Mths	**72.0**	77.9	(32.9)

( ) *result suspect --- no data available*

There are insufficient data analysed to compare urban/rural and sex differences in breastfeeding for Iraq's 18 governorates as a whole. Bottle feeding is much more extensive in urban areas compared with rural (24% vs 17%), although equally practiced by sex.

The October 1997 MOH/UNICEF survey during immunization visits has a special advantage over the MICS and other surveys due to the ample sample size for infants; it allows a much fuller examination of

[123] For a discussion of the relationship between consumption patterns and cultural orientation see Galal Amin "Some Economic and Cultural Aspects of Economic Liberalization in Egypt." Social Problems 28(4, 1981, p.430-441.

[124] Soheir Morsy "Health, Medicine and Social Science." Proceedings of the Founding Meeting of the Arab Regional Chapter of the International Forum on Social Science and Health, Beirut, Lebanon, 1996 (In Arabic).

[125]. **In the 1996 MICS, no acceptable analysed data are available for breastfeeding by urban/rural, by sex and for each Governorate, due to low sample sizes**. The indicators for breastfeeding encouraged by UNICEF and used by countries for the Decade Goals are varied and at times inconsistent with the perceptions of national professionals - for example, instead of the prevalence of breastfeeding for a specified age or age group in the first year of life, that for 12-15 months is used to reflect attainment at the end of infancy and 20-23 months for that of the second year. These narrow age ranges, although specific are constrained when the more accurate estimate of current (rather than recall) is used.

[126] The results for exclusive breastfeeding in infants aged 0-4 months cannot be used as the methodology for acquiring the information was suspect. The prevalence of exclusivity (nothing except breast milk) was reported as 57% in the North.

key relationships during important biological phases of infancy, such as urban/rural and by sex[127].

Key findings:

1. The prevalence of breastfeeding was 92.4% in infants (0-11 months), 81.4% at 12-15 months, and 50% at 21-23 months, all much higher than reported previously. This may be due mainly to economic reasons, although why this is related to the "oil for food" period is unclear.

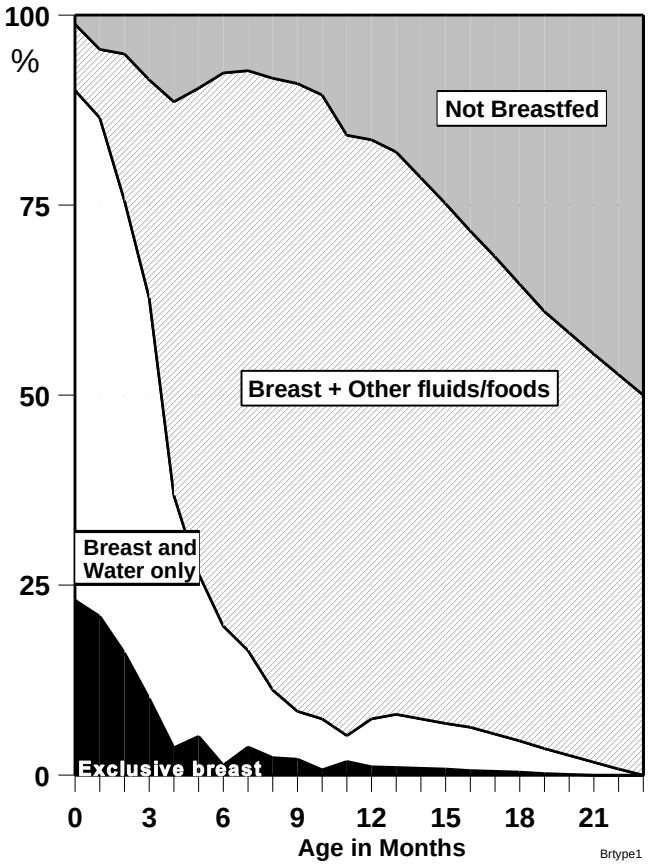
2. Exclusive breastfeeding (only breast milk) was 13.3% and complete (only water added) 48.4% in infants 0-5 months of age *(Figure 2.33 opposite)*

3. Bottle feeding with milk for infants at 21.1% (similar to the MICS's South/Centre results)

4. Complementary feeding (which does not consider quantity nor quality) from 6-8 months at 76.1% (also similar to the MICS).

The results highlight the problems of inappropriate breastfeeding, use of the bottle and lack of any complementary food in young children.

Figure 2.33
Pattern of Breast feeding by age - Iraq Oct 1997



[127] The sample size for infants was 1,846 for the breastfeeding component of the survey and 2,524 for the added foods, as compared with the MICS (total) of about 800 for the same age group. The major problem is the sample from PHC's, although there was no clear indication how this affected the results. Another issue is that mothers may respond to questions differently in the presence of PHC staff compared with responses at home.

2.5.2.3 Addressing Malnutrition

To address malnutrition efficiently, attention must be directed to all causal levels - direct (diet and health); underlying (household food security, care, water/sanitation, health services) and basic (education, resources - material, financial, human and organizational). This multi-sectoral approach is only just starting to be recognized, although there is still major emphasis on the direct areas through the health sector, which is necessary but insufficient on its own.

During the first National Nutrition Conference in April, 1996 a major conclusion was to develop two phases to counter malnutrition - a "short track" which relied mainly on screening and referring the malnourished to provide a more intense health care and the provision of complementary food[128]. The "long" track was to integrate health and other services between the formal health system (principally PHC's) and communities with Community Child Care Units (CCCU's) and act as a focal point for local activities for nutrition.

The proposed "Healthy Growth Programme" of the Ministry of Health, supported by UNICEF, has now grown to 1300 CCU's[129] in almost all the South/Centre governorates and is starting in the North.

From September 1996 to late 1997, over 200,000 children were screened[130] with 30-40% malnourished for referral to their local PHC's for review and added care. After re-screening, the malnourished are further referred to a supplementary feeding centre (SFC) for special foods and when available, added rations for the mother. The Iraqi Red Crescent, supported by the International Federation, reached a "case load" of some 40,000 malnourished children (or less than 10% of those in need) by October 1997, where each child receives imported foods (such as wheat soy blend with sugar) and the mother gets wheat flour, oil, etc., monthly for three months[131].

For those severely malnourished, Nutrition Rehabilitation Centres were established in major hospitals, more recently expanding to the districts. These have increased from ten in 1996 to a current 62, attending to about 1,500 children monthly where they receive therapeutic milk, supplementary food and nutrition education to complement the treatment of mainly diarrhoea and acute respiratory infections. On discharge, children receive added foods to be continued at the SFC[132].

Although the initial priority has been the "short track", elements of a broader approach to nutrition

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[128] P. Greaves/UNICEF - Report on the Healthy Growth Programme, May 1996

[129] These are usually based in schools, facilitated by Ministry of Education support. The People Local Council (PLC) headed by the governor have a key role. Volunteers are teachers, village heads, Mukhtars, retired professionals and at times representatives of Iraqi NGO's.
Each PHC is responsible for supporting their 4-5 CCCU's, of which there are two major types - ones in urban areas catering for large numbers of under fives' (up to 1000) and in many rural areas those with a smaller number, which have more direct contact with specific communities.

[130] Screening uses WHO weight-for-age reference criteria. For this purpose UNICEF has provided its own developed electronic solar-powered scales (UNISCALE) to each CCCU and PHC, with stationary and training support.

[131] The IRC support started in mid-1997. Prior to that time, a much more limited number were reached. There is no assurance that the IRC input will continue due to lack of food. Even so, the 40,000 is well below the estimated 750,000 malnourished children in the South/Centre in need (based on the MICS and confirmed by the April and October 1997 surveys)

[132] Most NRC's cater for children under 2 years of age, usually with recent infections necessitating admission to hospital, for an average stay of about one week. In some district NRC's, mothers come daily so that their duties at home, including child rearing are not compromised.

is developing. In the Health Sector, the linking of Control of Diarrhoeal Disease (CDD) with that of Acute Respiratory Infections (ARI), breast feeding and feeding during illness is an important start in which the CCCU's can reinforce through promotion, education and mobilization locally. In some governorates, CCCU's have played an important role in identifying immunization dropouts and assisting campaigns.

The lack of adequate assistance for nutrition by donors greatly limits the reach and support for the malnourished, especially for complementary feeding . This may be due to mis-perceptions about the positive effect of the increased rations on young child malnutrition or a "wait and see" approach while the "oil for food" evolves. Unlike the North, there are no funds available for the South/Centre in that programme.

The MOH (with UNICEF support), intensified efforts to improve breast feeding practices (a crucial element for Survival Rights) through campaigns, mass media and education materials. The Baby Friendly Hospital Initiative has resulted in 23 accredited hospitals and others awaiting recognition.

Iraq's established CDD programme was interrupted in 1990, stopping local production of Oral Rehydration Solution (ORS), a factor to counter the rising diarrhoea due to impaired WATSAN and health infrastructures. UNICEF provided ORS and helped CDD activities reactivate, especially through training and raising community awareness through mass media and campaigns. In 1994, to curtail the over-dependence on drugs in the case management of diarrhoeal episodes, the MOH (using WHO guidelines) issued a National Policy which prohibited the production of anti-diarrhoeal drugs and prescription of an anti-emetic drug for treatment of diarrhoea[133].

