Health and Democracy in Iraqi Kurdistan

by Rajesh Reddy '12

"Everyone shall have the right to obtain healthcare and medical treatment, regardless of their ability to assume the expenses thereof." - **Article 24 of the Draft Kurdish Constitution**

"Too many times, we have asked the government to help us. But it is in vain. They promise and do nothing. When I think of the budget and the millions and see my situation, I feel like I am dead."- **Sulaimaniyah woman who lost her father-in-law and baby to cholera**[i]

Post-Saddam Erbil is a panorama of development, with the number of hotels, consulates and hospitals rising at rapid rates. Since the new millennium, Kurdistan has embarked on an ambitious development program, expanding services and trade networks, while also establishing relations across the globe. Despite this growth, the country has seen periods of unrest just as recently as this year. [ii] **Protesters cite widespread corruption, a lack of basic services and the siphoning of state money into private pockets. The region's health system has suffered from weak existing infrastructure, insufficient capacity or quality of services, an influx of IDPs and difficult access to rural citizens. While reconstruction has meant renewed investment in new health centers and hospitals, overcrowding and limited services still plague the system. Secondary and tertiary health care rapidly grow in urban areas, and primary health remains a low priority. Health policy has stagnated and cannot overcome the antiquated system of party politics. Without a clear strategic policy direction and effective governance, Kurdistan risks further exacerbating the socioeconomic gap in its constituency and failing its responsibility to provide services to a growing population.**

The RAND corporation study "Health System Reconstruction and National Building" found that "nation-building efforts cannot be successful unless adequate attention is paid to the population's health. In addition, efforts to improve health can be a powerful tool for capturing of the residents."[iii] **A thorough analysis of health system reconstruction entails looking at two representative factors: infrastructure and resources, and coordination and planning.iv This paper will, using existing scholarship and personal interviews, consider both components.**

BRIEF BACKGROUND OF KURDISH HEALTH STRUCTURES

Prior to the Gulf War, Iraq once had the most effective and modern health system in the Arab world.[v] It was widely considered the most advanced in terms of technology, expertise and its primary health care system.[vi] Immediately after the first Gulf War, however, the population's health rapidly declined. The conflict severely damaged the country's infrastructure, and the Ba'athist regime of Saddam Hussein exacerbated the problem by cutting public health expenditures. As a result, health indicators like infant mortality, which had been improving since the 1960s, quickly deteriorated while incidence of infections diseases like cholera, typhoid, dysentery and hepatitis increased sharply.[vii] The Oil-for-Food Program, though marred by corruption, is believed to have averted a famine, though malnutrition remained a serious problem.[viii]

The Kurdistan Region had been neglected and oppressed by the Ba'athists since 1975. Internal conflict and the civil war from 1994-1998 further weakened the Kurdish region. As the Speaker of the Kurdistan Parliament Dr. Kemal Kirkuki explained, the region suffered from "a double embargo" of both international and domestic sanctions.[ix] Additionally, the central government had done little to build up the health infrastructure for the northern provinces.[x] Faced with these odds, the Kurdish areas were left to their own devices to build up a health hierarchy after 1991 from almost nothing.[xi] But with few resources over the decade, the post-2003 KRG inherited a region with very little infrastructure.

INFRASTRUCTURE & RESOURCES

The Kurdish health authorities have had their own budget since 2003.[xii] While the rest of Iraq suffers from continued instability, Iraqi Kurdistan is blessed with security and ample foreign investment. So after nearly two decades of self-rule, the KRG has had time to develop its political institutions and capabilities.

Since the joint administration agreement of 2006 that united the Erbil, Dohuk and Sulaimaniyah administrations, the Ministry of Health is responsible for all health policy and strategy.[xiii] The Ministry, faced with complications from the unification, has begun to decentralize the ministry and pass on some of the powers to local government and hospital managers to give them more autonomous control.[xiv] The reforms thus freed the ministry to concentrate on strategic planning since in the past, health ministers were responsible for all decisions, and these decisions were often made based on political demands and subjective planning.[xv] As former KRG Minister of Health Dr. Abdul Rahman Yones describes,

"The [former] system was based on providing a completely free national health service for

all, but the system deteriorated and does not function properly anymore in today's rapidly changing environment. We are working on improving it by bringing in some modern ideas from health care systems around the world, such as Lebanon and Iran."[xvi]

