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A Study of Education Opportunities for Disabled Children and Youth and Early Childhood Development (ECD) in Iraq

Phase 1 Report

April 2010

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1. Introduction

1.1 Study Background Children who live with physical, sensory, intellectual, mental and multiple disabilities are amongst the most stigmatised and all too often marginalised within the family, school and wider community. The resulting poor education outcomes affect their opportunities and increase their vulnerability to violence, abuse and exploitation. Despite growing advocacy in the 1990s and the adoption of the UN Convention on the Rights of Persons with Disabilities in December 2006, Iraq's international isolation[1] left it untouched by the movement. In a society where disability is too often associated with shame and the disabled are hidden from view, the lack of solid data on numbers and needs simply compounds their plight.

Although the right to education for all is enshrined in the 2005 Iraq Constitution, and 2010 heralded approval of a new Disability and Special Needs Care Act[2] (New Disability Act), Iraq is not yet a signatory to the UN Convention on Disabilities and faces a substantial challenge to develop the capacities to respond effectively to the educational needs of disabled children and youth. Work on establishing meaningful early childhood development policies, strategies and services in Iraq is equally in its infancy. It is in this context that UNICEF has commissioned this 6-phase study.[3]

1.2 Study Scope & Objectives The study comprises two interlinked strands:

Education Opportunities for Disabled Children and Youth (0-18 years of age) with the following three objectives[4] to support: i.) the development of contemporary and inclusive policies, strategies, programming approaches and initiatives to improve the quality of education for children with disabilities and ensure their inclusion at the primary education level; ii.) capacity-building of the government to implement the new policies and initiatives for children at all levels: central, directorate, district, community, and school in a phased manner in selected pilot locations; and iii.) implementation of new policies and programmes through direct support of 30 targeted schools in 4 governorates.

> **'Disability'** a functional approach is adopted referring to the interaction of personal impairment relative to individual situation and conditions, within the context of education. The process adopted to identify disability will be twofold: firstly the identification of impairment and secondly the identification of a setting in which the person is unable to participate on equal terms with other users because their impairment is not accommodated, eg: i. a person with severe myopia who has effective optical support and consequently can function in the full range of social settings (home, community, education), is not considered to have a 'disability'; ii. a person with severe depression who is unable to concentrate or remember information as a consequence, is unable to function in educational contexts where these are essential pre-requisites for effective performance and is therefore considered to have a 'disability'. *See Annex 7 for study definitions, developed to ensure a common understanding of key terms used in the UNICEF scoping documents*.

Early Childhood Development (0-8 years of age) with the objective to provide recommendations and guidelines that will inform the development of a comprehensive national strategy and policy on early childhood development to support improved coordination, institutional and human capacity, the expansion of services and the quality of early childhood development programmes, in addition to improving budget allocation awareness and raising awareness of early childhood development issues.

> **'Early Childhood Development'** the ordered emergence of interdependent skills of sensor-motor, cognitive-language, and social-emotional functioning. This emergence depends on and is interlinked with the child's good nutrition and health. The focus is on children under 8, and particularly in the first years of life because this is the period of the child's life when development is most rapid and requires most environmental input and protection from risks. (UNICEF 2006)

[1] United Nations economic sanctions were imposed on Iraq from 1990, following Iraq's invasion of Kuwait.
[2] As translated from the Arabic.
[3] Phase 1: Secondary data collection and introduction of the survey to key respondents; Phase 2: Survey and sampling design; Phase 3: Training and pilot; Phase 4: Fieldwork and data entry; Phase 5: Consultation following data Analysis and preliminary findings and recommendations; Phase 6: Drafting of final Reports, recommendations and papers
[4] Research outputs relating to objective 1 will include recommendations to inform implementation of objectives ii & iii. Implementation remains entirely the responsibility of UNICEF.

1.3 Phase 1 The aims of Phase 1 were: to introduce the study to, and gain the support of, key players at central, regional, governorate and community level in Iraq; and collect secondary data on the status quo (legislation, policies, practices, roles and responsibilities, budgets etc) to help increase understanding of the factors and variables that may have a direct or indirect impact on the two study components: eg. attitudes, infrastructure, war, demographics and population movements, rural/urban divide, poverty, education, gender, vulnerable groups, environmental factors including war and industry-related contamination.

This report describes the work undertaken in Phase 1 and resulting findings that have been used to inform the design of the survey, the survey instruments and the selection of survey localities within the four study governorates: Baghdad, Basra, Erbil and Najaf[5]. The governorates were selected to capture Iraq's geographic and demographic diversity, provide a comparative basis for data analysis and introduce characteristics that are specific to each governorate. Most importantly, government figures indicate that these four governorates contain the largest proportion of children with disabilities within their respective populations (MoLSA 2008).

Phase 1, led by Dr Al-Hashemy the Iraq Research Team leader, included field trips to each of the four governorates; a preliminary mapping of relevant players and initiatives; meetings and interviews with national and international agents from across the Government, UN and NGO spectrum (see Tables 1-4, Annex 8); preliminary school and institution visits (see Annex 6); procurement of relevant documentation, including Ministry of Labour and Social Affairs (MoLSA) statistics on schools, special needs institutions and those officially registered with disability (see Annexes 1-5); a four-day pilot survey in Baghdad (see Box 21); a complementary desk study; and participation in two disability conferences: *'Caring for People with Special Needs: a National Humanitarian Duty'* The Republican Assembly for People with Special Needs, 16-20 Aug. 2009; *'The Participation of the Handicapped in the Construction of New Iraq'*, August 2009 (see Box 15).

Phase 1 respondents unanimously welcomed and pledged their support to the study and the Phase 4 fieldwork. The school visits and the pilot survey allowed preliminary informal verification of government statistics and other data collected against realities on the ground.

Given the complex nature of Iraq, the scarcity of formal information on the core study topics, the lack of electronic records and often contradictory data, the work of collecting and verifying secondary data to ensure its accuracy and contemporary nature will continue throughout the ensuing study phases.

2. Country Overview in Brief

2.1 Recent History Iraq and the Iraqi people are still recovering from the devastating impact of the past three decades. Since the coming to power of General Saddam Hussein in 1979, Iraq has fought three wars[6], suffered a decade of UN-imposed economic sanctions and international isolation[7] and, as recently as 2007, teetered on the brink of civil war. The UN estimates that between 500,000 and 1.2 million Iraqi children died during the sanction years, years that led to hyperinflation, widespread poverty and malnutrition, and a major loss of Iraq's human capital, a loss that has accelerated post-2003.

2.2 Demographics Iraq covers an area of 435,055 sq. km, divided into eighteen governorates. The Iraqi Kurdistan Region, the northern region of Iraq, comprises the governorates of Erbil, Dahuk, and Sulaymaniyah, and is currently the only Iraqi federal region recognised under Article 113 of the Iraq Constitution, which approbates the KRG and its existing regional and federal authorities (see Section 2.3 Governance).