The MOH distributed micro-nutrients (Vitamin A, Vitamin D and Iron/folate) and promoted the production of iodized salt, although the oil-for-food programme now supplies this.

Attention to immunization, linked with Vitamin A distribution to both lactating mothers and young children, straddles CRC rights - those related to combating disease and malnutrition (articles 24 and 25), and that both parents and child are entitled to benefit from care services and facilities (article 18).

[133] However, the dependence continues according to the 1997 CDD Health Facility Survey.

PART THREE

Development and Protection Rights: Circumscribed Implementation

*What is most important about the Convention, it is that it takes the traditional category of children's essential **needs** and elevates them to the category of **rights**, codifying them along with adult society's responsibilities to ensure they are respected...Can anyone doubt that this represents a major legal-ethical breakthrough for humankind?*

James Grant, 1992

Within the framework of the CRC **Development Rights** represent a set of social, economic, and cultural rights which entitle children and their parents to benefit from care services and facilities, the right of the disabled child to enjoy a full and decent life, and the right to benefit from social security and grants. Other rights in this cluster decree entitlement to education at all stages, and the right to literacy.

Protection Rights entitle children to protection from all forms of sexual and economic exploitation, torture and from engagement in combat. This set of rights also codifies children's entitlement to legal and judicial protection.

CRC Articles are similar to the battery of Iraqi constitutional laws decreed prior to adoption of the CRC in 1994.[134] The commitment to improve living conditions and promote children's welfare is reflected by the improved pre-1991 Human Development indicators.

Iraqi Children's Development and Protection Rights, like their Survival Rights, are now confronted by the limitations imposed by economic hardship. These frustrate provision of the essential **needs** which must be elevated to the category of **rights** within the framework of CRC implementation. Iraq's NPA for implementation of the CRC is more about what ought to be done in support of Development and Protection Rights than what is now feasible.

3.1 National Support of Development and Protection Rights

3.1.1 Iraqi Statutes of Development and Protection rights

The Iraqi Constitution explicitly expresses the welfare state's agenda in support of social sector development in general and children's rights in particular. To complement legislation about Survival Rights, Iraq has a series of legal codes which closely resemble CRC articles of Development and Protection Rights.

Development Rights afforded children by Iraqi legislation cover developmental phases ranging

[134] For details see Basil Youssef op.cit., 1995. This part of the Situation Analysis draws liberally on Youssef's study commissioned by UNICEF.

from those of kindergarten children up to university education[135]. Iraq has a broader law for social welfare (*Social Welfare Law number 126 of 1980*), and another regulating Parents and Teachers Councils (*Law number 1 for 1994*). The latter authorizes decentralization, which although still limited in practice, is unprecedented for Iraq's highly centralized social sector.

Protection Rights also have an overlap between CRC articles and Iraqi legislation. There are similarities related to issues of labour, criminal use of narcotics, and juvenile welfare.

The Iraqi legislation conforms with all the rights covered by the CRC except two [136]. These relate to children's right to form societies and sports clubs, and to seek refugee status. Iraqi legislation does not allow the formation of voluntary association by minors, and no legal statutes deal with child refugee rights.

3.1.2 Institutional Support

Before the adoption of the CRC, a number of Iraq's ministries were responsible for defined facets of children's welfare, later identified as Development and Protection Rights within the framework of the CRC. These include specialized departments of Ministries of Health, Education, Higher Education, Labour and Social Affairs, Culture and Information, Trade, Internal Affairs, and Justice. The last includes the Office of the Prosecutor General, and specialized agencies for Juvenile Courts.

The Child Welfare Commission (CWC), established in 1979, and later headed by the Minister of Labour and Social Affairs, is the central authority on children's rights and welfare. The Commission is composed of representatives of most of the responsible ministries listed above, NGOs - the General Federation of Iraqi Youth (GFIY) and the General Federation of Iraqi Women (GFIW), and two expert consultants.

The CWC is responsible for formulating and executing policies on child development. These span sectors and range from the amendment of existing legislation to the development and implementation of annual programmes. The Commission's responsibilities extend to regional and international cooperation. For this, it supports studies and organizes conferences and seminars. However, the commission’s role of coordination has been less than effective in generating productive programmes to support children's welfare.

NGO activities are relevant but not specific to matters of Child Rights. The Iraqi Society for Childhood Support is the only NGO which proclaims Child Rights as primary concerns.

[135] The Ministry of Education Law of 1971 has a series of companion legislative codes: for Nurseries (1971); Kindergartens (1978) with Amendments; Compulsory Education (1976); Secondary School (1977); Vocational Schools (1978); Islamic Secondary Schools (1980); Higher Education (1988) and Eradication of Illiteracy (1980).

[136] Ibid.

3.2 The National Plan of Action

The NPA sets goals and priorities related to the Development and Protection clusters of the CRC and to certain specific articles. However, it does not include a specific mechanism for monitoring, a responsibility assigned to the Central Statistics Organization (CSO). Achievements are to reach numerically well-defined goals set for the mid-decade, and the year 2000.

The NPA goals identify a number of Child Rights about early childhood development, reduction of the education gender gap, advocacy for the convention through the mass media, and improved services for disabled children. Governmental support for education has the highest social priority, second only to the provision of food rations.

The Ministry of Education aimed to reduce by one third the gap between primary school enrollment and retention by 1995; and by the year 2000 to provide universal access to basic education and completion of Primary School level education by at least 80% of eligible children. The goals set for Primary School enrollment had already been reached over a decade earlier.

Efforts towards implementation of the CRC within Iraq's NPA mainly depended on the state's political commitment, international support and available resources. Political commitment has been demonstrated. International cooperation was limited to the support by U.N. agencies and some overseas NGOs, mainly in the Autonomous Northern Region. The isolation of Iraq from the international community of scientists and researchers limits expertise to help promote children's welfare and other social sector concerns. Further, there is difficulty in defining the most needy groups with consequent formulation of a Safety Net programme, at a time when almost all the population is affected by the economic decline.

UNESCO and UNICEF helped rehabilitate primary schools, provide school supplies and other support. This role extends throughout the Child Rights domain (see Section 3.4 below). An added value is accepting local currency payments by the government, freeing valued foreign currency to augment scarce resources more effectively. This is relevant even within the framework of the Oil-for-Food programme which falls short of providing even basic survival needs, much less the implementation of Development and Protection Rights.

3.3 Support of Development and Protection Rights

To facilitate implementation of the CRC, programmes must go well beyond Survival Rights. Support for education, especially of girls, helps preserve an essential component of Iraqi society under the present conditions of economic austerity. This is crucial at a time when other priorities put aside education requirements. Support of Development and Protection Rights includes planning, promoting community awareness and facilitating communication, and relevant information collection/use.

Programme priorities for 1997 and later focus on Education and Child Protection. These aim to preserve primary school enrollment rates, particularly females and enhance the **quality** of education. This starts with improved infrastructure (physical and human), equipment and supplies, including school water and sanitation facilities. Longer term improvement in the quality of education requires strengthening the Educational Monitoring Information System. This would enable policy makers to assess learning achievements and revise curricula.

Community-based participation through advocacy and social mobilization centre around the

promotion of parental participation. Most of the recently-established Community Child Care Centres (CCCU's) for nutrition and health are located in schools; hence are a potential focal point for community action in education also. Further, school children can become an important conduit for messages to families. Examples for all sectors apply: in water/sanitation for appropriate maintenance of local networks and equipment, efficient and safe water use; in health for campaigns, attention to children and families at great risk, use of local media, etc; education re-enforcement both in the school and the community.

As of 1993, 93% of all urban and 84% of all rural household own a television set; the data for radios would be comparable. Car ownership (but not necessarily functioning) has dropped form 23% to 21% in urban and 20% to 16% in rural areas, but is still substantial. There remains a vaste audience which is still mobile. The infrastucture for increased information use, especially applicable to improved care and houseold practices addressing the current situation.

Assistance and protection measures for children with special vulnerabilities, involves the support to special services for these children, and upgrading the skills of specialist teachers and social workers. Media campaigns can bring to public attention about these needs.

3.4 Child Rights in the Context of Economic Austerity

3.4.1 Education

Historically, Iraq has given education a high priority. However, the protracted economic hardship on Iraqi population has seriously affected every level of formal and informal education.

Article 28 of the Convention refers to the right of the child to education, calling for States Parties to make primary education compulsory and available free for all. This was done more than a decade before the CRC was adopted by the UN General Assembly. Further, there was a high political will to reduce illiteracy. 1977, the GOI launched the National Campaign for Illiteracy Eradication which covered over 2.5 million illiterate in the age group 15-45 years of which 70% were women[137].