While the current system is based on the provision of free national health services for all citizens, there has been no implementation by the KRG of either health insurance or of a social security system.[xvii]

Minister of Planning Dr. Ali Sindi described the pace of development, saying "Kurdistan is in better shape, which is really not true in infrastructure… Kurdistan is behind in main issues."[xviii] As of 2003 the central government allocates 17 percent of the federal budget to the Kurdistan Region. The Minister cited the $54 billion in U.S. aid to Iraq in 2004, stressing that only roughly $1 billion went to Kurdistan, despite the autonomous region's recent progresses. Furthermore, the region is still recovering from years of Ba'athist rule during which Saddam destroyed nearly 4,000 villages. The net effect of this policy was the influx of villagers into main cities like Erbil and Sulaimaniyah.

This flight to the cities is the cause of a key health sector issue: overcrowding. While northern Iraq's health care system is better provided with private health centers than its federal counterpart (1.3 PHCs per 10,000 compared with 0.5 for the country as a whole), their effectiveness is questionable. According to NGO officials in the region, while health facilities below the Green Line are prone to being fewer, more dilapidated and likely to be looted, overcrowding of central hospitals is just as serious a problem in the north. "Below the Green Line there is clearly more of a structured health system," says Erbil-based Qandil NGO project manager Marinka Baumann. "Health workers report to a district chief, who knows roughly what is going on in the policies and guidelines."[xix] In the Kurdish provinces, health services are also hampered by infrastructure problems like a degraded or disrupted electricity supply, sanitation and communication.[xx] The cumulative effect of low resources and strategic mishandling has contributed to growing discontent, especially among rural and poor populations.

Rural Healthcare

Inequality and poor health among these vulnerable populations threaten the social stability of the region. Few efforts by the KRG have improved health for rural populations, leaving large disparities between urban and rural health. The main cause of this disparity is the lack of access to healthcare.[xxi] Rural communities were promised approximately 30 new clinics by the KRG in 2009, but only a handful have been completed due to lack of allocated funds. Existing healthcare facilities in rural areas are similarly underfunded and also understaffed, thereby

ill-equipped to deal with demand. The World Health Organization (WHO) found that 70 percent of primary healthcare centers in all of southern Kurdistan are in need of renovation and have restricted access to water and electricity. Only two-thirds were found to be staffed by medical assistants with limited knowledge and resources. These statistics are worse in rural areas. Villagers often report visiting clinics during operating hours to find them closed; one villager reported not having successfully seen a doctor in twenty years.[xxii] Weak infrastructure in rural areas like poor roads, lack of electricity and clean water hinders future progress in healthcare.

According to the former health minister Dr. Abdul Rahman Yones, Kurdistan lacks sufficient educational services for nursing staff and medical technicians and a lack of specialist training opportunities for doctors.[xxiii] Nurses are in short supply, leaving doctors in the KRG area to often carry out tasks routinely performed by nurses.[xxiv] Dr. Affan Jafar describes the problem as a legacy of war: "During the conflict with Hussein in the 1980s, there was a large exodus of MDs from Kurdistan," Jafar says. "And then there was no investment in medical facilities for almost 20 years. As a result there was little training available for doctors."[xxv] The region has, however, benefited from an influx of medical specialists from the south. Hundreds of general and specialist doctors as well as young trainees have sought refuge in the northern cities.[xxvi] As of 2005, the majority of interns and doctors at the Sulaimaniyah Teaching Hospital were Arabs.

Despite the arrival of healthcare professionals from the south, Kurdistan still faces a shortage of specialized health services. This shortage is one of the reasons why, since 2003, the budget for healthcare has been focused on spending on secondary and tertiary care, providing disproportionately high funding on specialties and leaving little for primary care.[xxvii] Yet without adequate primary care, many patients, especially rural ones, do not seek care until the condition has progressed to a serious or critical stage. By that time, treatment requires far more resources and time.[xxviii] In the past few years, the Health Minister Dr. Zyran has committed to devote greater resources towards primary care efforts, saying, "I am trying to shift spending from secondary and tertiary care that benefit only five percent of the population to the primary health system that benefits 95 percent of the population."[xxix]