Iraq has an estimated population of 31.9 million (COSIT 2008) and a sex ratio of 101 men per 100 women. Half the population of Iraq is under the age of 18; and 43% under the age of 15 (UNICEF 2007). 6% of the population is over the age of 60 (COSIT 2008). Life expectancy at birth is 54.9 years for males and 61.6 years for females (MoH 2007). The healthy life expectancy at birth is 49 years for males and 52 years for females

[5] For the purposes of this study, the names used for governorates, districts and sub-districts, some of which are under dispute, are those used by the WFP VAM 2007 survey (*cf.* IAU/OCHA [2009] Governorate Profiles) and differ from those used by the UN Humanitarian Information Centre (UN HIC, renamed United Nations Information Management System [UNIMS] since 2005) amongst others The spelling and names used does not reflect any opinion held by CARA as to the legal status or frontier delimitation of any district or other area in relation to these disputes. Any variation in spelling in this report reflects the spelling used in the reports being quoted.

[6] The Iraq-Iran War (1980-88), the invasion of Kuwait (1990) triggering the first Gulf War (1990-1991) and the second Gulf War (2003).

[7] UN Security Council Resolution 661 imposed a full trade embargo on all but medical supplies, food and other humanitarian items as determined by the Security Council Sanctions Committee.

(WHO 2004 *cf.* WHO 2006). The literacy rate is 86% for men and 70.1% for women (COSIT 2008) and infant mortality is 35 per 1000 (MICS3 2006 *cf.* COSIT 2008).

The United Nations High Commission for Refugees (UNHCR) figures on population movements post 2003 state that as of March 2008 just under 2.4 million Iraqis were internally displaced, and an estimated 1.8 million living as refugees in the neighbouring countries, with Jordan and Syria bearing the brunt (Relief-Web/UCHO, Iraq: Humanitarian Profile, March 2008).

The division of ethnic groups is 75%-80% Arab, 15%-20% Kurdish, and 5% Turkoman, Assyrian, or other (CIA 2010). The largest religious group is Muslim at 97% (Shia 60%-65%, Sunni 32%-37%) with Christian next and other at 3% (*ibid*.). The main languages are Arabic and Kurdish (official in Kurdish regions) with Turkoman (a Turkish dialect), Assyrian (Neo-Aramaic) and Armenian spoken to a lesser extent (*ibid*.).

2.3 Food insecurity is a major issue and the World Food Programme (WFP) estimates that 2.6 million Iraqis are vulnerable to food insecurity (WFP 2008). In 2009, over 5 million families were registered for ration cards (Iraq Updates, 28 October 2008[8]). WFP estimates that if the public distribution system (PDS) were discontinued, an additional 3.6 million people would be likely to face food insecurity (WFP 2008).

2.4 Governance Although a contentious view amongst some, a 2008 COSIT report describes the Republic of Iraq as a parliamentary democracy. The Coalition Provisional Authority transferred sovereignty to the Iraqi-controlled Government on 28 June 2004, with Iraq's Constitution ratified by constitutional referendum on 15 October 2005.

The Executive branch of the government consists of the President (chief of state) and two Vice Presidents who form the Presidency Council (COSIT 2008). The Prime Minister is head of government and he, two Deputy Prime Ministers (*ibid*.) and 34 ministers appointed by the Presidency Council make up the Cabinet (*ibid*.).

The Legislative branch of government consists of a 275 member Council of Representatives elected by a closed-list, proportional representation system (*ibid.).* The Council elects the Presidency Council and approves the Prime Minister and two Deputy Prime Ministers. The country's legal system is based on European civil and Islamic law under the framework outlined in the Iraqi Constitution[9];

In line with Article 113 of the Iraq Constitution, the Kurdish Regional Government (KRG) has assumed the role of a federal government, handling KRG's domestic affairs. Central government in Baghdad remains responsible for international affairs.

2.5 Economy Iraq's economy is dominated by the oil sector, which has traditionally provided about 95% of foreign exchange earnings (COSIT 2008). Although looting, insurgent attacks, and sabotage post 2003 have undermined rebuilding efforts, oil exports are around levels seen before the invasion (*ibid*.). Other industries in Iraq include the manufacture of batteries, bicycles, clothing, cement, vegetable oil, tobacco, diary produce, tyres, ammunition, bricks, paper, steel and thermostone. Industries specific to the study governorates are listed in Section 11 below. An Oil Revenue Sharing Law was under consideration in 2007[10] to support the equitable division of oil revenues across the nation (Iraq Oil Forum 2007).

Between 2004 and 2007, Iraq received non-US pledges of $13.5 billion in foreign aid and more than $33 billion in total pledges (*ibid*.). Despite continuing political uncertainty, Iraq appears to be making some progress towards building the institutions needed to implement economic policy and reform. The government has negotiated a debt reduction agreement with the Paris Club and a new Stand-By Arrangement with the IMF

[8] Iraq's food rationing system, known as the Public Distribution System (PDS), was set up in 1995 as part of the UN's oil-for-food programme following Iraq's invasion of Kuwait in 1990. However, it has been crumbling since the US-led invasion of Iraq in 2003 due to insecurity, poor management and corruption. Every man, woman and child residing in Iraq receives monthly food rations through the Programme and 60% of the population is totally dependent on them. The Government purchases food ration items in bulk for the entire country with proceeds from the sale of oil under the Oil-for-Food Programme. It distributes 450,000 tonnes of food every month to the 15 central and southern governorates and to warehouses for the three northern governorates where the UN handles distribution on the government's behalf. Food distribution is accomplished through a national network of more than 44,226 privately owned corner stores. Of these: 33,627 are in the 15 central and southern governorates and 10,599 in the three northern governorates.

[9] Compulsory ICJ jurisdiction has not been accepted (COSIT 2008).

[10] The study has yet to ascertain its status in 2010.

(*ibid*.). The International Compact with Iraq[11] was established in May 2007 to help integrate Iraq into the regional and global economy. The Iraqi Government is debating a number of laws to help strengthen its economy and establish a modern legal framework through which to develop its resources (COSIT 2008). Reducing corruption and structural reforms will be crucial to Iraq's economic growth and stability (*ibid*.).

2.6 Budget Allocation Iraq's Ministry of Finance plays the key role in developing, analysing, and executing the budget, including distributing funds to individual spending units and preparing periodic financial reports (GAO 2008). Iraq's financial management law directs the Ministry of Finance to consult with the Ministry of Planning and Development Cooperation in establishing budget funding priorities. Individual Iraqi spending units in the 34 central government ministries, the 15 provinces, and the Kurdistan region provide expenditure estimates to the Ministry of Finance (*ibid*.). The Ministry of Finance, in consultation with the Ministry of Planning, uses this information to develop the budget and submits the draft budget to the Council of Ministers for approval before submitting it to the National Assembly for final approval *(ibid*.).

In 2004, the proportion of the health budget to GDP was 3.2%, the per capita total expenditure on health was 97 international dollars[12] and the per capita government expenditure on health 31 international dollars (WHO 2004). Education expenditure as a percentage of GDP was unknown between 1988 and 2008 (UNICEF 2008a) and accessing information remains problematic, although the study research team will seek to obtain more accurate and up-to-date information on both these critical areas of expenditure.