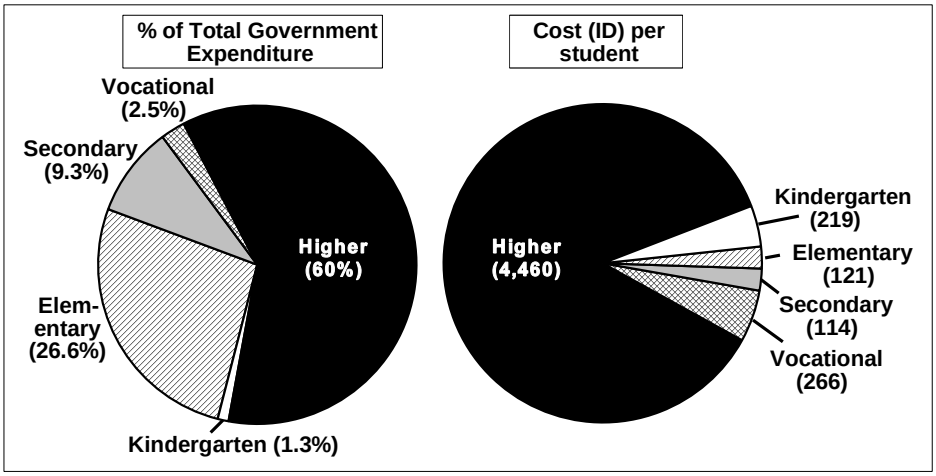
Despite the significant reduction in oil revenues during the period 1979-1986 (mainly due to the prolonged war with Iran), the total annual expenditure on education almost tripled from 1977 to 1987. On the other hand, while 48% of the education budget was allocated for primary education in 1977, this reduced to 26% in 1987. In terms of proportion to GNP in current prices, the percentage allocated to the education sector was reduced from 3.3% in 1977 to 2.9% of the GNP in 1987.

The extent of destruction of the education sector as a result of the Gulf War was extensive. In 1991, ID 1,427 billion was allocated to rehabilitate this sector. This amount was 6% of the GNP at current prices..

According to the Human Development Report/Iraq 1995, (60%) went to Higher Education of 30,000 students *(Fig 3.1)*.

About one-quarter (26%) went for elementary education for 3.32 million and 9.3% for secondary or intermediate (1.02 million students). The figure also shows the cost per student, which was ID 4,460 for those at university and about ID120 for those in secondary or elementary school.

Figure 3.1
Education costs



Source: Human Development Report/Iraq, 1995

[137] The campaign succeeded in reducing illiteracy rate among women in the same age group from 62.4% in 1977 to 25.2% in 1987 and among men from 24.4% to 13% during the same period of time.

In 1992, when the situation was not as bad as now, the Ministry of Education, in cooperation with UNICEF, conducted a survey to determine reasons for female drop-out from primary education. The survey found the major factors were economic (such as Inability of the family to meet education expenses) and social, rather than the deteriorating school conditions. Social factors included forbidding female pupils from continuing their education, growing number of family problems, poor desire of female pupil and her non-conviction of the importance of education and families' preference of female pupil early marriage.

Trends[138] (from 1960 to 1994) for educational enrollment, number of teachers and number of institutions[139] are shown in *Table 3.1.*

Table 3.1: Number of Schools, teachers and students (1960 to 1994)

Schools	**1960**	**1975**	**1990**	**1994**
Elementary	3,709	7,602	8,725	8,839
Secondary	383	1,234	2,700	2,937
Vocational	38	75	289	309
Teachers				
Elementary	25,130	69,224	130,115	155,705
Secondary	3,715	19,299	44,479	56,587
Vocational	579	1,607	8,816	9,729
Students (enrolled) '000's				
Elementary	760	1,765	3,328	3,251
Intermediate	111	376	814	838
Preparatory	25	133	210	265
Vocational prep	8	24	143	122
Teachers' training	9	15	30	31
Higher	12	71	175	203
Parallel education	-	-	15	19
GRAND TOTAL	925	2,384	4,715	4,729

At all levels, the rise of student attendance has been greater than the population growth, reflecting the increased proportion of those educated over time (*Table 3.1 and Figure 3.2* - note the scale is logarithmic). Interestingly, the rise in higher education is no greater compared with other levels. Further, the only group that appears greatly affected by the embargo (taking 1990 to 1994 as the guide) is teachers training, which dropped from 143 to 122 thousand students over that time. However, flattening is evident for elementary, secondary and higher education.

[138] Official statistics in this section, as in others, should be interpreted knowing the constraints in service-based information collection and analysis under the constraints of the embargo

[139] The educational system in Iraq has four basic levels: [1] Pre-school (4-5 years); [2] Elementary (6-11); [3] Secondary - Intermediate (12-14) and Preparatory or Academic (15-17); [4] Post-school: University (4-6 years), Teachers' Training Institutes and Colleges (2-5 years) and Technical Institutes (2+ years). Education to Secondary school is financed by the Ministry of Education; after that, apart from private institutes, by the Ministry of Higher Education and Scientific Research.

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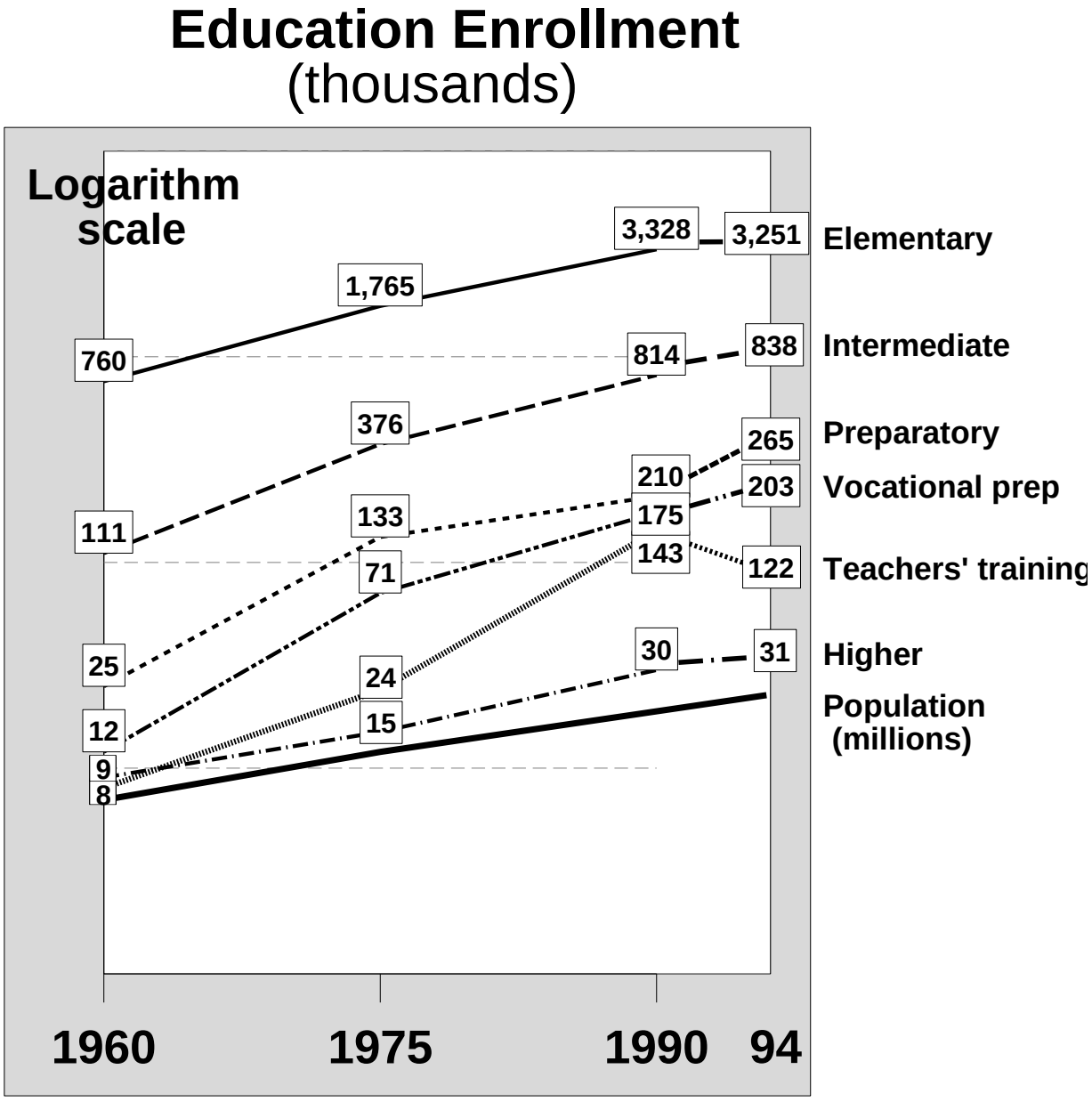
Figure 3.2

