

Impact of sanctions on the population of Iraq

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SUMMARY In this article the impact of sanctions on the Iraqi people is reviewed. The health services and situation in Iraq before sanctions were imposed in 1990 are described indicating their adequacy. The adverse effect of the sanctions on the health services and on health indicators are outlined, as evidenced by, among others, the increased malnutrition among children, increased infant and under-5 mortality rates and the increase in foodborne and waterborne diseases. The situation in Iraq illustrates the devastating effects of sanctions on people, particularly children, adolescents, women and the elderly, and highlights the need for more balanced and comprehensive humanitarian programmes.

Introduction

While natural disasters dominated in the past and usually caused swift and sudden destruction of human settlements, man-made disasters have become more common in recent times. Most man-made disasters are complex and involve many factors, which makes them challenging. In many cases, such disasters demand remedial action that extends beyond the mere provision of emergency relief. Humanitarian crises are not an isolated concern or phenomenon; rather they are intricately connected with the broader human rights issue under a given sanctions regime.

The present humanitarian crisis in Iraq continues to smoulder and takes a heavy toll in human lives and health conditions. It shows little sign of ending, in spite of a significant humanitarian assistance programme launched in 1996. The current level and type of humanitarian assistance seems to fall short of what is actually needed. The suffering of millions, especially children, women, the elderly and the dis-

abled, continues to be a cause of concern to the rest of the world.

Sanctions were imposed on Iraq in August 1990. The United Nations (UN) Security Council decided in Resolution 986 to launch the "oil-for-food" programme in May 1996. The Memorandum of Understanding concluded between the UN and Iraq stipulated the modalities of this humanitarian assistance programme. The severity of the Iraq humanitarian disaster arises from the massive and swift degradation of the country's infrastructure as a result of the two wars Iraq was engaged in (the war with the Islamic Republic of Iran and the Gulf War). A review of the progress of the programme shows that shortages of medicines, medical supplies and equipment have been relieved and distribution of supplies is reasonably efficient in most parts of the country. Yet, there has been no significant reduction of disease-specific deaths and illnesses. Malnutrition and under-nutrition are now chronic, and health facilities remain in a poor condition.

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The purpose of this paper is to present the direct health consequences of the sanctions as reflected in health conditions and health services performance.

Iraq before sanctions

Before 1990, Iraq belonged to the group of middle-income countries with a gross national product per capita of US\$ 2800. The state policy during the sixties and seventies strongly supported the creation of extensive and a well distributed physical and social infrastructure. Public services, including an extensive network of well equipped and well staffed health facilities, ensured wide and equitable access of the population to health care. Drugs, medical supplies and equipment were amply provided as needed to the health facilities. All in all, the Iraqi health system was probably one of the best in the Middle East at that time.

Public health services, notably epidemic disease control, sanitation and clean and safe drinking-water were well established; over 500 modern water treatment plants assured nearly universal access to abundant safe drinking-water and modern sewage treatment plants kept the sanitation system in the country at a relatively high level, comparable to that of some countries of Europe.

The extensive network of communications, including telephones, coupled with an efficient ambulance service for patient transportation in emergencies, allowed the health referral system to perform competently, and brought secondary and tertiary care within the reach of all those in need. This well developed and distributed infrastructure helped to secure the benefits of improved living standards and a higher quality of life for the Iraqi population.

Selected health indicators before the sanctions

A look at the health indicators for 1989 (Table 1) gives an indication of the health conditions in Iraq before the sanctions. These indicators are comparable to those of a country with adequate and equitably distributed health care, accompanied by complementary health promotion conditions.

It is worth noting that conditions related to poverty and poor environment, such as cholera, typhoid, poliomyelitis and tuberculosis, had low incidence rates. Diseases related to affluence and inappropriate lifestyle were also not reported in any significant numbers.

