Iraq and mental health policy: a post invasion analysis
Intervention 2011, Volume 9, Number 3, Page 332 - 344

Iraq and mental health policy: a post invasion analysis

Sonali Sharma & Jack Piachaud

The Iraq war, and the subsequent involvement of various stakeholders in the post conflict reconstruction of the health sector, presented an opportunity to learn about mental health policy development, challenges and obstacles within a post conflict context in 2003. This paper documents and explores mental health policy in post invasion Iraq, using qualitative methods and a health policy framework that analyses context, content and process. Findings indicate that there are many challenges, both in repairing an already weakened health sector, and in maintaining mental health as a health priority. In addition to security issues, fragmentation of power, change of leadership and lack of funding pose significant problems. Achievements are evident, though insufficient to address the overall mental health burden. The policy process is examined over a four-year period. Lessons learned are presented as best practice guidelines for post conflict mental health reconstruction.

Keywords: conflict, Iraq, mental health and complex emergencies, mental health policy, post conflict reconstruction, war

Introduction

More than 30 years of an oppressive regime, and the ensuing war in 2003, have devastated Iraqi society and imposed a large public mental health crisis on the population. Forced migration of over four million people, pervasive human rights abuses, and years of daily violence since the 2003 invasion, have taken a toll, both on the individual and on the society. Approximately 1.3 million internally displaced persons (IDPs) are estimated to be in Iraq (UNHCR, 2011). In addition, almost 50% of the total Iraqi population is comprised of those below 18 years of age, posing a significant challenge for policy on mental health. Although the overall impact is unknown, the increased mental health burden is high, and demands that mental health policymakers adequately respond to the crisis.

In order to better understand the experiences faced in the Iraqi context, and to contribute to the dialogue on best practice guidelines for other states in transition, this paper will examine mental health policy development in post invasion Iraq.

Methodology

Because the study was initially conducted in the autumn of 2007, the period selected for review was 2003 to 2007. For this period, a retrospective qualitative case study methodology was utilised (an intensive analysis of a process which took place in the past using qualitative methods to study it), supported by literature reviews and key informant interviews, in order to gather data. Over 40 documents from scientific and peer-reviewed journals, newspapers, various institutions (including the World Health Organization (WHO), the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), key nongovernmental organisations (NGOs) such as Medact, and donors, mental health institutions, academic institutions and unpublished 'grey' policy documents were collected and analysed. A

select group of international and Iraqi experts were surveyed, all with experience, either directly in Iraq or indirectly with post conflict health reconstruction in low and middle income countries. A snowballing technique identified potential interviewees. Of 35 people contacted, 21 responded (60%) and were interviewed over a six-week period in August–September 2007, either by telephone, or in person where possible. Interviews were conducted in English, using a semi-structured interview tool with 20 open-ended questions divided among the following topics: drivers and influences of mental health policy, planning of services, achievements in mental health, obstacles to mental health reform, effect of the war on the mental health burden, and the role of NGOs and other stakeholders. Of the 21 respondents, the group consisted of five civil society leaders in mental health service delivery, seven senior experts in policymaking for mental health service delivery, and nine mental health professionals, both from within and outside of Iraq, across six countries. Only three of these respondents were located (at the time of the study) in Iraq, due to security issues. Consumers were contacted, but all declined to participate due to personal security issues. Data obtained from key informant interviews was cross-referenced, and substantiated by written literature to ensure accuracy.

Methodology for data analysis consisted of thematic analysis on interview content, grey policy documents, and literature reviewed using Walt's analysis (Walt, 1994) as a framework for mental health policy analysis. Walt's analysis was chosen due to its framing of health policy within an economic and political perspective in low and middle income countries and its use across various countries and areas of health, including mental health (De Vries & Klazinga, 2006; Stockwell et al., 2005). The framework organises thematic content into four areas: context, actors, content of policy, and process, and specifically examines the interaction between these four areas. This paper is organised into two sections on context and content/process. The authors utilised this methodology as a means to better understand various influences and factors in mental health policy development, post invasion. Because this paper was submitted a few years after the key informant interviews took place, an additional review of the literature was conducted to analyse the period since 2007, in order to have a more comprehensive and updated view. However, due to budget and time constraints, follow-up interviews of respondents were not conducted, and therefore not incorporated into the policy analysis.