Drug Supply

The Kurdish healthcare system bears the additional burden of being inextricably dependent on Baghdad for drugs. Conflict in the south, says former minister Dr. Yones, severely reduces availability of basic life-saving medical supplies. Under national law, medical supplies and drugs must be acquired through

the federal government, which earmarks 17 percent of supplies for the region. This Central Drug Distribution Network is precarious as poor management and the ongoing security situation hamper distribution. Furthermore, the central government has not taken into account the influx of IDPs fleeing violence and instability in the south, causing an increase in shortfalls.[xxx] While some medicines are purchased locally by the Ministry of Health, this system also suffers from delays and shortfalls. Dr. Yones estimates that, due to conflict, corruption and inefficiency, Kurdistan receives only a third of its allocated drug requisitions.[xxxi]

Infrastructure

Health development in Kurdistan cannot improve without reforms in corresponding sectors. As the RAND study on health development and nation-building confirmed:

> Health reform is linked to other sectors, such as power, transportation and governance. Measures of success should focus on outcomes, such as improvements in basic health indicators—for example, lower infant mortality—rather than outputs, such as number of rebuilt hospitals or the number of doctors and nurses trained.[xxxii]

Health is so tightly linked to other sectors like electricity, housing, water and sanitation that development must occur parallel across these sectors.[xxxiii] Electricity and fuel are in short supply, with Erbil governorate receiving only five to seven hours of electricity on average daily. To make up for this shortage, nearly 80 percent of the governorate's population uses private generators. At around 8,500 Iraqi dinar (about $7 USD) per Ampere and a 64,000 dinar (about $55 USD) installation fee, many families report having to spend up to half their income just on electricity.[xxxiv] Similarly, fuel shortages have led many families to rely on the black market where prices remain steep.[xxxv] While major cities have experienced significant urban development, the region still suffers from a housing crisis. The price of housing has skyrocketed since 2003 when compared to average income levels. A European Council on Refugees and Exiles associated member report in 2007 describes the following example:

> An employee at Sulaimaniyah University, looking for an apartment to live in with her future husband makes US$ 200 (approximately 254,000 Iraqi Dinars, IQD) per month, while her fiancé earns only US$ 80 (approximately 101,000 IQD) per month. In Sulaimaniyah, houses are offered at a monthly rent of US$ 200-800. The couple does simply not earn enough to afford their own accommodation.[xxxvi]

The issue does not concern only shortage of housing but overpriced housing. Ex-

perts believe unofficial general inflation rates to be around 40-50 percent. Urbanization further contributes to housing price rise. Both rural Kurds and IDPs exerted stress on the urban job market and reduced the availability of affordable housing. This population influx has not only placed pressure on the low wage sector but also led to a fall in daily wages by about 50 percent in this sector.[xxxvii] Frustration with the rising cost of living and the lack of employment opportunities have spurred recent demonstrations in Sulaimaniyah.

COORDINATION AND PLANNING

Budget & Statistics

"The problem is always the budget."— Nawzad Hadi, Governor of Erbil[xxxviii]

Health indicators show that the Kurdistan Region is indeed enjoying some success. Infant mortality and mortality of children younger than five years have both been halved since 2006, says former Minister Yones.[xxxix] Nevertheless, many public projects are held up by political complications. The high degree of bureaucracy also presents a problem. Public hospitals suffer from inadequate budgets and are forced to appeal to the general director of health for the most basic needs. Indeed, those working in healthcare can all agree that, as Dr. Haweizy of the Emergency Management Centre puts it, "The budget is little, very little." [xl] For example, the Rizgary Hospital has a budget of just $5000 USD per month and must appeal to the Ministry for supplies. This budget crunch also serves to push physicians into private practice as salaries are far less in the public sectors—just about $800 USD a month.[xli]