2.7 Security Despite improvements in security from the latter part of 2008, Iraq is still an extremely fragile environment. Insurgent-led violence against the occupation forces and sectarian and criminal violence remain a daily reality for many.

2.8 Basic Necessities Daily life for the majority of Iraqis is still associated with a lack in basic necessities including electricity, water, sanitation, food, access to employment, education and health services.

2.9 Contamination A recent official Iraqi study found that more than 40 sites across Iraq were contaminated with high levels or radiation and dioxins, with three decades of war and neglect having left environmental ruin in large parts of the country (Guardian 2010):

> *'Areas in and near Iraq's largest towns and cities, including Najaf, Basrah and Falluja, account for around 25% of the contaminated sites, which appear to coincide with communities that have seen increased rates of cancer and birth defects over the past five years. The joint study by the environment, health and science ministries found that scrap metal yards in and around Baghdad and Basrah contain high levels of ionising radiation, which is thought to be a legacy of depleted uranium used in munitions during the first Gulf war and since the 2003 invasion.*
>
> *The environment minister, Narmin Othman, said high levels of dioxins on agricultural lands in southern Iraq, in particular, were increasingly thought to be a key factor in a general decline in the health of people living in the poorest parts of the country.'*

This study will need to be mindful of prevalence of congenital or other disabilities in survey locations and of a possible correlation with environmental factors.

3. Education, Disability & Health: Relevant Legislation

Iraq's educated and professional class, including teachers, academics and health professionals in particular, fled in their thousands following the assassination of colleagues as part of a targeted campaign, with devastating effect (Jalili 2007). Over 830 assassinations have been documented, including 380 university academics and doctors, 210 lawyers and judges, and 243 journalists/media workers (*ibid*.). This, in addition to the outflow of professionals during the UN sanctions years has left Iraq with an enormous task to rebuild not just its educational and health infrastructure but its specialist human capital.

[11] The International Compact with Iraq is an initiative of the Government of Iraq for a new partnership with the international community. The Compact is a five-year national plan that includes benchmarks and mutual commitments from both Iraq and the international community, all with the aim of helping Iraq on the path towards peace, sound governance and economic reconstruction (United Nations 2007).

[12] The international dollar is a hypothetical unit of currency with the same purchasing power as the U.S. dollar at a given point in time (Geary 1958). The years 1990 or 2000 are often used as a benchmark year for comparisons that run through time. It is based on the twin concepts of purchasing power parities (PPP) of currencies and the international average prices of commodities. It shows how much a local currency unit is worth within a country's borders. It is used to make comparisons both between countries and over time.

3.1 Rights to Education, Healthcare and Institutional Care The Iraqi people's universal rights to education, healthcare and institutional care, as well as the State's commitment to supporting the development of children, are enshrined in Articles 29 to 34 of the Iraq Constitution[13] (see Box 1).

Box 1. 2005 Iraqi Constitution: Articles 29-34

Article 29 'First: A. The family is the foundation of society; the State preserves its entity and its religious, moral and patriotic values. B. The State guarantees the protection of motherhood, childhood and old age and shall care for children and youth and provide them with the appropriate conditions to develop their talents and abilities. Second: Children have right over their parents re upbringing, care and education. Parents shall have right over their children in regard to respect and care, especially in times of need, disability and old age. Third: Economic exploitation of children shall be completely prohibited. The State shall take the necessary measures to protect them. Fourth: All forms of violence and abuse in the family, school and society shall be prohibited.

Article 30 'First: The State guarantees to the individual and the family -- especially children and women -- social and health security and the basic requirements for leading a free and dignified life. The State also ensures the above a suitable income and appropriate housing. Second: The State guarantees social and health security to Iraqis in cases of old age, sickness, employment disability, homelessness, orphanhood or unemployment, and shall work to protect them from ignorance, fear and poverty. The State shall provide them housing and special programmes of care and rehabilitation. This will be organised by law.'

Article 31 'Every Iraqi has the right to healthcare. The state takes care of public health and provides the means of prevention and treatment by building different types of hospitals and medical institutions.'

Article 32 'The State cares for the handicapped special-need people and ensures their rehabilitation for their reintegration into society. This shall be regulated by law.'

Article 33 'First: Every individual has the right to live in safe environmental conditions. Second: The State undertakes the protection and preservation of the environment and biological diversity.

Article 34 'First: Education is a fundamental factor in the progress of society and is a right guaranteed by the state. Primary education is mandatory and the state guarantees to combat illiteracy. Second: Free education at all stages is a right for all Iraqis. Third: The State encourages scientific research for peaceful purposes that serve humanity. And it supports excellence, creativity, invention and the different aspects of ingenuity. Fourth: Private and public education is guaranteed. This shall be regulated by law.'

Two earlier complementary laws: *1976 Mandatory Education Law (Article 9 [modified][14])* – a first step towards inclusive education in primary school grades 1 to 4[15] – and *Modified 1980 Social Care Act No 126*[16] went some way towards clarifying ministry roles and responsibilities, whereby the Ministry of Education (MoE) became responsible for the education of those with special needs who were not included in Act 126, and MoLSA for the institutional care of the disabled (eg. institutions dedicated to specific disabilities such as visually or hearing impaired) and orphanages.

Albeit important milestones, these two laws did not reflect the complexities associated with disability and special needs care and education, despite the growing number of disabled in Iraq as a consequence of war.

They also promoted division rather than coordination between the ministries and failed to impact in any systematic or meaningful way on Iraq's school and care systems. This failure reflects to a great extent Iraq's economic state due to the debilitating nature of the UN sanctions through the 90s, the resulting paucity of training and modern teaching aids, the loss of specialist teachers and the lack of investment, degradation and insufficiency of school buildings and equipment.

[13] Under Iraq's Provisional Constitution of 1970, the state guaranteed the right to free education at all levels – primary, secondary, post-secondary and university – for all its citizens. This remains the case under the current Iraqi constitution.

[14] *'The Ministry of Education will work to develop special-needs classes in standard schools at the elementary education level for people with learning difficulties, visual impairments, hearing impairments and all those who are not categorised as handicapped and fall within the modified 1980 Social Care Act No. 126, to guarantee their education, care, orientation and enhanced abilities to the stipulated level.'*

[15] Primary School

[16] The study has yet to obtain a copy of the1980 Social Care Act No.126.

This failure was confirmed by the Phase 1 visits to state schools undertaken by Dr Al-Hashemy in the four study governorates (see Section 10 and Annex 6).

3.2 2010 Disability & Special Needs Care Act (see Annex 2) The recent approval (January 2010) by the Council of Representatives of the New Disability Act marks a major new milestone in Iraq's embracing of its responsibilities towards those with disabilities and special needs. The Act has yet to be presented to the Council of Ministers for final approval. The scale of the task of translating the Act into reality on the ground is, however, considerable, not least because of current infrastructural realities of the education and care sector. The role of this study will be to support that translation.