Ethical considerations

A description of this project, and a request for informed consent, were sent by email to all respondents. Those in insecure environments with no internet access were briefed about the project by telephone. Personal information was not collected on participants, and all information obtained from interviews was anonymous, unless otherwise specified in the report. For participant protection, no protocol approval was needed for this study.

Limitations of our analyses

Limitations of the analysis include lack of consumers interviewed due to security issues and language barrier, under-representation of Iraq-based respondents due to insecurity and poor access to communication, exclusion of those who did not speak English; predominance of senior leaders and staff rather than mid-level respondents; and exclusion of those in insecure environments

or with poor access to telecommunications. In addition, observations by respondents are based on the period between 2003 and 2007 and therefore this study does not examine interviewee observations on changes in policy after 2007.

Background and context of mental health policy development

Following a bloodless military coup in 1968, the Ba'athists came to power in Iraq for almost four decades of totalitarian rule. Human rights abuses such as torture, assassinations, disappearances, detentions, forced conscription, and amputations were pervasive during this period (Amowitz et al., 2004).

Although Iraq initially prospered under Saddam's rule, the economy and civil society weakened with increasing militarisation of the country. Military expenditure rose from 19.4% of GDP in 1975, to 38.4% in 1985, peaking at 70.1% in 1981 (Al-Khalil, 1989). Further conflict ensued with the Iran/Iraq war from 1980 to 1988, the invasion by Iraq into Kuwait in 1990 and 1991, and subsequent UN sanctions due to the invasion of Kuwait. Oil revenues, which had generously financed much of the social services in Iraq through the 1970s, ceased and health care costs were no longer met. The UN Oil for Food Programme began in 1996 in response to the crisis, and required that two thirds of oil proceeds were earmarked for humanitarian needs (UN, 2010).

By 20 March 2003, when the invasion began, both from a socio-political and economic point of view, the region had weakened. As the invasion proceeded, further destruction took place, and internal displacement worsened with 402,000 persons displaced from 2003 to 2005 (IOM, 2007), and another 1.6 million after a shrine bombing in Samarra (ReliefWeb, 2008) (Table 1).

In the 1960s and 1970s, the health care system flourished and was a model for the region with mental health services well serving

Table 1. General country information – Iraq

Geographical area	440,000 square km
Population	30.01 million (2008)
Population growth rate	2.2% (average over 2005–2010)
Population aged 0 to 14 years	41.1% (2009)
Main languages	Arabic, Kurdish, Turkmens
Number of governorates	18
Main religions	Muslim 97%
	Christian, or other 3%
Ethnic groups	Arab 75–80%
	Kurdish 15–20%
	Turkmens, Assyrian, or other 5%
Socio-economic:	Lower middle income group (World Bank criteria)
GDP	USD $40.66 billion (2006)
Life expectancy at birth	59.1 years for males, 63.1 years for females
Literacy rates	54.9% men, 23.3% women

Country Information on Iraq (CIA, 2010). Health care system prior to the 2003 invasion.

the population (Sadik & Al-Jadiry, 2006). Good access to roads, sanitation, water, transportation and communications supported the health care system. The health care system penetrated both urban and rural populations, providing access to 97% and 79% of Iraqis respectively, before 1991 (WHO, 2005). Infant mortality rates were low. Health care was financed through the government, with services free of charge to the public.

The Iran/Iraq war, and the invasion into Kuwait by Iraq, increasingly constrained public spending on health care, and by 1991 total expenditure on health had declined, health care indicators worsened and health infrastructure had deteriorated. Health expenditure plummeted from 3.72% of the GDP, before the 1990s, to 0.81% of the GDP after 1997 (Iraq MoH, 2004). Infant mortality rates increased in the 1990s, with estimates of 500,000 child deaths (Lehmann, 2004).

In 1997, the system changed from a government funded scheme to a self-financing system in which the cost of care is shifted to the patient. Free health care ceased to the public (WHO, 2005). Despite hospital ownership by the Ministry of Health, health care became increasingly privatised.

Mental health system prior to the 2003 invasion

Mental health in Iraq during the Ba'athist period was a hospital-based, public model with an emphasis on long term institutional care. The government initially financed mental health care until the self-financing system was introduced in 1997. Many practitioners were forced into the private system, or fled as funding declined.

Mental health care was a low priority on the health agenda. Outside of the hospital-based system of care, psychiatrists had limited influence on national policy. The total mental health care burden prior to 2003 is unknown, due to scarcity of data on psychiatric epidemiology.