Any strategic efforts are hampered by a severe lack of validated health indicators required for needs assessment, planning and policy. Only the World Health Organization Iraq-wide indicators and subjective surveys by the World Bank, the World Health Regional Office for the Eastern Mediterranean (EMRO), and Iraq Comprehensive Food Security and Vulnerable Analysis offer reliable statistics. Some experts attest that "resource allocations are based more on political whim than actual health needs matching the population, epidemiological and socioeconomic profiles of Kurdistan's constituencies."[xlii] They cite the 2010 budget allocation of one-fifth of Erbil's total resources to build a new office for the Ministry of Health.[xliii] Furthermore, Sulaimaniyah province, the largest by population, receives the least resources with only 15.7 percent allocation. Impoverished rural areas receive 27 percent allocation and developed urban areas 73 percent.[xliv] Additionally, as Minister of Ali Sindi described in a meeting, the Kurdish region suf-

fers from the lack of an updated census, which is repeatedly blocked by political impasse. The Kurdistan Region suffers from health surveillance and management-related data that are not standardized and not optimally used.[xlv]

Private-public Relationship

Arguably the most serious factor contributing to healthcare inequality is the system of healthcare fees. While healthcare is officially free for all, the situation on-the-ground is far from this ideal. Public primary care centers officially operate between 8:30 AM and 12:30 PM. Patients pay a nominal co-pay of 250 Iraqi Dinars (IQD), which is equivalent to approximately 25 cents, and can see however many primary care physicians in one day as they wish. As a result of overcrowding and high demand, consultation times are very short (observed on average around two minutes).

The health system allows doctors to work in public hospitals during the day and operate their own private practice (to which they often refer their public hospital patients) in the evening. These practices actually "'feed off the hospitals' public diagnostic services to augment their own business."[xlvi] In the ancient city center of Erbil, a "doctor's alley" has sprung up, offering private services without any sort of monitoring or scrutiny. The Rizgary Hospital only operates between 8:00 AM and 1:30 PM, after which the building is left with only one doctor on rotation per department.[xlvii] Even during working hours, resources are strained. According to a Kurdish Globe report, "up to 140 people visit the ear, nose and throat departments every day, where they wait in a noisy reception area to see the doctors, who themselves are busy, trying to find working equipment. Asked if they can cope with the huge numbers of patients, Shirzat, a medical assistant, just says that they are 'too many,' before going back to work."[xlviii]

Public sector funding has often found its way to the development of urban private primary care centers. "Capital costs for the construction of nearly a dozen such centers was covered by USAID, originally intended for public use. However, these centers have recently been given governmental 'pilot' approval for private provision and use."[xlix] The quality of private centers are far superior to the public ones and can provide specialized healthcare services, such as T.B. centers, infertility clinics, lab test centers, dental poly clinics and other sought-after services. These private clinics, however, charge patients between IQD 15,000 and 25,000 IQD ($12-20 USD) for just the examination, which accounts for more than a quarter of an average family's monthly wages. Additional services, treatment or drug provisions cost even more. *Kurdish Globe* reports, "Patients pay 20,000 Iraqi dinars ($18 USD) for a meeting with a doctor in a private clinic for just a four to six minute consultation. Sometimes, patients wait months to see a good doctor."[l]

To temper the public-private divide, the KRG has opened up consultant clinics at the district level, where physicians can work from 3:00 to 6:00 PM in the winter and 3:00 to 7:00 PM in the summer. At such clinics, consultations and prescriptions cost around IQD 1,170 ($1 USD). In addition to this compensation, physicians receive a ministry salary. Rural, often poorer populations—who have insufficient medical coverage in rural areas and face overcrowding in urban public hospitals—benefit from the cheap specialist services.[li]

Nevertheless, the two-tiered system of public and private hospitals has reinforced existing inequities in access and quality of care. It also inhibits the socioeconomic development of the country as the poorer and rural elements of the population are left without adequate healthcare.[lii] Furthermore, the lack of real social welfare or a universal insurance safety net leaves poorer and older elements vulnerable to catastrophic health expenditures.[liii] The few pension and welfare benefits that do exist are not widely available, and "due to a lack of funding, not all persons in need receive social welfare and access may at times depend on political/personal links rather than actual needs."[liv]