Effect of sanctions on Iraq

The infrastructure, the public services and, above all, the health and human conditions of the population, particularly the children,

Table 1 Health Indicators, 1989

Indicator	Value
<i>Health status indicators</i>	
Birth rate	43/1000 population
Crude death rate	8.0/1000 population
Infant mortality rate	52/1000 live births
Under-5 mortality rate	94/1000 live births
Maternal mortality rate	160/1000 live births
Low-birth-weight neonates	5% (below 2.5 kg)
Life expectancy	66 years
<i>Health services performance indicators</i>	
Population with health care	85%
Population with safe drinking-water	93%
Pregnant women with maternity care	90%
Pregnant women with trained birth attendant during delivery	86%

the women, the elderly and the disabled, started to decline rapidly after 1991.

Since the economy as a whole is under siege, widespread unemployment and shortages of hard currency have resulted in significant erosion in the purchasing power of most families. They can no longer buy the food and medicines they need, the housing and utilities they require and, most importantly, the balanced food stuffs families need to maintain adequate nutrition. Table 2 shows selected nutrients available before and after sanctions.

As of May/June 2000, the Food and Agriculture Organization (FAO), World Food

Programme (WFP) and the World Health Organization (WHO) confirmed there were still about 800 000 children under 5 years who were chronically malnourished. The report also indicated a high prevalence of anaemia in schoolchildren. The occurrence of rickets (vitamin D deficiency) is still being reported. Diarrhoea contributing to malnutrition is high and wasting (low weight-for-height) in the under-5s is over 10% in Baghdad, Kerbala and Diyala governorates. There were 30 232 cases of kwashiorkor registered in 1998 and 264 468 cases of marasmus, while an estimated 1 910 309 children were suffering

Table 2 Selected nutrients from the government food ration compared with presanction times

Nutrient (per person per day)	Before sanctions 1988/1990	Daily ration	% decrease in availability
Food energy (kcal)	3120	1093	65.0
Protein (g)	82.5	26.9	67.4
Fat (g)	75.3	22.0	10.8
Calcium (g)	467	79.0	83.1
Iron (g)	26	8.2	68.5

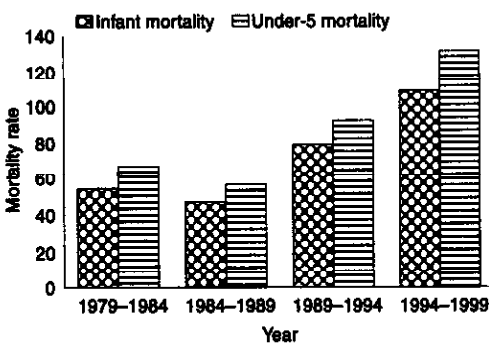


Figure 1 Infant and under-5 mortality rates per 1000 live births in Iraq (1979-1999) (Source: United Nations Children's Fund, 1999)

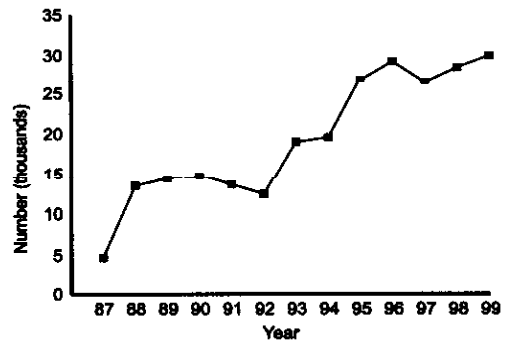


Figure 2 Number of reported cases of tuberculosis, Iraq 1987-99 (northern governorates excluded) (Source: Iraq, Ministry of Health)

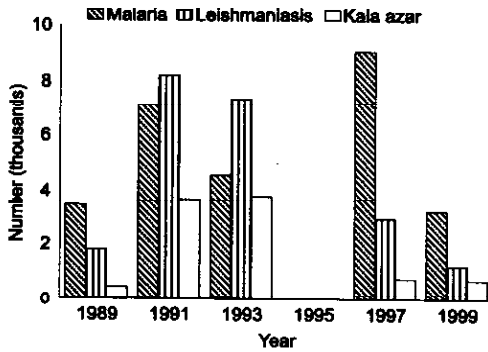


Figure 3 Number of reported cases of malaria, leishmaniasis and kala azar, Iraq 1989-99 (Source: Iraq, Ministry of Health)