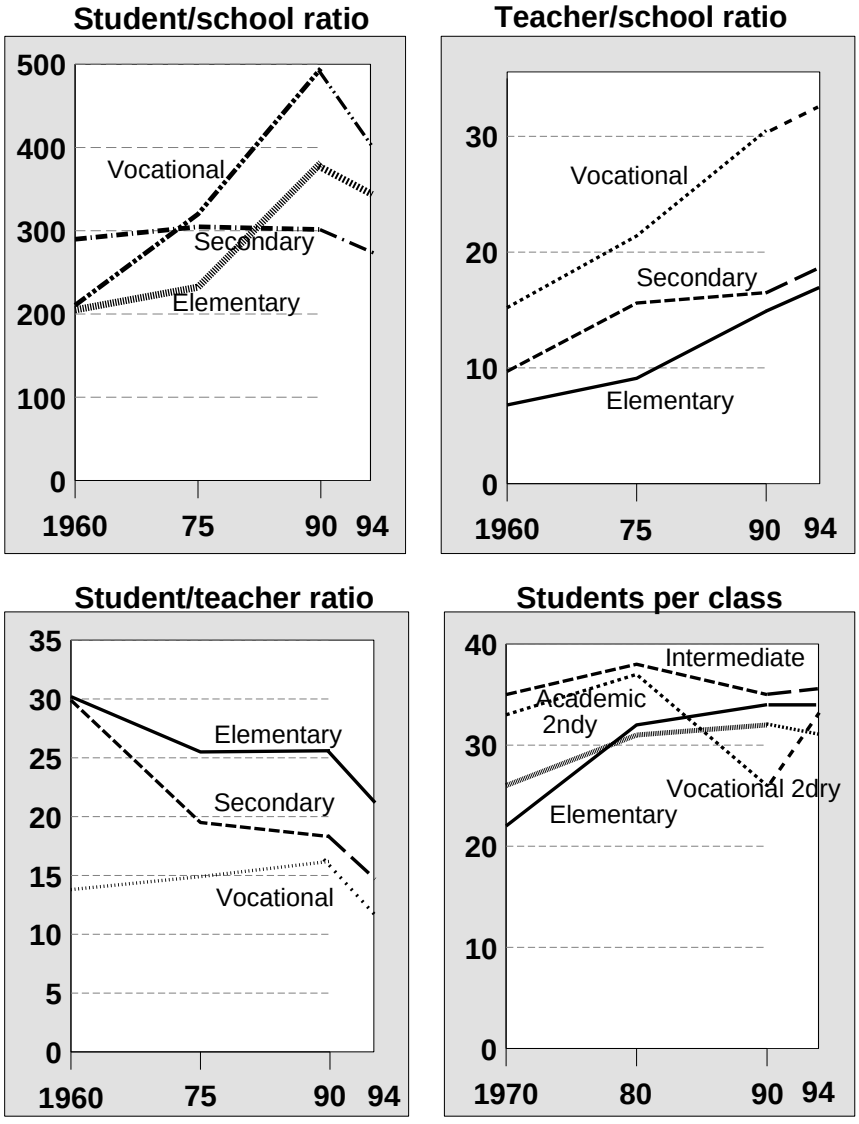


Source: Human Development Report/Iraq, 1995

Ratios for selected levels of education are shown in *Figure 3.3* It should be emphasized that these are averages for the whole country and do not revel variations by area (e.g. governorate or urban/rural) or within educational levels. For example, some schools may be overcrowded, others under-utilized.

The number of students per school, on average has decreased from 1990 to 1994, reflecting decreased enrollment, as the number of schools has continued to increase a little. **The teachers per school ratio** has continued to climb, reflecting the continuing employment of teachers and perhaps a significant number of replacement unqualified teachers. As in other sectors, many qualified teachers have left, due to their inadequate salaries. The motivation of those who remain is seriously effected by lack of school facilities and their own personal hardship. The increase in teacher school ratio is less apparent for secondary schools. The student teacher ratio has fallen from 1990 to 1994, reflecting less students. The number of students per class (apart from vocational secondary) appears about the same from 1990 to 1994.

Figure 3.3
Trends in Schoolenrollment 1960-1994



Source: Human Development Report/Iraq, 1995

UNESCO has documented the number of students attending levels of education[140]. Comparing the number of pupils/students from 1988/9 to 1996/7; those at high school (intermediate and preparatory) appears increased (by 7.5%) over that time; those at other levels have decreased: primary school by 2.2%, kindergarten by 13% and vocational school by almost one-half (46%). These findings are not necessarily different from those in the graph just described due to different years and definitions of school level, for example for "vocational" compared with "vocational preparatory".

The number of school dropouts remains low (of the order of 2-3%); those of failures is much higher, as has been in the past [141]. The Ministry of Education reported 14.2% failed primary and 28.4% failed secondary school for the most recent year.

The extent of lack of school attendance was shown in the Multiple Indicator Cluster Survey (MICS). For Iraq as a whole, most children (84%) aged 6-11 years enroled in primary school during the prior school year, 1995-6. However, less children (about two-thirds or 68.8%) entered school in the first year[142]. The 84% estimate for South/Central Iraq represents an 8% decrease from the 92.4% figure for 1992. There was at most, little difference between the South/Centre and the Northern Governorates (Autonomous Region)[143] - Table 3.2

Table 3.2: Percent of Primary School Enrolment and Entry Rates - MICS 1996

	IRAQ	South/Centre	Northern
Primary School Enrolment Rate (6-11 years)	**84.0**	84.4	81.4
Primary School Entry Rate (6 years)	**68.8**	67.8	75.4

In the South/Centre, urban-rural differences in enrollment are 10% for primary school enrolment, and reach 20% for school entry. There were no gender differences for this group (Table 3.3)..

Table 3.3: Primary School Enrolment and Entry Rates South/Centre Governorates - 1996

	Urban / Rural		Sex	
Primary School Enrolment Rate (6-11 years)	**Urban**	**Rural**	**Male**	**Female**
-South/Centre	88.3	76.3	87.5	81.0
Northern Autonomous	86.0	72.4	86.3	75.7
Primary School Entry Rate (6 years)				
-South/Centre	74.6	53.3	68.8	66.6
Northern Autonomous	78.0	69.9	78.0	72.4

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[140] First draft outline for the Programme Review of the Central, South and Northern Governorates of Iraq (unpublished and undated), based on the UNESCO IBE 1996 (World data on education) presumably for the earlier years and Ministry of Education, Iraq "Impact of the Embargo on the Educational Sector" (Arabic Version),

[141] In 1980/81, the failure rate for intermediate students was reported as 50%.

[142] The entry rate might reflect better the regular attendance at least for six year olds - Personal communication UNICEF Education Officer

[143] A marginal difference of a few percent must take into account the sample effect and that different observers worked in the South/Centre and North

For the northern governorates, the school attendance urban/rural gap is limited (86% vs 72% for children aged 6-11 years and 78% vs 70% for school entry) and there is a marginal gender gap in favour of males (Table 3.3). Further analysis revealed that school attendance by children aged 12-14 was 68%. The gender gap in education is conspicuous for the teen years, especially in the rural areas. Among rural children aged 12-14 years, 40% of the girls attended school during 1995/96, compared to 67% of boys. By the time children reached 14 years of age a mere 13% of females attended school compared to 66% for males. (*Sample sizes are low for precise estimates, especially for single years*). These results are consistent with a preference for home-based protection of adolescent girls and in some cases, early preparation for marriage of girls.

Between country comparisons

Trends in child schooling attendance rates reported from Iraq and selected neighbouring countries show a relative decline or lack of progress for Iraq in the last decade (Figures *3.4 to 3.6*). This is especially the case for females enrolled in Secondary School.