Primary Care

Primary care is the "provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community."[lv] A report by Melinda Moore of the RAND Corporation found that "primary care facilities and services are not yet systematically organized, managed or monitored."[lvi] Primary care physicians are meant to serve a gateway function, treating what they can in their capacity and funneling the rest into specialized services. In Kurdistan, however, this referral system is neither adhered to nor enforced. "Simple conditions that can be treated at the care center (eg. diarrhea, fever) are overwhelmingly referred to hospitals, and patients' requests for drugs are generally unchallenged by physicians."[lvii] Primary care physicians often send patients to their evening private evening practices where prices are unaffordable to rural and poorer populations. Thus, physicians have negative incentives to fulfill their referral role or spend more time with patients in public hospital settings. Due to low co-pay in the Kurdish public health care system, patients also over-utilize services, leading to an overextended and overcrowded system. Without proper primary care, rural and poorer populations often do not receive care until their condition has progressed to a critical or serious stage.[lviii] The jumble of public, private, and unlicensed providers means that, in reality, "there is no 'system,' but a fragmented set of services…with a parasitic orientation towards the use of public hospitals." [lix] To strengthen the primary care system, interventions must

focus on three key areas. First, organization and management of [primary care] services must be reformed. This includes more efficient distribution and management of facilities, better referrals and continuity of care and continuous quality improvement. Second, the health care workforce (especially primary care physicians and nurses) must be strengthened through both education and training to improve qualification and through management interventions to enhance distribution performance. Lastly, data collection and analysis, surveillance and response systems and management information systems need to be improved.[lx]

IDPs

Perhaps the most vulnerable group, internally displaced peoples (IDPs), are hit the hardest by the widening inequality gap. Nearly 2.8 million people have been displaced within Iraq as of 2009, and Kurdistan hosts the largest number of IDPs. Sulaimaniyah province houses almost half a million IDPs, the largest displaced population outside Baghdad.[lxi] The Sulaimaniyah Governorate hosted over 360,000 IDPs as of February 2006. By the end of 2007, the governorate absorbed 67,844 IDPs displaced by the Samarra bombing, of which the majority resided in Sulaimaniyah City (46 percent) and most of which were ethnic Arabs (65 percent).[lxii] Furthermore, they have not indicated any willingness leave; in 2008, the Iraqi government offered $600 to families that return home, but fewer than one percent have accepted. Kurdish officials are also reluctant to permanently accept these IDPs. "We don't have enough job opportunities in Kurdistan," said Head of the Department of Foreign Relations Falah Mustafa Bakir, "but we don't want to send them back to the insecure situation in the south…Iraqis should stay in Iraq."[lxiii]

In an interview, a United Nations Office for Project Services (UNOPS) coordinator described the unique situation of Sulaimaniyah IDPs. While Erbil has been able to absorb the mostly skilled labor that comes there way, Sulaimaniyah has found the task much more difficult:

> "Sulaimaniyah differs from Erbil. The city has not expanded, so people have to go to the outskirts," she says. "Also, standard of living is lower and there are less job opportunities and Arab education institutions. Poorer elements often go to Sulaimaniyah, and the only jobs are daily wage and low-skill, low-pay jobs. They are not living in good living conditions because of low availability, high costs and their low income."[lxiv]

These poorer IDPs live precarious lives in refugee camps in the outskirts of the city, where they survive with a lack of basic sanitation and few health resources.

Kurdistan Health Foundation, a local NGO, discovered that many refugees are largely blocked from accessing the public health system. This problem, says local human rights activist Venus Shamal Karim, constitutes part of "a pattern

of neglect" on the part of Kurdish officials.[lxv] Dr. Nasik Abdul Wahid, a pediatrician providing services to the IDPs, relayed that "the local authorities are required to provide health services to the refugees under law, but the truth is people in this camp can only get medical services by paying. And it's too expensive."[lxvi] Many of these IDPs are still waiting on the KRG to transfer their food ration cards from Baghdad, without which they cannot access the system of government food support.

In the Sulaimaniyah province, the paperwork itself for transferring registration takes about one month, during which IDPs are left without access to food rations. Water shortages and low access to clean food supplies also deter healthy living as an increasing number of IDPs are exposed to contaminated water sources. [lxvii] IDP monitoring indicates that 62 percent of IDPs in Sulaimaniyah are living in overcrowded conditions, and 100 Arab families from Baghdad and Diyala are living in the Qalawa Camp located eight kilometers outside the city. This camp suffers from poor sanitation and common ailments like dehydration, diarrhea and rashes. Furthermore, officials have deemed this camp illegal and seek to relocate its inhabitants.[lxviii] Another camp in Erbil, Al-Khazir, was set up temporarily in May 2007 for 150 families from Mosul only to be closed in September of the same year. While most IDPs live in apartments within the city, the destitute in the camps face what former Minister Yones agrees is an inhuman predicament. The KRG and government of Iraq "insist on policies designed to encourage people to go home… As a result, the poorest people among the displaced have been left to live in camps, rather than resettled in permanent housing."[lxix]