The Act embraces a holistic approach, addressing not only care and education, but also discrimination, coordination, transport, awareness-raising, training and human resources, financial concessions, financial benefits etc (see Box 2). It also creates a dedicated Association with responsibility for all issues relating to those with disability and special needs to ensure achievement of full potential and the wherewithal for a dignified life. Most critically, the Act ensures that the Association Council encompasses representatives from thirteen ministries as well as a Senior Representative from the Office of the Prime Minister, which should

Box 2. 2010 Disability & Special Needs Care Act – key articles (clauses)

Article 1 Provides key definitions (see footnote 16)

Article 2 (1) Providing for the disabled and special-needs people and the eradication of discrimination against them because of disability; ***(2)*** Providing for the requirements of the disabled and special-need people's inclusion into the society; ***(3)*** Establishing the special administrative formations to provide for the disabled and special-need people; ***(4)*** Contributing to securing a dignified life for the disabled and people with special-needs; and ***(5)*** Respecting differences and accepting disability as part of natural human diversity.'

Article 3, (4) 'Providing public and private education opportunities as well as vocational and higher education for the disabled and special-need people.'; ***(5)*** 'Developing the cadres and staffs working in the field of the disabled and special-need people care as well as building and updating a special database thereon.'

Article.5 (1) 'A special body under the name of The Disabled and Special-need People Care Association to be created. This association is to enjoy a moral character with financial and administrative independence and to be represented by the president of the association or the person he authorises'; ***(2)*** establishes links to the Cabinet; ***(3)*** establishes the association's engagement at the federal level. The Association is to be seated in Baghdad with branches in the centres of the federal regions and sections in the governorates that are not joined to a certain federal region.'

Article 7 outlines the members of the Association: Ministry of Finance (MoF), Ministry of Labour and Social Affairs (MoLSA), Ministry of Health (MoH), Ministry of Civil Society Affairs (MoCSA), Ministry of Education (MoE), Ministry of Higher Education and Scientific Research (MoHESR), Ministry of Sport and Youth (MoSY), Ministry of Trade (MoT), Ministry of the Interior (MoI), Ministry of Housing & Reconstruction (MoHR), Ministry of Defence (MoD), Ministry of Justice (MoJ) and Ministry of Planning and Developmental Cooperation(MoPDC) and a Senior Representative from the Prime Minister's office of no lesser standing than General Director.

Article 9 (1) drafting of policies underpinning the work of the Association; ***(2)*** proposal of annual budget; ***(3)*** reporting mechanisms; ***(4)*** proposal of laws, regulations, statutes, and projects; ***(5)*** coordination of specialised bodies to secure needs of disabled; (6) forming of specialised committees; ***(7)*** drafting training, research, awareness raising on prevention of disabilities, reducing effect and the aggravation of disabilities; ***(8)*** Participation and dissemination at international conferences and the sharing and exchange of expertise; ***(9)*** draft statutes clarifying roles and responsibilities of departments, sections and affiliations; ***(10)*** opening of branches in the federal regions or governorates falling outside federal regions; ***(11)*** submission of biannual reports to cabinet.

Article 21 (1) a 10% income tax exemption; ***(2)*** easy loans; ***(3)*** a sliding scale of monthly benefits reflecting degree of disability as assessed by a medical committee; ***(4)*** provision of education, transport, treatment or other relevant service as provided by a mandated agency.

Article 22 tax concessions on private transport for disabled and people with special needs

Article 23 provides legal fee exemption if disabled and people with special needs are prosecuted in court.

finally support a coordinated approach and see the plugging of the 'roles and responsibilities' gaps that currently exist between key ministries: MoE, MoLSA and the MoH[17].

4. Maternity Care in Iraq

Given the focus of this study on early childhood development and children with disability, the nature and quality of Iraq's anti-natal, perinatal and post-natal care is of considerable importance with regard to preventable disabilities and early diagnosis.

Box 3. Comparative Development Figures

<5 Mortality (per 1000 live births) *(UNICEF 1999; MICS 2006):*

- 1984-89 56
- 1994-99 131 (UN Sanction years)
- 2001-06 41

<5 Malnutrition *(UNICEF/MoH 1999; MICS 2006):*

- 1991 9.2%
- 1997 25%
- 2006 21%

The average annual number of births per 1,000 persons in Iraq is 30.09 ranking Iraq 48th highest in world (CIA 2010). 2006-2007 WHO Family Health Survey (FHS) results (see Box 4) compare with the 2006 MICS figures: 88.5% of deliveries attended by skilled personnel and 95.0% in urban areas. In rural areas skilled attendance at births was 78.1%.

4.1 Midwifery Training There are 3 levels of training (MoH/WHO 2004): direct entry programmes at the intermediate level: 3 years after 9 years of general schooling; direct entry 2-year programme after 12 years of schooling; and 2 post-basic programmes: 1 year for graduates of the intermediate and technical levels; 3 months for BSc graduates. Graduate programmes are available in Erbil, Mosul and Baghdad and Karkook Universities with planned programmes in Basrah and Al-Kuffa *(MoH/WHO 2004).* Nurses and midwives teach in the midwifery programmes that are run on demand for even a single student (*ibid*.). There are more than 5,000 traditional birth attendants (TBAs) and new recruits continue to enter this group. About 50% of all deliveries are by TBAs and direct entry midwives (*ibid*.).

Box 4. 2006-07 WHO Family Health Survey (FHS): Key Statistics

Place of Delivery or Abortion/Miscarriage (WHO FHS 2006-07: Table 13) 64.1% of women delivered at hospital compared to 34.3% at home. Hospital deliveries were higher in urban areas (70.0% urban to 55.1% rural). The level of education influences the place of delivery. Home deliveries are higher among women with no education (46.8%) in comparison to hospital deliveries of women with secondary and higher level of education (76.6%). Hospital deliveries are much higher in the 15-19 age group 79.0% but decreases in the higher age group (45-49) where home deliveries are higher. 58.3% of women with abortion or miscarriage seek hospital care, 35.3% home care and 5.3% health centres or private clinic care. Women in urban areas seek hospital care. Higher rates of abortion/miscarriage received care at hospitals in the Kurdistan region (66.0%) than in the South/Centre of Iraq (57.6%).

Delivery Care (WHO FHS 2006-07: Table 14) 79.7% of women were delivered by skilled attendants (doctor, midwife or nurse) and 18.4% by traditional birth attendants (TBAs). More deliveries were attended by skilled personnel in urban than rural areas (85.5% and 70.5% respectively). Deliveries among the age group 45-49 were attended mainly by doctors 44.8%. Only 27.9% of deliveries in that age group were attended by midwife or nurse. Deliveries among women with secondary and higher education were attended more by doctors 55.3%, compared to 36.0% by midwives and nurses. There were noticeable regional differences. In Kurdistan, most were attended by doctors.

4.2 Training Issues Arising Heads and deans of nursing schools may not be nurses and may come from professions such as veterinary science, agriculture or medicine; poor coordination between the MoH and MoHESR in developing and managing nursing education programmes; absence of post-basic training in nursing specialisation; teachers lack qualifications including minimum preparation for a teaching role (MoH/WHO 2004).