When the invasion occurred in 2003, the mental health care system was already severely constrained in regard to public resources and human capital, and limited in its capacity to meet the demands ahead (Table 2).

Socio-cultural context

The stigma attached to mental disorders has remained consistent over time in Iraq. Context analysis reveals: 1) the large degree of stigma leads users to seek care from primary care doctors, internists and neurologists, rather than psychiatrists; 2) most users of the mental health care system are primarily the severely mentally ill; 3) there is great reliance on local religious and cultural healers for assistance; and 4) family and communities, rather than the system of care, often assume responsibility for treating mental illness. Furthermore, according to Sadik (2010), negative attitudes towards treatment, work, marriage and recovery from mental illness impact the degree of social inclusion, despite the fact that most of the Iraqi public understand the scientific underpinning of mental disorders.

According to a WHO report (2003), *'rural life in Iraq is strongly influenced by tribal traditions, long held norms and religious teachings.'* Iraqi civilians often seek assistance from local and religious healers as the first point of contact. Coordination is poor between traditional and allopathic systems.

The mental health system post 2003 invasion

Since the 2003 invasion of Iraq, the exact mental health burden is unknown. Lifetime prevalence of any mental disorder is reported at 18.8% (Alhasnawi et al., 2009). High rates of anxiety, depression and posttraumatic stress syndrome (PTSD) (Hussein & Sa'adoon,

Table 2. History of Mental Health Services: Timeline (pre) 2003

705 AD	First mental hospital in the world established in Baghdad
1927	Baghdad Medical School established and modelled on UK system
Early 1950's	Mental health services established in Iraq with two psychiatric hospitals established, both in Baghdad; Al-Rashad Hospital, a 1,200 bed chronic care facility and Al-Rashid Hospital (now Ibn-Rushid Hospital), a 74 bed facility for acute psychiatric care
1960s–1970s	Establishment of mental health centres and mental health units in hospitals, school mental health programmes and mental health promotion efforts
1980s to 2003	Wars and UN imposed sanctions; General decline in health services, many psychiatrists and other doctors flee Iraq, plans for mental health strategies blocked by regime in power
2003 (pre) invasion	A few weeks before the war in 2003, ex-regime released convicted forensic prisoners (people with mental disorder who were in jail) into streets
Immediately post invasion, 2003	Violence, looting, and destruction of health infrastructure further undermines health services; Al-Rashid Hospital, the 1,200 bed chronic care psychiatric facility, was hit particularly hard
	Many international NGOs entered the scene out of goodwill to assist with humanitarian needs

From: Sadik & Al-Jadiry, 2006; U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), 2005.

2006; WHO, 2007) are documented. Among children, 47% experienced traumatic events from 2004–2006 (Razokhi et al., 2006) and high exposure levels to traumatic events correlate with mental, behavioural and emotional issues, with prevalence rates of 10–30% for posttraumatic stress disorder (Dimitry, 2011). In Mosul, 37.4% of children and adolescents in primary care centres were found to have mental disorders (Al-Jawadi, 2007). Suicide rates among young women in Kurdistan are increasing. Substance abuse has escalated with lifetime prevalence at 0.9% (Al-Hasnawi et al., 2009). Reasons cited include: conflict, economic strain, geographical location (bordering countries with high rates of abuse and poor border control), weak oversight of pharmaceutical system resulting in a high rate of prescription drug abuse (Aqrawi & Humphreys, 2009). Opiates are widely used. Cocaine and cannabis are also available. Alcohol, although historically banned, is on the rise as well.

The mental health system remains two-tiered, with 92% of psychiatrists working both in public and private services, 2% in government only, and 5% solely in private practice (WHO, 2006). The public system transitioned from a self-financing model to a centralised one. Fewer than 100 psychiatrists, and minimal ancillary staff, serve the entire population of 27 million, or 1.6 professionals in mental

health facilities per 100,000 (WHO, 2006). Multi-disciplinary practice is virtually non-existent. There is no social insurance and no community residential facilities. The availability of mental health services for children and adolescents is very limited (Al-Obaidi, Budosan & Jeffery 2010).

Most inpatient psychiatric treatment is for severe and persistent mental illness. Mood disorders are treated on an outpatient basis. A biomedical model of treatment is in use. Mental health in primary care is limited. No support exists for consumer groups or families (WHO, 2006). Medications are frequently unavailable.

Mental health policy development: content and process post 2003 invasion

The analysis reveals that the content of mental health policy development remained fairly constant over time, but the process was continually challenged and thwarted by obstacles. The impact on government planning, action and policymaking is often an indirect consequence of conflict (Ugalde et al., 2000).