Corruption

While Kurdistan has recently been flushed with foreign investment and growing revenues, "ordinary Kurds are struggling to survive, while state money gets siphoned off into private pockets."[lxx] A whistleblower in the Ministry of Planning confirmed the lack of transparency in the process of public works bidding. [lxxi] Businessmen often encounter political leaders who sell public works projects to relatives who may or may not be capable of their execution. The project often gets sold repeatedly until a real construction company is hired. At this point, a fraction of the original funds are still available.

While the Iraqi budget has been growing—a projected $82.6 billion for 2011[lxxii] and with the 17 percent share for Kurdistan, there still remains a growing gap between ordinary Kurds and the political elite. Contaminated water supplies have led to cholera outbreaks and with erratic electricity supply, many are left without power to boil their water.lxxiii In Sulaimaniyah, people have reported getting running water for four hours every three days and electricity for three to four

hours per day.[lxxiv] Journalist Ari Harshin concludes that the KRG operates like a mafia state: "There is no transparency. They are dividing the budget of the Kurdish Regional Government between the PUK and the KDP, 58 percent for the KDP, 48 percent for the PUK. It is a very strange model of democracy."[lxxv]

Frustration with the government has led to demonstrations dating back to 2006. Dissatisfaction has arisen over alleged corruption, restrictions on freedom of press and lack of public services. According to a the United Nations High Commissioner for Refugees (UNHCR) report on Sulaimaniyah, "there was a high incidence of fraud cases reported during the first quarter of 2007, and bribery and corruption are common."[lxxvi]

POLICY RECOMMENDATIONS

The KRG should encourage private sector development not by direct investment but by attracting foreign companies to invest in the health sector. According to a study by Dr. Goran Abdullah, 80 percent of the doctors in Kurdistan believe the private and public sector should be separated, and 85 percent would be willing to work for the public sector if monthly salary were increased by 300 percent.[lxxvii] Since Kurdistan is still in a development phase, the private sector and foreign investment should be the main sources of funding for secondary and tertiary services. Public subsidies should be re-directed towards basic public health programs such as "immunizations…sick-child care, family-planning, prenatal and delivery care and treatment for tuberculosis and STDs.[lxxviii]

The current system has proven highly inefficient. Public hospitals are in danger of becoming little more than referral stops to costly private centers.[lxxix] This public sponsorship of private care should be limited so that the public no longer has to pay a significant portion of their income for private care. Furthermore, policymakers must focus on regulating the wide variety of private clinics. On this note, NGOs should be more formally incorporated into the health structure as they play a vital role in treating poorer populations.[lxxx]

There are enough primary health centers (PHCs), but they, and the size of the population served per PHC, need to be standardized and categorized across provinces.[lxxxi] PHCs are supremely important in local settings and act as the first and main primary care providers for communities. They also ensure that resources are more effectively used and that patients are properly referred so that conditions do not progress to a serious stage before treatment. Similarly, increased use of telemedicine and expanded health education campaigns can promote safe and healthy behavior in communities.[lxxxii]

There is an urgent need for better epidemiological profiles and health statistics. Without updated and available indicators of health system structures,

processes and outcomes, the Ministry of Health cannot base its policies and budget resource allocations on evidenced health needs. Melinda Moore of RAND lists enhanced surveillance and response systems as one of the most important and feasible interventions for improving primary care.[lxxxiii] Such surveillance should be used not only to track disease, but also to monitor programs and target policies.[lxxxiv]

Health governance capacities are severely lacking. With Kurdistan's current decentralized model of health care, the Ministry of Health must strengthen planning and management competences as well as accountability. Accreditation and licensing systems are outdated and un-enforced and continuing medical education is weakly enforced. Such poor leadership and management competences have lead to inefficient and ineffective use of resources and staff.[lxxxv] Continuing education systems and licensing and recertification systems for medical processionals should be established.[lxxxvi] Medical students should be trained in primary care and more students should be trained as primary care specialists. Family medicine is the foundation of modern medical care and should therefore be incentivized.[lxxxvii] Likewise, there is a need for more and better trained nurses. They should receive enhanced training in clinical skills throughout their education so they can be better used at PHCs.[lxxxviii]

KURDISTAN: A FALSE DAWN?