Figure 3.4

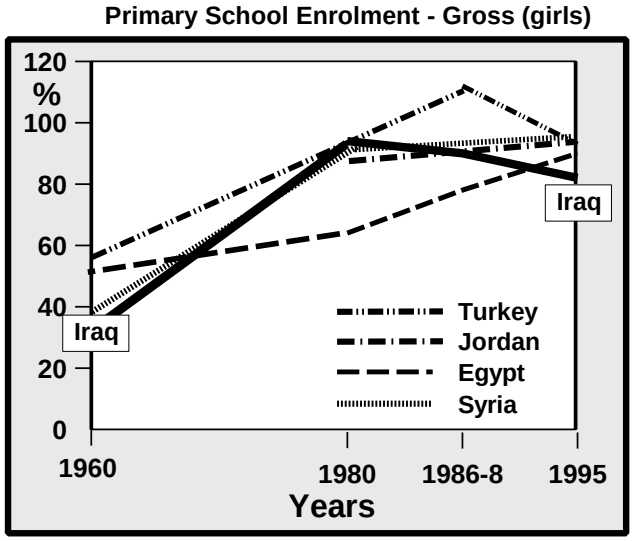


Figure 3.5

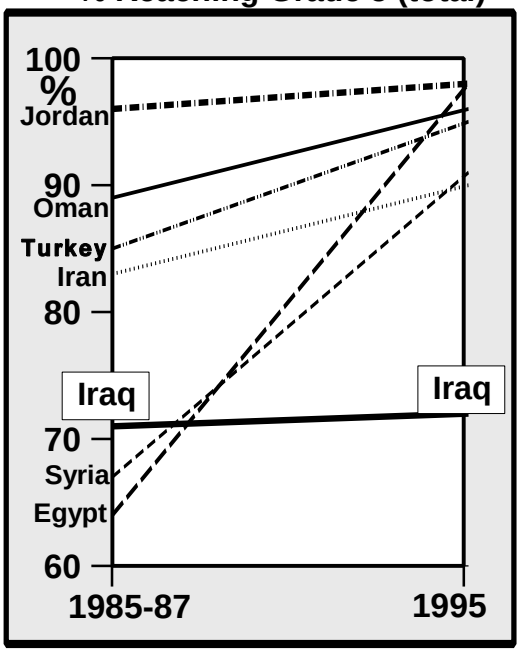
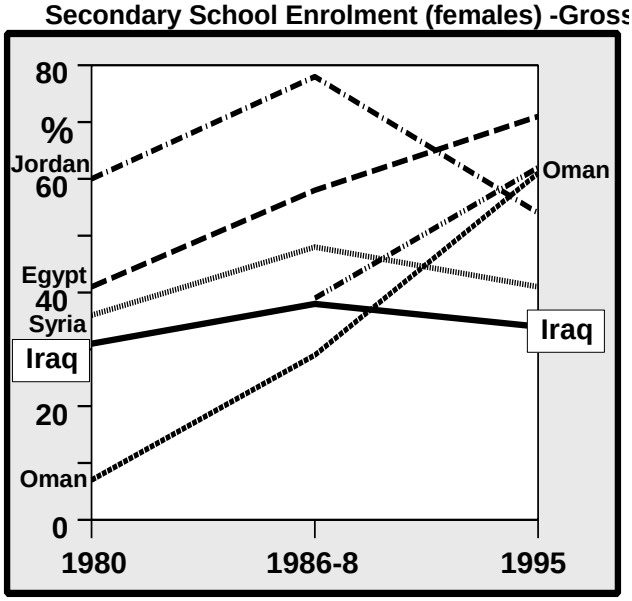


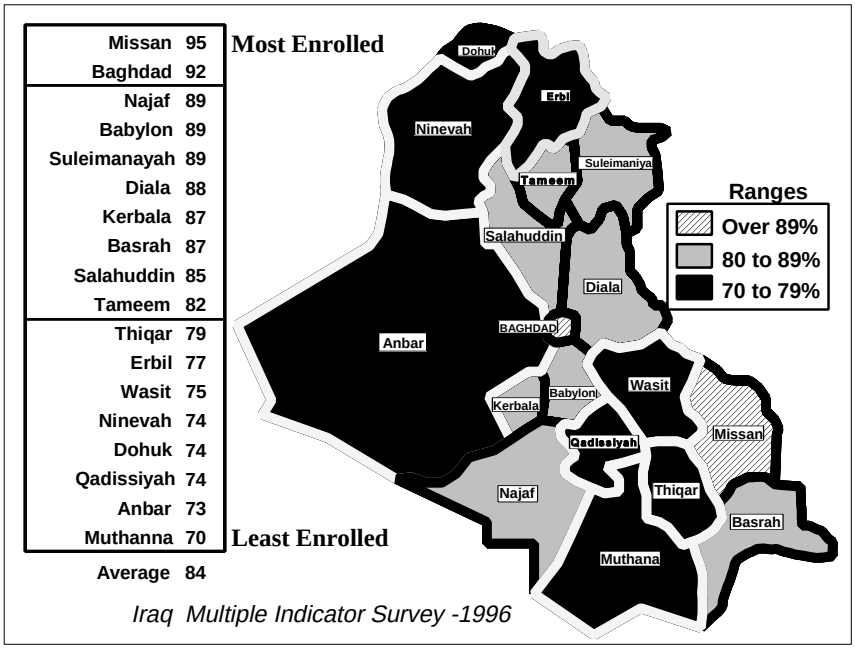
Figure 3.6



Sources: State of the World's Children 1990, 1998; Statistics on children in UNICEF-assisted countries

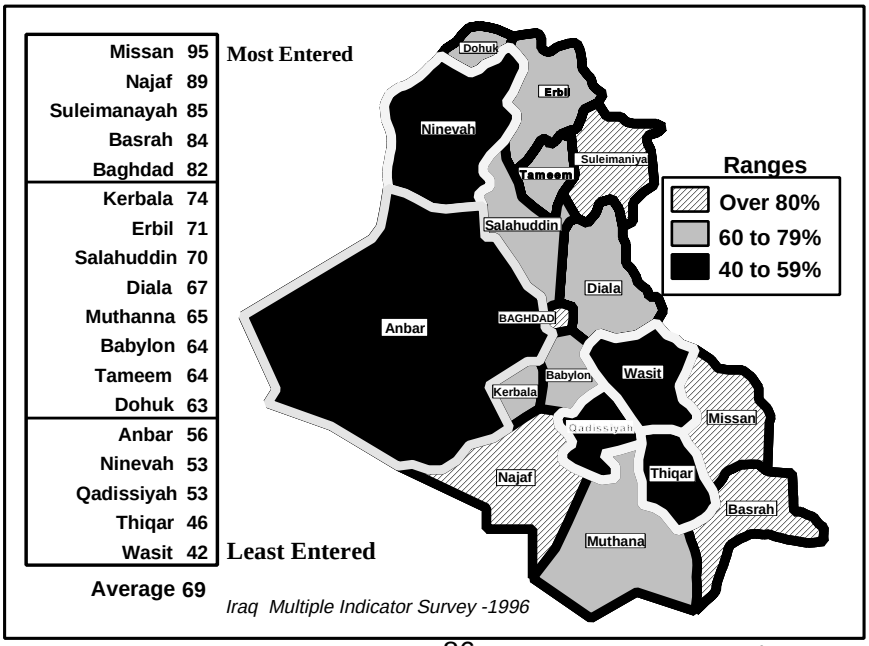
Results by governorate (*Figures 3.7 and 3.8*) show wide variation in enrolment (6-11 years) of 70 to 95% and even wider for school entry rates - 42 to 95%. The ranking order by governorate for each group (enrolment, entry) appears similar. Oddly, Missan has the best result, despite its highest malnutrition rates.

Figure 3.7:
Percent of Children 6-11 years enroled in Primary School - by Governorate



Iraq Multiple Indicator Survey -1996

Figure 3.8:
Percent of Children who Entered Primary School - by Governorate

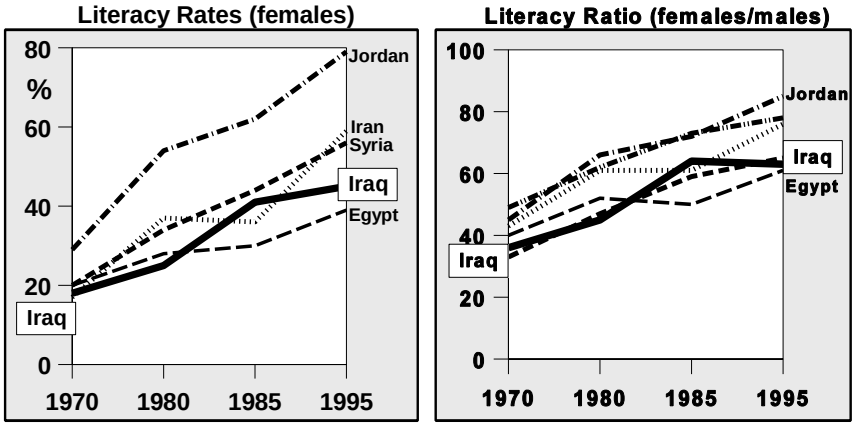


Iraq Multiple Indicator Survey -1996

The MICS reveals that only 36% of mothers of the urban areas of the northern governorates are literate, and only 17.7% in rural areas. MICS information for the South/Centre is unavailable.

Comparisons of literacy rates between countries show an increasing trend for all since 1970 (Figure 3.9). Iraq has slowed down from 1985 to 1995. The literacy ratio (%females literate/% males literate as a percentage) is a reflection of disparity between the sexes (100% would mean equal rates). Again, all countries have shown an increase, with very similar slopes and a narrow range between countries, shown by the bunching of lines in the graph. Again, recently the results for Iraq show no progress in comparison to the others.

Figure 3.9



Sources: State of the World's Children 1990, 1998;
Statistics on children in UNICEF-assisted countries -1990

These findings, though negative, do not begin to accurately reflect the compromises of Iraqi Children's Development Rights as these relate to the educational sector. As noted regarding access to water, information on access to education does not indicate the quality of education, nor the decline in school facilities.

These include lack of the most basic school supplies such as blackboards, chalks, pencils, notebooks[144] and paper, inaccessibility to any water and absent or defunct sanitation. Some children deprive themselves from water and food before going to school so as not to develop the need to use a toilet. Others have to return home if the need arises. Due to shortage, up to four children may be assigned to each desk . If children have to sit on the ground, some parents do not send their child to school on the day when it is their turn.