The move towards self-financing of hospitals prior to 2003 also resulted in

person's ability due to a defect or incapacity
normalcy; ***'the disabled'*** any person who has
ial life like normal people as a result of a
ion in functional performance; ***'care'*** the
special-needs; ***'rehabilitation'*** a coordinated
cational services for helping the disabled and
ctivity with the aim of empowering them to
g their capacities to becomes self-reliant and
productive members of the society to the greatest possible extent; ***'inclusion'*** the procedures, programs, plans and policies that aim to achieve the disabled person's full participation in the different fields of life without any form of discrimination and on the basis equal treatment to that of others; ***'discrimination'*** Any act of prejudice, exclusion or restriction as a result of disability and special needs that lead to the derogation or abnegation any of the rights secured by the effective laws in the state or enjoyment of the practice of the rights thereof on equal basis.

the re-assignment of facilities previously used by the nursing schools, reducing physical capacity. Many remaining nursing schools are dilapidated, a state exacerbated by the looting following the 2003 invasion. Teaching equipment and materials are scarce and even scarcer in Arabic or Kurdish *(ibid.)*.

4.3 Birth Registration The 2006 UNICEF MICS report states that 95% of children under-five years were registered at the time of the MICS survey. There were no significant variations in birth registration across sex or mother's education, but older children were more likely to be registered than younger children. It is highly likely that the high level of registration is linked to Iraq's Public Distribution System (PDS), a food rationing programme on which approximately 60% of the population depends.

It will be useful to investigate this likely link further during the study, but this relatively high level of registration will considerably ease the task of identifying children of between 0 and 18 years of age in the selected study survey localities.

5. Early Childhood Development (ECD)

The introduction of a conceptual ECD framework will be a central task for this study and an essential component of any future education and community development strategic plan for Iraq. ECD lays the foundation for future learning given that developmental delays often appear in pre-school years. Identifying and addressing developmental delays as soon as possible can help a child to reach the same developmental level as peers and prevent future problems with learning. There is little or no ECD provision in Iraq and little pre-school provision.

Although UNICEF has been and still is supporting a number of initiatives responding to the lack of schools based psychosocial care in Iraq, with a major teacher training programme introduced in 2009, the lack of access to psychosocial care is especially evident among pre-school age children –due in great part to a social bias that has historically failed to embrace early childhood education. Khawla Khanekah, UNICEF Education Officer in Erbil, stated that *"The value of preschool education has not yet been established in the community," she observes, "leaving aside the impact of traumas on the child in the early years of life."* (Catalyst, November 2007).

Box 5. Kurdistan Inclusive Education Programme (KIEP)

Pre-school Education The KIEP caters for children from ages 0 to 18 years. Pre-school level caters for children up to 6 years of age, 0 to 5 being considered the most critical years in the learning life of a child. It is an 'early intervention' teaching programme for children and parents (including other key members of the family) using play, movement and exercise to improve children's abilities, increase the chance of self-reliance and prepare them for primary school. The programme is delivered in the presence of at least one of the parents in an Early Education Centre, ie. either a dedicated space within a school or a hall divided into 3 sections, one for disabled children, another for autistic children and one for meeting with parents. This early learning programme for children with disabilities is supervised by the Special Education Directorate in the Kurdistan Ministry.

Marike Klappe, an Education Specialist for UNICEF Iraq … agrees, noting that *"low enrolment in kindergarten means few children have the opportunity to develop and to find release from the tension of traumatic experiences. This affects school readiness both mentally and emotionally"* (*ibid*.).

The introduction of the Kurdistan Inclusive Education Programme (KIEP) by KRG Minister of Education in 2006, encompassing a crucial ECD component, provides a useful model. This programme was also established with the financial support of UNICEF amongst other international organisations and is managed by a Special Education Directorate within the KRGMoE created for the task (see Box 5).

Box 6. Definition of Special Needs

The Iraqi National Scientific Committee on Special Education (NSCSE) defines the concept of a slow-learning child as 'A normal child in his general framework but one who finds a difficulty for one reason or another to attain the average educational level his normal peers attain. Moreover, he is not to be classified within the category of the mentally-retarded people.' (Special-Education Pupil Examination and Diagnosis Sheet, NSCSE, Ministry of Education, 2009; see Annex 5).

6. Disabled Children in Iraq

The UNICEF Multiple Indicator Cluster Survey MICS (2005–06) provides cross-sectional data on the percentage of children screening positive for or at risk of disability for 191,199 children aged 2–9 years in 18 countries worldwide. Children screening positive for disability in Iraq were 21%. In many countries, children not attending school were more likely to screen positive for disability than those attending school, indicating that programmes monitoring the frequency of child disability

in countries with low and middle incomes through schools will be incomplete. These results also emphasise the possibility that children with disabilities are unlikely to share the same education opportunities as their non-disabled peers (Gothlieb *et al.* 2009). Reliable data on services for children with disabilities in Iraqi is extremely limited. A 1999 overview report (Williams 1999) for submission to the UN Security Council Panel on Humanitarian Affairs echoes the WHO 2005 findings (see Box 9), stating that before 1990 there were 43 institutions for children with disabilities (of which 18 in Baghdad) with a modest total capacity of 5,000, run and supervised by MoLSA. The UN sanction years led to a chronic lack of investment and by late 1991 all four specialised training institutions and national coordinating institutions (Referral Institutions and the National System for Disability Prevention and Early Detection) were closed. The chronic lack of educational and training materials and reduced educational capacity resulted in increased economic vulnerability of families with disabled children who presented an additional financial burden. Williams notes that children with disabilities (physical or mental) were discriminated against in the mainstream schools and refers to intense competition between disabled unemployed adults and unemployed non-disabled adults.

Box 7. World View: Children with Disability

Disability is a worldwide health concern affecting up to 25% of the world's population (UNICEF 2003; UNDP 2003). The situation concerning children is dramatic. They make up around a third of the world's disabled population, of which 65% is preventable (Peat 1997). For every child killed in a conflict situation, three more are permanently disabled (UNICEF 2003). According to Inclusion International (2004), 98% of children with disabilities in low income countries do not go to school.

The causes of disability include infectious diseases like malaria, polio and leprosy, tuberculosis, trachoma, otitis media, meningitis and parasitic diseases. The second major causes are war, trauma or accidents (primarily road accidents). The third most common cause of disability is congenital and non-infectious diseases such as epilepsy (WHO 2003).

Poor quality perinatal care results in disabilities such as cerebral palsy (Helander 1993) and other causes of disability include malnutrition due to vitamin A, iron and iodine deficiency (Durkin 2002) and chronic medical conditions such as rheumatic diseases and diabetes. The HIV/AIDS epidemic has further contributed to the prevalence of disability because many people living with HIV develop different types of impairments and functional limitations (Chase *et al.* 2000).

Many children living with disabilities live in rural or remote areas that seriously impact on their ability to access available services due to cost, lack of public transportation and lack of knowledge about available services. Families from remote and rural areas may never see healthcare professionals. Even if the services are available, the cost of medical care will be prohibitive to most families (Cameron 2005).