Key components of mental health policy development in Iraq, post 2003, include:

- Lobbying, strategy and planning at the Health Ministry level,
- Prioritisation of mental health care on the health agenda,
- Shift away from long term institutional care towards public and primary mental health care,
- Equitable distribution of access to care,
- Emphasis on capacity building, and
- Reliance on international collaborations.

The process of mental health policy development depends strongly on the governing body in power, public mental health leadership, and foreign support. Security issues and sectarian violence, lack of coordination, competing models of mental health, corruption, stigma and culture, posed grave difficulties in moving the agenda forward. Key points, both with respect to content and process, will be discussed below.

Political transitions challenging the mental health agenda

Political transitions of power within Iraq, from 2003 to 2007, affected both the pace and timing of mental health policy development after the invasion. The four phases of government: 1) Coalition Provisional Authority (CPA) post invasion in 2003; 2) U.S.-led Iraq Interim Government from 28 June 2004; 3) Iraq Transitional Government from 3 May 2005; and 4) first elections on 15 December 2005, leading to an Iraqi cabinet and a four year government in March 2006; led to changes in leadership and lack of continuity of the mental health care agenda.

Health and public mental health leadership

Varied leadership within the health sector played a large role in both propagating and delaying a national strategy and implementation of mental health policies.

During the CPA's tenure, power struggles between USAID and the Pentagon initially led to a quick change of health leadership and delays. According to respondents, from the onset, there were missed opportunities, poor health sector planning, and lack of post conflict and regional expertise among management of the CPA (Medact, 2008, Chandrasekaran, 2006).

The first Iraqi Interim Health Minister and the CPA declared mental health care a key priority area in 2004 (Fleck, 2004). This declaration led to specific appointments, committees and achievements within the mental health care arena. The first mental

health budget was written for US $2.5 million, or 0.32% of the total health budget from the CPA (Jones et al., 2006). Funds were put into mental health care training, psychiatric units in hospitals, and site visits. An Iraqi (expatriated) psychiatrist assumed the first position of National Advisor in Mental Health in February 2004. International collaboration, inauguration of a National Mental Health Council, and formulation of a comprehensive National Strategy ensued. By October 2004, a draft Mental Health Act was submitted and approved by the Cabinet. Although limited in its content, it put mental health care on the map as an integral public health priority.

After the one-year appointment of the National Advisor, the hands of leadership changed again and significant effort was required to keep mental health care on the agenda. High turnover of Health Ministers from 2004 to 2007, further fragmented mental health care policy efforts. The approved Mental Health Act was stalled. Receptivity was tested each time a new Health Minister came into power, and mental health care was not sustained as a consistent priority over time.

The current Minister of Health, Salih Al-Hasnawi, is a psychiatrist and he has maintained mental health care as a priority, with a particular focus on integration of mental health into primary care, as reflected in the 2009–2011 Health Strategy.

International collaboration and the role of foreign influence

Immediately post invasion, there was an outpouring of support and goodwill from the international community and the Iraqi Diaspora. The International Red Cross came to the rescue of the Al-Rashad Hospital, which was looted and damaged following the invasion (Humaidi, 2006). The WHO has played an instrumental role in supporting the Health Ministry, convening expert consultations in Cairo in 2003 and 2005, and conducting epidemiological studies to better understand the mental health burden (Alhasnawi et al., 2009). WHO and partner agencies ensured that each Governorate had a refurbished mental health centre.

The U.S. SAMHSA collaborated with the CPA in early 2004, prioritised mental health on the health agenda, and mobilised SAMHSA resources (Curie, 2006). SAMHSA took the lead in convening two Action Planning Meetings in 2005 in Amman, Jordan (SAMHSA, 2006), and in March 2006 in Cairo, Egypt (Benderly, 2006). A multi-agency Iraq Planning Group was still in operation in 2007, with weekly conference calls and activities.

In the United Kingdom, the Royal College of Psychiatry convened an Iraq Sub-Committee in 2005, Annual Fringe Meetings and a volunteer scheme to bring mid-career level psychiatrists to Iraq for capacity building. A delegation to Iraq's Kurdistan region took place in July 2007 and established a formal link between the Royal College Volunteer Scheme and the Kurdistan Regional Governorate.