There is no public budget for school maintenance. Broken windows, leaky roofs, and defunct latrine and washbasins remain in disrepair. Even when electric power is available, children "learn" in an atmosphere of dim light, poor ventilation and water leakage from classroom ceilings. Health and safety

[144] Apart from the state's scarce resources, other issues arise in terms of approval of items by the Sanctions Committee. These include pencils and textbooks designated as "non-essential". "Unsanctioned Suffering: A Human Rights Assessment of United Nations Sanctions on Iraq." New York, 1996, p.6. Center for Economic and Social Rights (CESR).

hazards on school grounds and in the vicinity include naked electric wires, garbage, insects and rats, and stagnant water resulting from the blockage and discharge of sewage pipes. Most schools do not have a first aid kit.

Schools in the northern governorates have added problems specific to armed conflict and cold climate. Some of the schools are occupied by refugees and displaced people. Heaters are unavailable, except for a limited number provided by agencies. A survey in early 1997, showed that 80% of sampled primary and intermediate schools had serious structural damage.

UNESCO list the priority needs (for the South/Centre) based on 4,157 severely damaged schools (about 1/3rd of all schools); 323 thousand desks in need of repair; 1.34 million books damaged; 488 computers and accessories; destroyed equipment in 107 vocational schools (1/3rd of all these schools); and about 900 thousand teaching kit, laboratory sets, etc affected. According o the MOE, the total cost for replacement or repair is $645 million. Further, 84% of all schools need rehabilitation. The stopping of production in the Ministry's printing facilities and workshops has caused not only an inability to replace textbooks, school aids etc., but also a loss of much needed income to the order of ID 1.95 billion.

UNESCO also indicates the need for an additional 678 schools or a 5% increase (at all levels) over that anticipated during 1996-7, numbering 12,567.

In the Northern Governorates, 780 primary and 15 secondary schools need rehabilitating; water and sanitation facilities for 180 schools and equipment/supplies required for teaching about 130,000 primary and 100,000 secondary school students with desks, kits, stationary, etc)

The Oil for Food programme provides every six months, only $12 million for the South/Centre and $15 million for the Autonomous Northern governorates. This amounts to some 10% of basic requirements.

Non-formal education: In 1994 the Ministry of Education (with UNICEF and the GFIW) developed a programme of Non-Formal Education for drop-out girls of the age group 10-14 years, reaching 12,000. More importantly, the programme encouraged many of the girls to rejoin the schools after completion of their Non-Formal Education. In 1996, the MOE stopped this programme, with priority for the reactivation of Yafeen schools. These schools help older children who had dropped out of primary education. This policy shift is understandable in light of the MOE's limited resources but adversely affects gender equity, female literacy and income generation opportunities.

The Yafeen programmes have the potential to deal with the increasing number of working/street children. Their flexible school schedules would provide these children and other drop-outs, with access to a condensed version of primary school curricula, skill training, and vocational education.

On a very limited scale, to support their level of schools, communities are starting with private contributions. However, this is no substitute for state responsibility and programmes in support of public welfare and the Child Rights to education.

As the unprecedented trend of declining school enrollment continues unabated, so does the related violation of the national Compulsory Education Law. Iraq, once honoured by UNESCO for its active promotion of Education, is now experiencing the unavoidable compromise of the CRC for education.

3.4.2 Protection Rights

The educational goals set within the framework of the CRC are to simply preserve children's motivation to remain in school, and the social esteem for education is dwindling right to education in the face of economic decline. However, by necessity, families are forced to saddle their children with the burden of labouring, within or outside the home sphere. Children are losing their motivation to attend school due to the new survival dominated realities of everyday life.

In spite of the "political will" in support of Protection Rights, and Iraq's Compulsory Education Law, the shielding of children from economic exploitation is now close to impossible. Child Protection has now a new expanded meaning beyond its conventional referents, such as children with physical and mental disabilities, orphans, and juvenile delinquents.

The distinctions between child work, child labour and street children, do not readily apply to the Iraqi context.[145] Hence the term “labouring/street children” is used in this part of the Situation Analysis. This refers to children who labour part or full time in workshops, popular restaurants, and on the streets to beg, sell cigarettes, wipe the windshields of cars which stop at traffic lights, etc. Many of these children are full-time pupils. This is done with great difficulty; also the poor quality of education and corporal punishment limits motivation.

In Erbil, a recent survey found that children of displaced families and returnees are reportedly forced by their families to do so even when they are sick[146].

Children who are malnourished and who spend as long as 12-13 hour working daily suffer further deterioration to their health. Some complain of recurrent pain in the backs and limbs. Added constraints include malnutrition, illness and limb/body pains.

The continued neglect of labouring/street children in programmes and research is an affront to the CRC and delays solutions.

3.4.2.1 Children, Labour, and Economic Austerity

With economic austerity, the Iraqi authorities cannot enforce the law regulating compulsory education, nor prevent economic exploitation in the form of child labour. To do either would obstruct families' efforts to avoid further poverty.

There is a growing number of street and working children and juvenile delinquency (from 2,600 juvenile court cases in 1991 to 4,420 in 1996). This goes on par with the decreased attendance at school, drop-outs and repetition rates. Because of the economic hardship, there is now a weak enforcement of the existing comprehensive laws on child work and compulsory education, compounded by little experience to deal with this new phenomena.

The numbers of working/street children are unknown, but their presence on the street is notable.

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[145] Soheir Morsy "Child Labour in the Arab Middle East." Unpublished report prepared for the Meeting of the International Working Group on Child Labour (IWGCL), Bangalore, India, 1994.

[146] Survey of CEDC in Erbil, Department of Social Affairs, Jan 1997, University of Salahuddin, Save the Children/UK, and UNICEF.

Authorities also recognize an increasing problem of juvenile delinquency. Children arrested on the streets and taken to state operated "observation homes" cannot receive the type of protection they are entitled to not only by the provisions of the CRC but also by Iraqi legislation.

Foster families for orphaned or certain labouring/street children are unavailable. The lives of ordinary Iraqis are "regulated by the ration card" as stated by a specialist on delinquent children. Every family is assigned a ration for each member. Another mouth to feed without any ration is a deterrent to accepting a foster child.

3.4.2.2 Disabled, Orphaned and Traumatized Children

Iraq's Social Welfare Law of 1980 provided for the care of children with disabilities, orphaned children and those victimized by dysfunctional families. The Ministry of Labour and Social Affairs (MOLSA) is responsible for the social care for all disabilities except for special education for slow learners. In 1990, MOLSA was running 43 institutes attending to 3,452 disabled (mainly for the deaf and dumb, and mental disabilities). These services were considered among the best in the Middle East.

The 1987 census reported just under 50 thousand disabled children aged 0-14 years (or 0.6% of their population). [147] A re-estimate will come with the 1997 census results, although the total is expected to be much greater.

Of the 25 State Homes with the capacity for 1203 orphans and children from broken families, the 18 now open have deteriorated. The 863 beneficiaries rely on UN assistance, such WFP for food. Reform schools for delinquents have also been similarly affected.

The structure of institutes serving the disabled has declined and the early detection mechanism and categorization of children with disability is no longer functioning. This is compounded by a lack of proper referral services for childhood disabilities, high reliance on costly/sophisticate technology for child disability treatment/rehabilitation, traditional attitude towards disabled and inability to share experiences and new approaches with neighbouring countries in the region. Further, a centre-based instead of community-based approach to disabilities is favoured.

Of special concern are traumatized children, about whom information is limited. An international team in 1991 interviewed 214 children of primary school age in Baghdad and Basrah[148]. The Team found a high level of psychological stress. Five months after the war, 75% had fears of losing their families and 62% doubted that they would reach adulthood. Of the adults, females aged 21-40 years appeared to be the most traumatized.

Two follow-up studies commissioned by UNICEF in 1992 and 1993 confirmed these findings, indicating the long term effects of war-related trauma. Of note (reported in the CRC/Iraq pp 64-5) is that done in Baghdad by Mustanssirya University with the Iraqi Society for Child Support in March 1993, covering 2000 children from schools in Baghdad. In general about half of the children reported combinations of several psychological symptoms, such as anxiety, anger, aggression, feeling of isolation, lack of self-confidence, lack of attention span and concentration.

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[147]- The Status of the disabled institutes in Iraq and requirement for its improvement. Ministry of Planning, 1992, table 6, page 58.

[148] Health and Welfare in Iraq after the Gulf Crisis, International Study Team, Harvard University, Mimeo., Oct 1991. The Baghdad sample was from families affected by the Amriya Shelter bombing.

Of note in the study was the reporting of increasing child abuse (from 22% to 42%) in the family, primarily due to the inability to provide food and clothing for the child.

A start has been made to support a Baghdad-based programme attended to war-related trauma among children and their families, but little else seems to be done. The same applies to children with disabilities.

For the Northern Autonomous Region, UNICEF reports that the serious deterioration in socio-economic conditions, with sustained exposure to the armed conflict, has increased the vulnerabilities of children, especially the disabled and traumatized among them.[149]

In summary, with the collapse of the national social security structure, local authorities could not sustain adequate services for CEDC. Further, extended kinship networks are rapidly losing their prior cohesion and traditional social support functions. These once provided communal child care and protection for orphaned children and those with physical or mental disabilities.