6.1 Overall Disability Statistics for Iraq The 2007 World Bank Iraq Household Socio-Economic Survey report provides statistics on the type and number of disabilities and causes of disability by age, sex, governorate and rural vs. urban. Disability categories 'limp, walking or movement disability', 'mental retardation' and 'other' formed the highest % of disabilities across all age groups and governorates and was equal for males and females (see Table 14, Annex 1). The highest percentage of individuals with a 'limp, walking or movement disability' was in Baghdad followed by Erbil, while the highest percentage of 'mental retardation' was found in Najaf followed by Basrah and the highest percentage of 'other' disabilities was found in Erbil followed by Basrah (*ibid.*). The cause of disability across all age groups was overwhelmingly 'born with disability', followed by 'war', 'disease' and 'other' (see Table 15, Annex 1). A higher percentage of causes that were related to 'work', 'landmines', 'civil conflict', 'war' and 'traffic accidents' was recorded for men, while the percentage of 'born with disability, 'disease' and 'other' causes was higher for women (*ibid.*). The highest percentage of people born with their disability was recorded in Najaf while the highest percentage of disabilities caused by work and landmines was found in Erbil (*ibid.*). The highest percentage of disabilities caused by war were found in Baghdad and followed by Basrah while disabilities caused by disease were highest in Basrah followed by Najaf (*ibid.*). The most prevalent types of disability were 'walking' and

Box 8. Diagnosis of Special Needs

MoLSA has only one central medical committee in Baghdad, composed of a psychiatrist, an ENT specialist and an orthopaedic surgeon, which is the only authority that determines the type and degree of disability. According to their diagnosis a person can qualify for social care. Most of the children in social care establishments suffer from severe disabilities and are unable to attend regular schools. In other governorates, medical committees affiliated to the MoH undertake the task of diagnosing disabilities in children.

If a child has not been diagnosed in its pre-school years then its first diagnosis will take place as part of the school enrolment and assessment process and if found to have special needs, the child will be reassessed on an annual basis thereafter, although in reality this annual follow-up is far from systematic. *The diagnostic form used is attached as Annex 5.*

'physical movement', followed by 'mental retardation' and 'blindness' (see Table 16, Annex 1). Across all disability types, the number of people with these disabilities was higher in urban areas than rural areas (*ibid*.).

6.2 Child Disability Statistics MICS 2006 data held by the Ministry of Planning and shared with Dr Al-Hashemy during a meeting dated 23 August 2009 (see Table 1, Annex 8) indicated that 15% of Iraqi children had at least one disability and that the percentage of disabilities was highest in the central governorate urban areas as compared to other urban areas (15%) dropping to 12% in rural areas (*ibid.*).

The most common disability was with speech and difficulty sitting, standing and moving, each recorded at 5%. In the Kurdistan governorates the highest levels of disabilities were recorded at 19%, while in the other governorates it was recorded at 14%. Erbil recorded the highest overall percentage of children between 2-14 years old with at least one disability (25%) while Najaf governorate had 20% of children between 2-14 years old recorded as having at least one disability, the most common of which was the difficulty of sitting, standing and walking recorded at 7% (*ibid*.).

Box 9. Care for the Disabled (Source: WHO 2005)

Iraq saw considerable growth in the area of disabled care, special services and dedicated institutions in the twenty years from 1979 to 1999, with specialist institutions rising from 11 in 1979 to 51 in 1987 and a parallel increase in capacity from 3,220 to over 7,000 in 1987, before dropping back to 47 institutions with a 5,327 capacity in 1999. During this period of growth, institutions existed for social and psychological care, for disability diagnosis, and for the physically disabled. The number of institutes for the deaf reached 22, of which 7 in Baghdad. The institutes ran 2- phase programmes: nursery for 3 to 6 year olds and primary school for 6-9 year olds.

MoLSA continued to support the disabled under the 1980 Law No. 126 for those without work or suffering from disease or disability, by providing a monthly 'salary'. Resolution No.208, also issued in 1980, aimed to assist 30,000 disabled people to access employment from 1980-1991, work which ceased due to the financial constraints of UN sanction years.

Year	No. of Institutes	Male	Female	Total
1979	11	1,333	1,887	3,220
1987	51	2,918	4,242	7,160
1990	44	2,690	3,903	6,593
1999	47	2,177	3,150	5,327

The use of different categories in the recording of statistics on the disabled, however, renders direct comparison impossible. For example, the 2006 MICS statistics record disability in terms of 'difficulty with speech, sitting, standing and moving' whereas MoLSA uses categories such as 'deafness and muteness' and 'acute retardation' (see Section 6.5 below).

6.3 Disability due to Conflict-related Injury Events post-2003 have seen a further increase in disability due to conflict related injury in the overall Iraqi population. During a 6-month period (April to September 2004) the MoH operation centre reported around 3,800 deaths and 15,500 injuries resulting from terrorist activity and military operations (MoH 2004 'Health in Iraq').

6.4 Blindness and Low Vision[18] The data on blindness and low vision[19] in this section originates from two 1994 and 1997 MoH surveys (MoH 2004 'Health in Iraq'). The 1994 survey found the prevalence for blindness in the overall Iraq population to be 0.5%, with more than 33% of blindness cases caused by cataract and about 20% of cases due to glaucoma. The 1997 survey on a cluster sample of 80,000 people, revealed prevalence for blindness and low vision at 0.64 and 0.68 respectively (MoH 2004 'Health in Iraq'). More than 51% of cases of blindness occurred under the age of 60. About 6% of blindness occurred in children in the age group below 10 years and about 10% occurred in the age group below 18 years (MoH 2004 'Health in Iraq').

6.5 Institutional Care for Children As noted earlier, MoLSA is responsible for institutional care and the provision of benefits. Although there is a Central Government allocated budget to cover food, transport

Box 10. 2009 Child Social Care Establishments

Dr Al-Hashemy 17 August 2009 meeting with the Minister of Labour & Social Affairs (see Table 1, Annex 8)

There are 90 MoLSA Child Social Care establishments (educational and vocational) for people with special needs across Iraq (excluding Kurdistan) caring for 3088 beneficiaries (1901 male/1187 female) aged between 2-16 years suffering various physical and mental handicaps as follows: Baghdad: 29 units, 1502 beneficiaries; Basrah: 6 units, 268 beneficiaries; Al-Najaf: 5 units, 204 beneficiaries. Between them these institutions have a total 993 employees: Baghdad 884; Basrah 77; Al-Najaf 32, although only 10% hold a first degree.

Most children in social care suffer from severe disabilities and are unable to attend regular schools.

[18] Blindness is defined in the 2004 MoH 'Health in Iraq' rep
both eyes after correction with spectacles, while low vision is
chart after correction with both eyes.

[19] Terminology as used in the 2004 MoH 'Health in Iraq' repo

and other Social Care Establishment facilities, as in the education system, staff lack training and the units require modern educational facilities. Over 200 social workers are available but their lack of experience makes them largely ineffective.