Many groups organised around the impending demand for mental health care and psychosocial services. Disenfranchised Iraqis, who had long standing concerns about the health sector, saw the invasion as an opportunity to help their country in the absence of an oppressive regime. There was an opportunity for free action that had not existed before. Iraqi psychiatrists in the UK established the Iraqi Mental Health Forum to provide supervisory and technical assistance, programme development expertise and supervision to young providers in Iraq.

According to the nongovernmental organisation (NGO), Coordination Committee on

Iraq (2007), 80 international NGOs and 200 Iraqi NGOs were present as of 2007. A small proportion focused on mental health care. Unfortunately, many NGOs had to withdraw from Iraq, as a result of security issues, including death threats and killings of those providing services.

Capacity building through short term training was conducted outside of Iraq in collaboration with the UK, Kuwait and Jordan, in 2004 and 2005.

Financial contributions supplemented the Ministry of Health budget. In May of 2004, Japan donated USD $6 million for mental health care services. The CPA requested from Congress USD $850 million for health, with $100 million earmarked for ambulatory care (Garfield, 2003). More recently, the Ministry of Health, with the support of USAID and IMC-Iraq, has been systematically supporting the integration of mental health care into primary care in 20% of basic health facilities (Sadik et al., 2011). Because of the success of the programme and the influence of donors, the Ministry will continue to fund and expand the programme to the rest of the country.

Competing models of mental health care

In response to a survey question on models of mental health care, respondents indicated that competing models of care were a source of power struggles within and between stakeholders. Health maintenance organisations (HMOs), centralised and self-financing models were considered. Policymakers endorsed reform and deinstitutionalisation of the inpatient psychiatric hospital, Al Rashad. In general, there was a lack of emphasis on the existing Iraqi health infrastructure and using local capacity to rebuild the system. The consensus for Iraq's model was a public mental health model with an emphasis on primary care, multidisciplinary teams, and links to community based care (Humphreys & Sadik, 2006).

Furthermore, the Iraq Ministry of Health Strategy, 2009 – 2011, emphasises primary health care as a main priority, with mental health care as one of the core initiatives (Iraq MoH, 2008).

Special populations at high risk for developing mental health issues, such as refugees, IDPs, children, women, and the disabled, have specific needs that should be considered in policy formulation for an appropriate model of mental health care. Child and adolescent mental health care is virtually nonexistent, for example, and advocacy efforts around these issues call for increased support and policy steps (Al-Obaidi, 2010).

Sectarian violence in the health sector

Respondents repeatedly cite security as the major obstacle within the health sector. Sectarian violence and discrimination by political affiliation are widely pervasive throughout the health sector. Death threats against doctors, kidnappings, extortion and murders, posed a significant threat to the health workforce. Of the 34,000 doctors registered in Iraq before 2003, 17,000 fled, 2,000 were murdered and 250 were kidnapped (O'Hanlon & Campbell, 2007). The number of psychiatrists is purported to be below 30 for a population of 27 million. Postgraduate qualifications and training programmes in psychiatry suffer due to the severe shortage of mental health professionals.

Newspaper reports and respondents consistently allude to the Ministry of Health as a sectarian monopoly, teeming with corruption and involvement in alleged human rights abuses.

Corruption

Mismanagement of funding and private contracts thwarted reconstruction efforts.

Inefficient use of funds by private contractors has been well documented (Chatterjee, 2007; U.S. Senate, 2006). Lack of transparency, funding misappropriations and diversion of supplies to the black market are among the key issues contributing to further drains of the public system.

Stigma of mental health

The stigma attached to mental illness in Iraqi society is a barrier to mental health policy making. It influences the position of psychiatry within medicine, and affects demand for psychiatric services.

Implications of culture

Respondents stated that Iraqi culture is an obstacle in reaching consensus, working on teams and collaborating across ethnic factions. Political affiliation, past historical tensions and the removal of Ba'ath party members from positions within the Iraqi government after the invasion promulgated mistrust. Further ethnographic research is needed to examine culture as an obstacle in detail.

Policy recommendations

Policy recommendations can be elucidated from this analysis in post invasion Iraq, consistent with international guidelines and expert opinion. Presented below are a series of recommendations for post conflict mental health care, taking into consideration the context, content and process of policy development in Iraq.