3.5 The Social and Economic Impact of Land mines

The Autonomous Region of Northern Iraq is one of the most mine-ridden areas in the world. The Mines Advisory Group (MAG) estimate that there are between ten and twenty million land mines scattered in rural areas, principally near the border with Iran.[150] By the end of 1996, MAG had surveyed over 2000 minefields with an unknown number remaining to be detected and surveyed..

Mines have a devastating impact on the socio-economic status of the population, and particularly the vulnerable groups. This is especially apparent when it is realized that much of the area is still an agrarian based society. Many IDPs have chosen not to return to their villages near the border because of the presence of mines, and if they do it is sometimes too dangerous to farm the land. The potential presence of mines and unexploded ordnance (UXO) is therefore a serious barrier to implementing programmes aimed at bringing a degree of normality back to the rural areas of the region.

From January 1991 to the end of 1996, there have been 2,391 deaths and 4,324 injuries reported among civilians as a result of mines or UXO.[151] However, many accidents go unreported and the true figure of injuries and deaths is almost certainly much higher. For example, MAG estimate that only 50 per cent of deaths are reported.

[149] The Draft of the Situation Analysis for the Autonomous Region states that "a wide range of disabilities were also identified and some children had been born with (a) disabilities while the majority had acquired a disability..." 1997, p.28

[150] Mines Advisory Group, Northern Iraq, Overview of the Program, January 1997, p.2.

[151] Ibid.

3.5 Hidden Vulnerabilities of War and Sanctions

There is ready acknowledgment of the existence of the disabled, orphaned and perhaps, those psychologically traumatized. This is not the case for domestic violence, which is "sheltered" in the privacy of the home but seriously affects children's welfare and the CEDAW.

3.5.1 Domestic Violence

Violence against women is a Human Rights concern with a profound impact on the physical and mental well-being, not only of the primary victims of domestic abuse but also of their children. Children who witness maternal abuse are at risk of being themselves assaulted themselves and of developing adjustment problems[152].

Domestic violence may affect Child Survival in subtle ways. While many studies, including the 1996 MICS show a positive correlation between maternal education and child health/survival, the mechanism is not clear:

> *There is increasing evidence that schooling works not by imparting new knowledge or skills related to health, but by eroding fatalism, improving women's self-confidence, and changing the balance of power in the family....Mothers with higher self-esteem take a more assertive role in their child's feeding- they take swifter action when a child is sick,...New empirical data also link abuse of women by their husbands to the nutritional status of their children..*[153]

When the male traditional role of provider is undermined, the potential for abuse increases, as does the risk to children's welfare. In Iraq, it is probable that incidents of domestic violence have increased in conjunction with economic austerity. One possible example is that husbands may blame their wives for their unhealthy malnourished children.

Although there is no information on domestic violence, its awareness should be raised, as well as its relationship to child health, girls' education and its violation of the CEDAW. Domestic violence must be recognized as a social and public health problem under the current socially disrupted situation which affects women especially.

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[152] R. Teske and M. Parker, "Spouse Abuse in Texas: A Study of Women's Attitudes and Experiences." cited In L.L. Heise, J.Pitanguy and A. Germain "Violence Against Women: The Hidden Health Burden," Washington, D.C.: The World Bank, 1994, p.28.
A survey of battered Texan women showed children of over a third of the battered women were also battered.

[153] L.L Heise et al, op cit., 1994, p.28.

3.5.2 Environmental Impact of War: The Alleged Effects of Depleted Uranium

Depleted Uranium (DU) is extracted from uranium through a process that makes it a metal with properties of great density, range and velocity, hence its use in shells. Once these hit their targets the particles dissipate into the air. This is reported to have been used by the U.S. during the Gulf War.[154] Reports, mainly by Iraqi physicians, propose that DU is the cause of congenital malformations, leukaemia and an undiagnosed disease.[155] Although studies of DU have been few, Hoskins states that DU "...may be the cause of fatal illnesses including cancer and mysterious new stomach ailments showing up in Iraqi children"[156]. If DU is indeed a problem, then any remaining sources risking exposure should be removed.

[154] James Mathews "Radioactive bullets Raise Cancer Fears". News Section, Journal of the National Cancer Institute Vol 85(13), 1993, p.1029-1030.

[155] The International Scientific Symposium on Post War Environmental Problems in Iraq (ISS), op.cit.

[156] Eric Hoskins - medical coordinator of the Harvard International Study Team which surveyed health conditions in post-war Iraq and Kuwait

CHAPTER 4

IMPLEMENTATION OF CHILD RIGHTS AND NATIONAL PLAN OF ACTION FOR IRAQI CHILDREN

4.1 Priority Problems to Address

The government has shown the commitment to improve the situation of women and children in Iraq, despite the economic constraints which effect social programmes. The Oil for Food Programme has provided temporary, partial support. Its thrust is for the rehabilitation of structures and provision of supplies/equipment in the major sectors of health, water/sanitation and education. What it lacks is the necessary resources to improve the quality and extent of services, including social mobilization and enhanced community participation. Programmes require support for planning, management and implementation, for training, supervision and logistics. The necessary cash assistance, at least in the South/Centre governorates, is lacking.

Specific problems and their strategies for improvement are as follows:

i Widespread protein energy malnutrition (PEM).

Strategies: The macro- and micro- economic decrease is the major cause. Its improvement will rely on continued advocacy for increasing the oil-for-food and eventual lifting of sanctions. Combating malnutrition requires an improved household economic and food security, combined with a multi-sectoral approach in health, education and water/sanitation services, with adequate feeding and hygienic practices. Fortification of food with vitamin A, iron and iodine would ensure addressing known deficiencies in micro-nutrients.

– Nutrition status assessment as an outcome measure is becoming institutionalized for advocacy, planning and policy. This must continue and extend from the national to local levels as well as a better perception/understanding of its causes (lack of food, health and care). This will improve awareness and support social mobilization to address these causes.

Some key issues for nutrition need consideration:

- Gradual reduction and eventual elimination of infant formula, milk substitutes and bottle feeding for babies under six months of age. Concurrently, the importance of adequate complementary feeding from six months of age in the household must be stressed and supported, especially during and after illness

- Until food security and the economy is sufficiently improved[157] direct feeding programmes will be required for a target population of at least 250-500,000 under fives for complementary and 50,000 for therapeutic feeding in the South/Centre (and ? 50,000/10,000 in the North) through Community Child Care Units (CCCUs'), supported by the MOH infrastructure. It is critical to include feeding as part of a total package of GMP, referral and appropriate health/nutrition education messages. Further, the needs of pregnant/lactating mothers must be addressed.

[157] An increase in the rations will improve household food security, but often still insufficient for young child and pregnant/lactating mothers' needs

- More use can be made between the CCCU (often located in a primary school with a teacher as director), the school health education programme, child-to-child strategies (with school children as communicators to the household and community) and with local council representatives. Such a link provides a nidus not only for nutrition, but also for watsan, education, CEDC and community-based initiatives/programmes.

- Rations from the oil-for-food appear to often last only about 3 weeks of the required four. This indicates that households are still food insecure with a continued need to purchase added food, balanced against other essential requirements. In addition, the lack of foods of animal origin further fosters under-nutrition and micro-nutrient deficiency, such as iron deficiency anaemia. Continuing advocacy is needed to ensure increased quantity and improved quality occurs in a timely fashion and is sustained. This includes iron fortified wheat flour, Vitamin A fortified cooking oil, iodized salt and animal proteins within the food basket.

- Local food production must be supported, at least for improved storage and pest control. The planned rehabilitation of poultry production should lead to some improvement in income and nutrition.

- Inputs from multiple sectors (health, water/sanitation, power, education and social services) will greatly contribute to improved nutrition, as will effective information/education and communication on demand for services and home food habits, hygiene and health practices.

ii **Pneumonia and diarrheal diseases, with malnutrition, augments the already high infant and under-fives' mortality rates.**

Strategies: A better awareness and understanding by health providers, caretakers and communities on the deadly linkage of these conditions is needed.

- The extent and severity of these conditions should be countered with improved programme management, training and supervision of personnel at sub-district level and lack of community involvement and awareness. The Integrated Management of Child Illness incorporates Control of Diarrhoea and Acute Respiratory Infections, Measles and Malaria and improved Breast feeding. It is a key strategy in the Ministry of Health Plan, and its continued implementation aims to cover all PHC's by the year 2000.

iii Uncertainty of polio eradication, measles control or neonatal tetanus elimination.

Strategies: The excellent results from immunization coverage still do not ensure reaching the NPA goals, due to lack of resources and need for optimal community participation. Immunization efforts and surveillance need to be sustained. This must ensure adequate supplies, equipment, cold chain maintenance, logistics for regular vaccinations and campaigns (polio, measles and tetanus toxoid for mothers) as required. Continuous attention is paramount, especially for high risk areas with lower coverage rates.

iv. **Continued high rates of maternal mortality.**

Strategies: Improved access to-and use of - pre-natal and delivery, and of family planning services are being addressed by the Mother-Baby package of the MOH. This is to ensure safe motherhood services and practices and reduce the prevalence of low birth weight in the newborn. Anaemia, affecting more than half of pregnant women, must be countered by effective use of iron/folate, improved feeding and iron fortification of wheat.. Chronic protein-energy and vitamin A deficiency must also be countered.