Annex 1 Tables 18-24 provide 2008 MoLSA statistics on the numbers of beneficiaries in care homes, institutions and workshops according to type of disability, age group, sex and governorate, excluding Kurdistan. The highest number of beneficiaries in the 3 Central/South study governorates was in the age group 9-12 years, followed by those aged 6-9 years (see Table 18, Annex 1). The lowest number of beneficiaries in care institutions and workshops was in the age group 15-18 years (*ibid*.). The predominant disability of beneficiaries in care homes and workshops was 'deafness and muteness' at 20%, followed by 'acute retardation' (16%), 'severe hearing loss' (11%), 'simple hearing loss' (10%) and 'moderate retardation' (8%) (see Table 19, Annex 1). In each of these categories, the number of male beneficiaries was more than double the number of female beneficiaries, except for the category 'deafness and muteness' where the number of male and female beneficiaries was roughly equal (*ibid*.). Institutions specifically for the care of 'the deaf and mute' cater for the highest number of beneficiaries at 1,563 (see Table 20, Annex 1), followed by institutions for individuals suffering from 'mental retardation' with 830 beneficiaries (see Table 22, Annex 1) and individuals with motor disabilities and the blind with 289 beneficiaries (see Table 21, Annex 1).

One of the shortfalls of the MoLSA data is that it only provides information on children formally engaged in the institutional care system and misses out all those who are not. This key data will be captured by the survey phase of this study.

Although MoLSA is responsible for the provision of social care to the disabled and elderly within a network of institutions across Iraq's governorates, doctors and health personnel providing healthcare to these categories are seconded from the MoH.

A further key area for investigation as part of this study will be to fully understand individual ministry mandates in a system which despite some overlap demonstrates a considerable lack of collaboration between key ministries: eg. MoE, MoLSA, MoH, Ministry of Planning. The newly drafted Disability Act Association clearly seeks to address this absence of collaboration.

7. Mental Health Status and Care in Iraq

The stigma attached to mental health remains a major challenge, especially in low and middle income countries (such as Iraq) where there may be considerable indifference and a lack of scientific knowledge about mental health issues (Syed *et al.* 2007).

As part of the Phase1 secondary data gathering exercise, a background paper was drafted by Dr Abdul Kareem Al-Obaidi, an Iraqi child psychiatrist, Chair of the Iraqi Association for Child Mental Health, and the study research team's adviser on child mental health in Iraq. The purpose of the paper was to illustrate realities on the ground and increase understanding within the study research team of child mental health issues in the context of Iraq. Dr Al-Obaidi drew on personal experiences, as well as more formal sources. The following section incorporates extracts.

Box 11. Attitudes to Mental Health (Source: WHO 2006/07)

The WHO 2006/07 Family Health Survey report notes that the occurrence of mental disorders in the community might have been underestimated. There are a number of cultural factors that are important in understanding the prevalence and pattern of mental disorders in the population of Iraq. Some of these are: the high stigma associated with mental disorders in ... Iraq […] could limit acknowledgement of symptoms and their reporting to interviewers by respondents; the long conflict period could have contributed to ... acceptance of some of the conflict experiences as 'normal' for the population (considering their personal abnormal reactions as 'normal' reactions since everyone in the population is experiencing the same); the development of resilience in the population due to repeated exposure to conflict and adverse events; and the role of available social support from family and the community, [including] the protective role of religion.

The 2006 WHO Report, 'Healing Minds' refers to *"an overall impression that a large part of the population has been experiencing a wide variety of mental health and substance abuse problems in the last three years"* but the lack of research on the subject has made it difficult to gauge the true scale and impact of the ongoing insecurity in Iraq post 2003 on the mental health of the Iraqi population. Clinical impressions suggest large-scale problems, particularly in relation to post-traumatic stress disorders (MoH 2004 'Health in Iraq'). With a

predicted affliction of more than 10% of any population with different psychiatric disorders, the people in Iraq are clearly rendered more vulnerable due to the years of continuing violence they have been subjected to. Studies conducted in several residential areas in Baghdad where bombing and explosions took place reveal high rates of post-traumatic stress disorders particularly amongst children (MoH 2004 'Health in Iraq').

7.1 Mental Health Care Facilities Professional care for the mentally ill in Iraq began about 60 years ago with the introduction of mental health hospitals. Mental healthcare within the general hospital system was only introduced three decades ago (Sadik and Al-Jadiry 2006). There are currently two state psychiatric hospitals, both in Baghdad, and 23 psychiatric units attached to general hospitals across Iraq, 16 in Baghdad (WHO 2006 'Healing Minds'). Six are university-based departments, and the MoH runs all facilities (*ibid*.). Interest in child and adolescent mental health (CAMH) is a comparatively recent phenomenon in Iraq (Al-Obaidi *et al.* 2009a). There are, consequently, no separate inpatient mental-health services for children and adolescents. Child and adolescent mental health (CAMH) services are usually provided in outpatient mental clinics for the general population. Psychiatric drugs are almost exclusively the mode of therapeutic intervention.

Box 12. Impact of Risk of War on Children Post 2003

A study carried out in January 2003 with field visits to Baghdad, Basrah and Karbala, concerning the psychological impact of the imminent threat of conflict on Iraqi children, and the ability of these children to withstand the current troubles was collected from more than 100 households in Baghdad and Basrah. In addition, in a second study, over 200 12-year-olds completed a questionnaire to assess their mental health.

In the first study, 21 families were visited and in-depth interviews conducted with 85 children and youngsters aged 4 to 18. The family visits were conducted in different areas of Baghdad and Basrah. With few exceptions, the entire group reported that the imminent threat of war was influencing their daily lives. Most think about the threat every day. The fear engendered in this threat generally manifested itself via thoughts of death- both of family members and themselves- and in general feelings of fatigue, resignation, sadness and detachment. There was a very visible lack of communication between parents and children, with the children being ill informed and therefore more apprehensive about the impending war. Children as young as four and five years old were found to possess real concepts of the physical threats of bombs and guns: destruction of houses, burning homes, and the killing of people. More than 50% of the group reported sleeping problems and nightmares. A majority stated that they suffered from severe concentration problems.

In the second study, two schools were visited and 232 questionnaires were collected from children aged 10 – 16 years (mean age of 12.7 years). The three-page questionnaire consisted of an Iraqi Child & Adolescent Questionnaire, The Impact of the Threat Questionnaire, and the Birleson Depression Inventory. In response to the questionnaire, 68% of children feared they might not live to be an adult, 88% feared something terrible might happen to their families, 62% had intrusive thoughts about the threat of war, 60% had difficulty concentrating or paying attention, 67% showed feelings of hyper arousal, 54% thought life was not worth living and 66% felt lonely and isolated. *Source: WHO 2006*

Al-Rashid Mental Hospital, established in 1956 in Baghdad, is a long-stay institution with a forensic psychiatry unit. It has bed strength of 1300, of which 250 are forensic psychiatry beds (WHO 2006 'Healing Minds'). Ibn Rushed Psychiatric Hospital, established in 1968, is a short-stay hospital with 74 beds also located in Baghdad. There is also an attached drug dependence centre with 15 beds, established in 1979 (*ibid*.). Psychiatric units in general hospitals have bed strengths of 20 beds. Child mental health facilities are also available. These units are located at the Baghdad Teaching Hospital (30–40 beds), Al-Yarmouk Teaching Hospital (12 beds), Al-Kademia Medical College - formerly known as Saddam Medical College Teaching Hospital - (20 beds), Mosul General Hospital (30 beds), Basrah General Hospital (30 beds) and Al-Najaf General Hospital (30 beds) (*ibid*.). Al-Mukhtar Hospital in Baghdad, founded in 1989, is a private hospital with 20 beds. There are also 12 schools and institutes for the mentally disabled, under the supervision of MoLSA (*ibid*.).