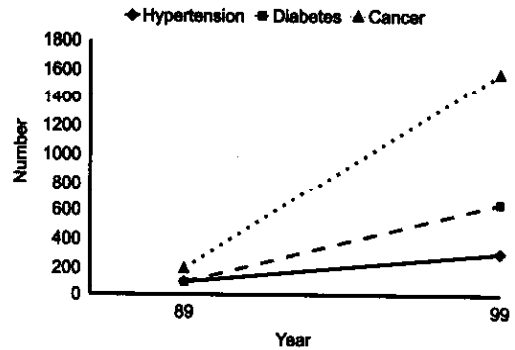


Figure 4 Prevalence of hypertension, diabetes and cancer, Iraq 1989-99 (Source: Iraq, Ministry of Health)

from other protein-, calorie- and vitamin-related malnutrition in 1998. These figures confirm the general evidence that stunting in children is a clear expression of chronic low nutrition over a long period of time. What is even more alarming is that there is a real possibility that many of these children will fail to catch up and achieve their potential intellectual growth and development in later life. Particularly significant are the unacceptably high infant mortality rate and deaths of children under 5 years (Figure 1).

Waterborne and foodborne diseases such as cholera, poliomyelitis and typhoid, vector-borne diseases such as malaria and leishmaniasis, and other bacterial diseases such as tuberculosis are on the increase (Figures 2 and 3). The numbers of infants with low birth weight and women with severe anaemia have also increased. This again indicates the general decline in the performance or services output of the hospitals and range of services in primary health care facilities.

Many secondary and tertiary care clinical support services, such as blood transfusion and ambulances for referral, have also

deteriorated. Most of the health facilities are in poor condition with insufficient equipment and often without a power supply, which makes them unsafe and unsuitable for good patient care

Unsafe drinking-water, polluted environment and poor sewage systems continue to endanger the health of large sections of the urban and semi-urban population.

There has been a statistically significant increase in the incidence of cancers, including leukaemia particularly in the south, which remains unexplained because the cause has not been investigated. This and other obscure health and environmental effects are yet to be studied and fully assessed. Regrettably chronic diseases are showing higher rates of death and emerging as public health problems. In only 8 years since 1990, the number of deaths of people over 50 years as a result of hypertension, diabetes and cancer has increased sharply as shown in Figure 4.

Conclusion

The Iraq humanitarian crisis is unique in many aspects, being the result of two wars

and the prolonged period of international sanctions. Since the implementation of Security Council Resolution 986, some improvement has been seen in the availability of drugs and medicines, medical supplies, and hospital equipment. However, restoration of health facilities, warehouses, transport and logistics has gone at a slow pace due to lack of funds. Importation is subject to approval of contracts by the 661 Committee of the Security Council. The list of items on hold is often very long and of a very large value.

During the 1998 review of progress, the Secretary-General of the UN made supplementary proposals on humanitarian requirements, but most of these could not be implemented because of inadequate funds or non-allocation of funds, including cash funds. The basic infrastructure of power, water and sanitation has remained largely unrestored. In the absence of these critical

inputs, the importation of huge quantities of medical supplies has failed to produce a commensurable impact on health care.

Economic and trade sanctions for long periods can have severe humanitarian consequences. It hurts children, adolescents and women disproportionately. This is an example where the civilian and human cost of sanctions has been far too high compared with the objectives achieved. It is to be hoped that lessons will be learnt and, in future, more balanced and comprehensive humanitarian programmes will be put in place. A new concept of a "pre-assessment" protocol before sanctions in future are even contemplated may be useful.

It is dreadful to think of entire populations subjected to avoidable health conditions; it is even more dreadful to contemplate an entire generation of young people having their right to human development compromised.

Sources

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