"We are not a democracy, but we are democratizing." – Qubad Talabani, KRG Representative to the United States[lxxxix]

It is clear that Kurdistan has made vast progress in the past decade; after inheriting scarce infrastructure, the region has seen significant and rapid development and unprecedented foreign investment. Observers agree that Kurdistan is in far better shape than the unstable south and central regions. Nevertheless, when it comes to healthcare, KRG policy requires serious reform. Public funds go to waste as most Kurds live on unreliable electricity and water and face an ever-rising cost of living. With a growing post-war population and an expanding budget, the regional government must re-direct public funds and attack corruption that stunts public works projects. Public hospitals suffer from under-budgeting, overcrowding and weak management of resources. Physicians lack incentives to improve care, and nurses are in short supply and undertrained. Meanwhile, rural populations, poorer elements and IDPs lack access to proper care—after struggling to see a doctor, they often find themselves referred to private services that they cannot afford. The KRG must confront the growing socioeconomic gap between ordinary Kurds and the political elite. Demonstrations in Sulaimaniyah this year have revealed Kurdish frustration with their officials. Kurds are demanding basic services and an end

to the corruption. The KRG must answer their calls, define its values and reform accordingly, or Kurdistan's status as "beacon of democracy" may prove to be a false dawn.

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[i] BBC
[ii] Rand Health System Reconstruction 1
[iii] Rand Health System Reconstruction 2
[iv] Rand Health System Reconstruction 2
[v] Iraq: Socioeconomic 10
[vi] Rand Health System Reconstruction 2
[vii] Rand Health System Reconstruction 2
[viii] Dr. Kemal Kirkuki (Interview 01/05/11).
[ix] (Corpwatch)
[x] (IRIN, IRAQ: Special)
[xi] (KRG, Health minister)
[xii] (Swiss 10)
[xiii] (Swiss 10-11)
[xiv] (Swiss 11)
[xv] (KRG, Health Minister)
[xvi] (KOFF)
[xvii] Dr. Ali Sindi. In interview with the author. 5 January 2011.
[xviii] (IRIN 2004)
[xvix] (IRIN 2004)
[xx] (Kurdishaspect)
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[xxii] (Reuters)
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[xxiv] (Lancet Profile)
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[xxvi] (KRG, Health Minister)
[xxvii] (KurdishAspect)
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[xxxv] Iraq: The Socioeconomic Situation 3
[xxxvi] Iraq: The Socioeconomic Situation 7
[xxxvii] Nawzad Hadi. In interview with the author. 5 January 2011.
[xxxviii] Lancet
[xxxix] (KurdishGlobe, An Ailing Healthcare)
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[xli] (Tawfik-Shukor 3)
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[xliv] (Melinda Moore 4)
[xlv] (Shukor, Khoshnaw 4)
[xlvi] (KurdishGlobe, An Ailing Healthcare)
[xlvii] (KurdishGlobe, An Ailing Healthcare)
[xlviii] (Shukor, Khoshnaw 4)
[xlix] (KurdishGlobe, Health reforms vital in Iraqi Kurdistan)
[l] (Iraq: The Socioeconomic Situation 15)

[li] (Shukor, Khoshnaw 5)
[lii] (Shukor, Khoshnaw 5)
[liii] (UNHCR Sulaimaniyah 34)
[liv] (Melinda Moore 7)
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[lix] Melinda Moore 10
[lx] (Lancet)
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[lxxvi] (KurdishGlobe, Health reforms are vital in Iraqi Kurdistan)
[lxxvii] *World Development Report* 1993,7
[lxxviii] (Shukor, Khoshnaw 5)
[lxxix] See Denise Natali's Kurdish Quasi-State for more on dependency on non-governmental organizations and institutions
[lxxx] (Melinda Moore 11)
[lxxxi] (Melinda Moore 17)
[lxxxii] (Melinda Moore 28)
[lxxxiii] (Melinda Moore 25)
[lxxxiv] (Shukor, Khoshnaw 4)
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[lxxxvi] (Melinda Moore 20)
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[lxxxviii] (BBC)