- *Security is the first priority* in ensuring sound policy development. Insecurity fragmented the process in Iraq, and constantly posed a challenge.
- *Mental health care should be an integrated part of the overall health strategy* and focused on public mental health. A sustainable mental health care strategy is required that will survive changes in leadership. Lobbying of ministers, political will, a clear national mental health plan and budget, as well as support from the international community, can all aid in this process. The strategy should include activities such as: integration of mental health care into primary care, building specialist mental health care, community-based mental health, and mental health promotion and outreach activities.
- *Coordinated mental health planning and programming is necessary* using international guidelines (e.g. IASC, 2007) and a minimum set of activities immediately post invasion, in addition to rapid needs assessments, multi-disciplinary teams, strategies based on need, and ensuring that all stakeholders are coordinated and working to support Ministry priorities.
- *Local capacity, resources and knowledge should be harnessed* to formulate a system that meets cultural needs and regional demands. Post conflict and regional experts should be consulted. Increased collaboration with the traditional community will enhance access and early identification.
- *Improved governance and management is recommended,* not only for mental health officers, but also for the overall health sector. Government performance standards, improved accountability and increased transparency measures should be put into place to the extent possible.
- *The mental health workforce should be expanded so that mental health services are maximally scaled up.* Targeting primary care providers to identify, treat and refer persons with mental disorders will provide direct access to a great number of people. Workforce expansion should include mental health training for primary care providers and support staff, including: psychologists, clinical social workers, psychiatric nurses,

midwives and paraprofessionals. Clinical psychiatrists can contribute by transitioning their role from clinical work to training and building capacity of basic service providers. Capacity building with clinical supervision should be the role of specialist teams. If capacity is limited, policymakers must be creative with local, regional or international expert supervisory teams. Coordination with other Ministries to make an investment in education, integrate mental health into pre service and in service training curricula, and to provide research opportunities, is recommended.

- *Investment from within the country is essential.* Transitional governments should enable and support local leadership, facilitate external experts working in conjunction with local expertise, and harness available resources within the country to promote the most culturally sensitive and appropriate solutions.
- *Efforts to reduce stigma, and a focus on mental health advocacy, should be integral to the overall health promotion strategy.* This can be achieved through mass media educational campaigns, awareness-raising activities, emphasis on primary health care and education and links with community stakeholders. Advocacy for mental health care should come from all sectors, and should focus on human rights. Development of consumer groups and family/caretaker coalitions can be advantageous in providing support.
- *Mental health care includes not only treatment of people with mental disorders, but also a deeper understanding of local risk and protective factors,* and the development of targeted community and psychosocial interventions.
- Although cited specific to the Iraqi context, *the culture of hierarchy* within medicine and across all disciplines relevant to health and wellbeing must be addressed to promote an environment of teamwork, collaboration and trust.
- *The use of global networks and international expertise can be harnessed* in resource poor settings, however, in good coordination with the new government in power.
- *Links should be made with religious and traditional healers.* Capacity building, involvement in stakeholder meetings and education are some of the recommended activities among community leaders and healers.

The recommendations above are specific to this analysis of Iraq, and are also in line with expert opinion and international guidelines. This study demonstrates the difficulties of mental health policy development in a fragile state, but also highlights that progress can occur with a core set of activities and priorities. It is the author's hope that this analysis will provide insight to policymakers and practitioners in post conflict settings, and contribute to the development of mental health care in the most vulnerable settings.

Acknowledgements

This analysis was financially supported by a research honorarium, the Perry Award, received through the Psychiatry Residency programme of Cornell University's Payne Whitney Clinic at New York Hospital in 2008, and in part through Medact [www.medact.org] in the UK.

This paper is dedicated to the late Jack Piachaud, and could not have been written without the guidance of Marion Birch (Medact), Vikram Patel (who introduced me to Jack), participating respondents, the Iraqi Diaspora, and Dr. David Hamburg (for his invaluable mentorship).

References

Alhasnawi S., Sadik S., Rasheed M., Baban A., Al-Alak M.M., Othman A.Y., Othman Y., Ismet N., Shawani O., Murthy S., Aljadiry

M., Chatterji S., Al-Gasseer N., Streel E., Naidoo N., Mahomoud Ali M., Gruber M.J., Petukhova M., Sampson N.A. & Kessler R.C. (2009). The prevalence and correlates of DSM-IV disorders in the Iraq Mental Health Survey (IMHS). *World Psychiatry*, 8 (2):97-109.

Al-Khalil S. (1989). *Republic of Fear: The Politics of Modern Iraq.* London: Hutchinson Radius.