- Greater awareness is needed about the link between appropriate breast feeding, child spacing and family planning. As with nutrition, control of diarrhoea/ARI and immunization, adequate training, supervision, monitoring, logistics, appropriate message delivery and community participation is needed.

v, Inadequate water and environmental sanitation conditions, especially in rural areas, combined with harmful health and food hygiene practices affect the health and development of communities, with special reference to women and children, and of institutions such as schools and hospitals. The supply side, i.e. provision of chemicals for water treatment, repair and maintenance of existing plants and networks is being partly attended through the Oil for Food. However there is no consideration for improving the quality of services and the need to educate communities and school children about the proper use of water and sanitation facilities, especially latrines. Sewage treatment plants and networks cover only one-quarter of the urban population and none of the rural. This raises doubt on the achievement of water and sanitation goals, especially in rural areas.

Strategies: The government needs support in preparing an assessment of the WATSAN sector to come up with a national rehabilitation plan, to include monitoring. Strategies should include improved service delivery to targeted areas of greatest need based on sub-districts identified in the recent water and sanitation services survey (complemented by a high prevalence of water-borne diseases), to include feasibility and presence of demonstrated community participation at least in organization and contribution of free labour. This requires improved coordination between the local authorities and communities.

- Revitalize the Health and Education Ministry joint school health programme, with needed coordination and support, such as transport. Opportunities are missed for educating young school children on behavioural changes concerning the proper use of water and sanitation facilities, especially latrines.

- Conduct a survey on sanitation and hygiene practices to assist in the preparation of IEC materials on proper use of WATSAN facilities, safe handling of water and food, sanitary disposal of wastes and the promotion of hand washing.

- Prepare training materials for both local WATSAN facilities (planning, monitoring, evaluation and supervision of projects, organizing communities and communication skills) and for communities (managing associations, operation and maintenance of facilities, sanitary toilet construction, and communicating sanitation and hygiene messages).

vi. Access to and quality of education. The access to school is seriously affected by the sharp deterioration of school buildings, lack of infrastructure maintenance, poor health/hygiene conditions, closure of schools, teachers' absenteeism and chronic shortage of basic educational supplies. The Oil for Food Programme is providing a rather limited contribution to the improvement of conditions within the section; mostly in infrastructure rehabilitation.

Strategies: Strategies while supporting improved physical infrastructure and basic supplies, should also address neglected areas of concern, such as educational planning, teachers' training/motivation and production of teaching aids.

- Coordination between the MOE and MOH is needed to improve continued poor hygiene conditions in schools and health practices.

vii The breakdown of the socio-cultural fabric of the society, due to the economic collapse and decline of basic services has resulted in a substantial increase of the

number of female-headed households, working mothers, street children and child labourers.

Strategies: Increased awareness is needed for policy and decision makers, society at large and the private sector about the nature, scale and causes of these new threats to the well-being of children and women in especially difficult circumstances. The potential role they can play through coordinated approaches requires stressing.

- Partnerships between the government and other potential actors, such as private sector and NGO's need to be developed. Attitudinal and behavioural changes at the institutional, community, family and individual levels are required to identify, understood and tackle these problems, where their novelty and the complex inter-linkages demand innovative approaches.

The last four problems (viii-xi) to address cross-sectoral issues are also considered in the following section on advocacy for child rights.

viii. A major concern is a weak capacity of governorate, district and sub-district level government sectoral staff and extension workers in health, nutrition, water and sanitation, and education to improve the quality of basic services as well as beneficiary demand for these services.

Strategies: Extend reliance on centrally determined services and information, education and communication materials (and their use) to encompass special local needs and situations. This requires mobilizing the necessary policy changes and resources.

- Integrate and target services reinforced through the local councils and community-based institutions.

- Provide adequate information, in an understandable and relevant form, both centrally and locally on the various indicators relating to progress towards the NPA goals. Such monitoring with cross-sectoral integration helps advocacy, planning and social mobilization activities based on the NPA and CRC.

ix. Current trends suggest that many the goals and targets of the NPA will be difficult to achieve unless substantial additional physical and financial resources for child survival and protection are available in 1999 and 2000. Also as demanding will be the implementation of the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), both ratified by the GOI.

Strategies: Even with such resources, an effective partnership must be developed between government, NGOs and private sector, to agree on how to reach these goals, the necessary behavioural changes and how to effect these through a sequence of carefully-planned activities and events. Successful prototypes have included mobilization during National Immunization Days, Vitamin A capsule distribution, the Baby and Mother Friendly Hospital Initiative, etc.

x. Unclear and isolated communication, information and education channels hinder achieving the behavioural changes required for the NPA goals.

Strategies: An integrated agreed strategy is needed between the involved sectors to develop "core" materials and messages for adaptation to specific local requirements. This should result in a clearly articulated proper sequence for promotion, implementation and monitoring (*see also page 6*).

xi. Families, and especially women have insufficient access to the knowledge and skills for self-action in health and well being, and optimizing the demand for and use of available services provided by GOI, NGOs and private sector.

Strategies: Strongly promote the "Facts for Life" approach, whereby families are conversant with essential information on preventive health measures conveyed through media, school systems, and religious and community organizations. Disseminate and present the information in multiple ways - book, leaflet, poster, slide shows, transparencies, radio, film, television, etc., where necessary to be modified for local conditions. Such messages must take into account the current constraints of the present situation.

4.2 Partnership for Children

The ratification of the CRC in 1994 by the GOI and the approval of the National Plan of Action for Iraqi Children by the National Assembly in 1995 has sparked a growing national interest and created a broad-based action for children, to be placed in the centre of the political and social agenda. The Government prepared the initial State Party Report of Iraq on its compliance for CRC implementation. The Committee on the Rights of the Child met with UN Organizations and bodies to discuss the GOI report on 27 January 1998 in Geneva, to be followed by a plenary session in September 1998.

Despite the current economic hardship, the GOI succeeded in implementing some of the Mid-Decade Goals for children, especially where there was community participation, e.g. in the areas of immunization, Vitamin A provision and ORT.

4.2.1. Advocacy Strategies

1. The Child Welfare Commission (CWC), mandated by the government to promote and coordinate NPA activities, should also serve as the focal point for policy advocacy and social mobilization. The CWC should review the outcome of the plenary session of the Committee on the Right of the Child with the Government of Iraq, analyze the current situation of children in Iraq and revise the NPA.

2. The National Assembly should continue to pursue a legislative agenda for child-oriented policies, based on the CRC and achievement of NPA goals. This would require dialogues, fora and field visits of legislators as well as orientation of legislative staff in advocacy, social mobilization and use of information related to progress of the CRC and NPA. Policy priorities would be reflected in the annual government and sectoral ministry's development plans.

3. The Annual Statistical Report on the Situation of Children and Women should be published every year by CWC in collaboration with the Central Statistics Organization (CSO). Weaknesses and gaps in information such as infant and maternal mortality[158] and Children in Especially Difficult Circumstances (CEDC) must be address. The CSO recently executed the Multiple Indicator Cluster Survey of September 1996, providing crucial national and sub-national information for monitoring the NPA and

[158] This and other key information should be available from the 1997 Population Census later this year

Mid-Decade Goals[159]. An orientation and training manual on monitoring and evaluation (ME) would be required on NPA indicators, with selected case studies.

4 A multi sectoral NPA communication task force should be organized by GOI from information units of selected government departments and institutions to produce, package and release of information needed by various target groups - including policy-makers, implementors and beneficiaries.

5. The resulting public education, using mass media and education related to child and maternal health issues, through all available channels should be based on inter-sectoral consensus of core messages.

   The messages should focus on the following initially:

- Immunization against the six childhood diseases, and TT for women of child bearing age.
- Frequent ante natal case visits (at least four) during pregnancy.
- Proper dietary intake, especially among girls and women, and prevent micro-nutrient deficiencies (anaemia, vitamin A, iodine deficiency).
- Meeting the needs of women and their role within the family and the community.
- Household food security.
- Proper infant and complementary feeding practices, within the context of the International Code for Marketing of Breastmilk Substitutes and Baby and Mother Friendly Hospital Initiative.
- Understanding the importance of feeding, health and care in maintaining good nutrition
- Use of latrines for sanitary excreta disposal, hand washing after defecation, correct personal, environmental and hygienic practices.
- Links between diarrhoea, use of contaminated water, excreta disposal and poor personal hygienic practices.
- Importance of regular school attendance especially for girls
- Issues related to Children in Especially Difficult Circumstances (CEDC)/CRC, with focus towards progressive elimination of child labour and reduction of the negative impact of working children.

[159] As well as a baseline for the Oil for Food Programme