Al-Obaidi, A. K., Budosan, B. & Jeffery, L. (2010). Child and adolescent mental health in Iraq: current situation and scope for promotion of child and adolescent mental health policy. *Intervention, 8*, 40-51.

Amowitz, L. L., Kim, G., Reis, C., Asher, J. L. & Iacopino, V. (2004). Human Rights Abuses and Concerns About Women's Health and Human Rights in Southern Iraq. *JAMA, 291* (12), 1471-1479.

Aqrawi, R. & Humphreys, K. (2009). Responding to Rising Substance Misuse in Iraq. *Substance Use and Misuse, 44*, 1744-1748.

Benderly B.L. (2006). Afghanistan, Iraq: *SAMHSA Supports Mental Health Efforts*. SAMHSA News, 14 (4). Available at http://www.samhsa.gov/SAMHSA.News/VolumeXIV.4/article10.htm. Accessed 30 August 2007.

Central Intelligence Agency (CIA). The World Fact Book. Iraq 2010. Available at: https://www.cia.gov/library/publications/the-world-factbook/geos/iz.html. Accessed Oct, 9th 2010.

Chandrasekaran R. (2006). *Imperial Life in the Emerald City: Inside Iraq's Green Zones*. New York: Knopf.

Chatterjee P. (2007). *High-Tech Healthcare in Iraq, Minus the Healthcare. Special to Corp Watch.* January 8, 2007. Available at www.corpwatch.org/article.php?id=14290. Accessed September 18, 2007.

Curie, C. G. (2006). Health Diplomacy in Action: Helping Iraq Rebuild its Mental Health System. *Journal Muslim Mental Health, 1* (2), 109-116.

De Vries, A. K. & Klazinga, N. S. (2006). Mental Health Policy Reform in Post-Conflict Areas: A Policy Analysis Based on Experiences in Bosnia Herzegovina and Kosovo. *European Journal of Public Health, 16* (3), 246-251.

Dimitry, L. (2011). A systematic review on the mental health of children and adolescents in areas of armed conflict in the Middle East. *Child Care Health Development* 2011 [web published ahead of print].

Fleck, F. (2004). Mental Health a Major Priority in Reconstruction of Iraq's Mental Health System. *Bulletin of the World Health Organization, 82* (7), 555.

Garfield, R. (2003). Challenges to Health Service Development in Iraq. *Lancet, 362* (9392), 1324.

Humaidi, N. S. (2006). Resettlement Prospects for Inpatients at Al-Rashad Mental Hospital. *Journal of Muslim Mental Health, 1* (2), 177-183.

Humphreys, K. & Sadik, S. (2006). Rebuilding Iraq's Mental Health System. *Behavioral Healthcare, 26* (7), 34-35.

Hussein, A. H. & Sa'adoon, A. A. (2006). Prevalence of Anxiety and Depressive Disorders Among Primary Health Care Attendees in Al-Nasiriyah, Iraq. *Journal of Muslim Mental Health, 1* (2), 171-176.

IOM (2007). *Iraq displacement: 2007 year in review.* International Organization for Migration Available at http://www.iom.int/jahia/

webdav/shared/shared/mainsite/media / docs/reports/2007_year_in_review.pdf. Accessed 28 August 2008.

IASC (2007) *Inter-Agency Standing Committee Guidelines.* Available at www.humanitarianinfo.org/iasc. Accessed 30 October 2007.

Iraq Ministry of Health (MoH). (2004). *Health in Iraq: The Current Situation, Our Vision for the Future and Areas of Work*. Baghdad, Iraq; Iraqi Ministry of Health.

Jones, S.G., Hilbourne L.H., Anthony C.R., et al. (2006). *Securing Health. Lessons from Nation-Building Missions.* Rand Center for Domestic and International Health Security. Santa Monica, CA; Rand Corporation. Available at http://www.rand.org/pubs/monographs/MG321/. Accessed 2 March 2008.

Lehmann, C. (2004). Iraq Desperate To Rebuild Shattered Health System. *Psychiatry News, 39*(21), 1.

Medact (2008). *Rehabilitation under fire: healthcare in Iraq 2003–2007.* London: Medact.

Ministry of Health (MoH): *Annual Report.* (2008). Ministry of Health, Iraq.

NGO Coordination Committee in Iraq. Available at http://www.ncciraq.org/. Accessed 11 November 2007.

O'Hanlon M.E. & Campbell A.H. (2007). *Iraq Index*. Brookings Institution Report. Washington, DC; The Brookings Institution: September 17, 2007. Available at http://www.brookings.edu/fp/saban/iraq/index.pdf. Accessed 10 September 2007.

Razokhi, A. H., Taha, I. K., Taib, N. I., Sadik, S. & Al Gasseer, N. (2006). Mental Health of Iraqi Children. *Lancet, 368*(9538), 838-839.

Relief Web (2008). *Internal displacement update for Iraq.* ReliefWeb Available at http://www.reliefweb .int/rw/rwb.nsf/db900sid/ASAZ-7DAFVF?OpenDocument. Accessed 28 August 2008.

Sadik, S., Abdulrahman, S., Bradley, M. & Jenkins, R. (2011). Integrating Mental Health into Primary Care in Iraq. *Mental Health in Family Medicine, 8,* 39-49.

Sadik S. & Al-Jadiry A.M. (2006). Mental Health Services in Iraq: Past, Present and Future. *International Psychiatry: Bulletin of the Board of International Affairs,* 3 (4).

Stockwell, A., Whiteford, H., Townsend, C. & Stewart, D. (2005). Mental Health Policy Development: Case Study of Cambodia. *Australas Psychiatry, 13*(2), 190-194.

Ugalde, A., Selva-Sutter, E., Castillo, C., Paz, C. & Cañas, S. (2000). The Health Costs of War: Can They Be Measured? Lessons from El Salvador. *BMJ, 321* (7254), 169-172.

United Nations (UN) (2010). Office of the Iraq Programme. *Oil-for-food.* Available at http://www.un.org/Depts/oip/background/index.html. Accessed 10 October 2010.

United Nations (UN) (2010). *UN Data: Country Profile Iraq Programme.* Available at http://data.un.org/CountryProfile.aspx?crName=Iraq#Summary. Accessed 20 July 2011.

United National High Commission on Refugees (UNHCR) (2011). *UNHCR – Iraq Fact Sheet.* May 2011. Available at http://reliefweb.int/node/421317. Accessed 20 July 2011.

U.S. Senate Democratic Policy Committee Hearing (2006). *An Oversight Hearing on the Bush Administration's Plan to Rebuild Iraq's Hospitals, Clinic and Health Care System: What Went Wrong?*

28 July 2006. Available at http://democrats.senate.gov/dpc/hearings/hearing36/transcript.pdf. Accessed 18 September 2007.

U.S. Substance Abuse and Mental Health Services Administration (2005). *In Transition: Al-Rashad Mental Hospital*. SAMHSA News. May/June 2005, 13(3). Available at http://www.samhsa.gov/SAMHSA_News/VolumeXIII_3/index3.htm. Accessed 30 August 2007.

U.S. Substance Abuse and Mental Health Services Administration (2006). *Helping Iraq Restore its Mental Health System*. SAMHSA News. 2006, 13(3). Available at http://www.samhsa.gov/SAMHSA_News/VolumeXIII_3/index2.htm. Accessed 30 August 2007.

Walt, G. (1994). *Health Policy: An introduction to Process and Power*. 4th edition. Johannesburg and New York: Zed Book Ltd. and Witswatersrand University Press.

World Health Organization (2006). *WHO-AIMS Report on Mental Health System in Iraq*. Iraq Ministry of Health, Baghdad, Iraq; Geneva: WHO.

World Health Organization (2007). *Health Action in Crises: Highlights. No. 165 8 to 15 July 2007.* Available at: http://www.who.int/hac/donorinfo/highlights/en/. Accessed 20 July 2007.

World Health Organization, Eastern Mediterranean Regional Office (2003). *Report on the Consultation on mental health and rehabilitation of psychiatric services in post-conflict and complex emergency countries:* 28–30 July 2003 Cairo, Egypt. Geneva: WHO.

World Health Organization, Eastern Mediterranean Regional Office (2005). *Health Systems Profile, Country: Iraq, June 2005.* Available at: www.emro.who.int/iraq/pdf/HealthSystemsProfile.pdf. Accessed 1 October 2010.

Sonali Sharma MD MSc is currently working as a Technical Advisor in Mental Health with HealthNet TPO in Amsterdam.
email: sonalisharmamd@gmail.com
Jack Piachaud (passed away on 10 February 2009), was a clinical psychiatrist with over 20 years of experience in learning disabilities, was editor of Medicine Survival and Conflict, was involved with Medical Foundation for Care of Victims of Torture in the UK and was contributing to Medact's work in the UK.