There are outpatient psychiatric clinics in all the general hospitals. In addition, the mental health component of the general medical services is being developed and general practitioners and medical assistants are receiving specialised mental health training. There are a few community care facilities such as homes for the elderly in Baghdad and Mosul, and institutes for homeless children and orphans (*ibid*.).

The WHO Report also notes *'the increased fear of rape and the lack of general security have had a profound psychological effect on women'* and that *'creeping religious conservatism, lawlessness and economic uncertainty have also been conspiring against them in peculiar ways. Parents so rattled by reports of rapes*

and kidnappings keep their girls under a closer watch than ever before. Girls accustomed to pool outings and piano lessons are instead locked up at home.'(*ibid.*)

7.2 Child & Adolescent Mental Health (CAMH) in Iraq One small CAMH clinic was established in the Baghdad Central Child Hospital after 2003, but with very limited resources. There are also a number of institutes for special needs children and residential homes for orphans. Lack of resources and trained staff undermine the services within these institutions. Behavioural play and other forms of psychotherapy are not routinely practiced.

In a media interview in 2004, the UNICEF Iraq representative stated: *"aside from physical suffering, an estimated 500,000 traumatised children in Baghdad and other besieged cities would need psychosocial rehabilitation after the war."[…] "'the prevalence of psychological distress is high […] [C]hildren display changes in personality such as low mood, lack of initiative, indecisiveness and an inability to plan for the future."* (BBC World, 2004).

Box 13. Mental Health in Iraq Post 2003

These findings are from a 2006-7 WHO survey in which one adult (aged 18 or over, male or female) was randomly selected in each surveyed household to complete a self-reporting questionnaire (SRQ) to assess mental health state, using 20 questions on specific health events relating to the previous 30 days.

% of Positive Answers More than 50% had felt nervous, tense or worried in the preceding 30 days. A large proportion indicated they were easily tired, often had headaches and felt tired all the time. 3.5% of respondents stated that they had thought of ending their own life, while 7.8% had thought themselves a worthless person.

Regional Differences South/Central respondents had a higher proportion of positive answers than Kurdistan respondents, a situation reversed where there was less agreement, eg. in the South/Central region 16.7% agreed with the statement that they cry more than usual. In Kurdistan the percentage of people who agreed with this statement was 22.1%. The percentage of females agreeing with SRQ statements was almost always higher than that of males and in some cases this difference was extreme, eg. only 17.8% of men said they were easily frightened, in contrast to 37.0% of females. Difference was also seen by age, with those of 50 years and older having a higher agreement percentage for each question.

Overall Findings 35.5% of respondents had a mental health score of 7 or more and can be considered as having significant psychological distress and potential psychiatric cases. There is a gender difference with regard to the SRQ score: 40.4% of females scored 7 or more as compared to 30.4% of males. The score was also higher as the age group increased: almost half (49.9%) of those 50 years and older are in this category, compared with 35.1% of 30-49 year olds and 27.3% of 18-29 year olds. The difference between regions is negligible.

Source: WHO FHS 2006-7: Table 21

The Iraqi juvenile justice system is supported by general psychiatrists and a small team of psychologists and social workers. However, they have no specialised training in the treatment and rehabilitation of young offenders. There are also no CAMH services in Iraqi schools.

7.3 Impact of Conflict and Insecurity on Child Mental Health Since the 2003 invasion, hundreds of thousands of Iraqi citizens have been killed or injured, amongst which tens of thousands of children (Burnham *et al.* 2006). It is estimated that 50% of the four million internally displaced or refugee Iraqis, are children.

Children's needs in times of crisis are complex and intimately linked to their need for fundamental security, food, shelter, education and family connection. The violence of the past 6 years has left a significant number of orphans for whom no organised services are available. Malnutrition, deterioration of education services, increasing truancy, child labour and child trafficking, all threaten the well-being of Iraqi children (Al-Obaidi *et al.* 2009b). Reports also indicate that insurgent groups and militias are increasingly involving minors in Iraq, including orphans and children of insurgents, in armed operations including the use of children in car bombing (MSNBC 2008). Children have also been arrested and detained. A 2005 Human Rights Watch report states that children are held in the same cells as adults and subjected to the same treatment, including torture (HRW 2005).

The fundamental security of Iraqi children has been violated and redressing this will require a holistic, rights-based approach with resources to meet their basic needs, advocate for their security and protection, recognise and meet the needs of more vulnerable children or refer them to agencies with appropriate resources (Jones 2008). Although the recent armed conflict in Iraq has had a profound impact on children, the origins of the

poor public healthcare system, infrastructure, schools and mental healthcare have their roots in the decades immediately preceding 2003. Access to health services for under-fives is extremely limited, particularly in rural areas, and under-five mortality rates in Iraq are amongst the highest in the Middle East region (Awqati *et al.* 2009).

Children exposed to armed conflicts are more likely to have mental disorders (Attanayake *et al.* 2009). Living with constant risk of harm during exposure to armed conflict has unique emotional, social, trans-generational and ideological influences on child development (Punamaki 2008). The situation is even more complex for Iraq's disabled children increasing the risk of violence, abuse and exploitation, and there is concern about an increase in physical violence against children within families.

It is difficult to obtain precise figures on the prevalence and severity of child and adolescent mental health disorder, and on the scale of unmet need for treatment due to a number of factors including: limited data; lack of awareness and understanding of CAMH; lack of local CAMH expertise; lack of funding; lack of research skills and tools; the low priority placed on data collection by state agencies, and the dangers of conducting research in insecure areas. This said, the extant literature provides important insights: Ahmad *et al.* (1998) reported a high prevalence of post traumatic stress symptoms among a sample of displaced children at the Iraqi-Turkish border in Kurdistan in the aftermath of the 1991 Gulf war. 20% of these children reportedly met the DSM-III-R[20] criteria for post traumatic stress disorder (PTSD). In 2005, PTSD was reported among 14% of children in Baghdad, and 30% in Mosul (Razoki *et al.* 2006). Jones (2003) provided an account of children's worries and fears facing daily hazards and discomforts in IDP camps in the north of Iraq. Data from a cross-sectional study in the city of Mosul revealed mental disorders amongst 37.4% of children and adolescents attending primary health care (PHC) facilities. The most common disorders included post-traumatic stress disorder (10.5%), non-organic enuresis (6%) and separation anxiety disorder (4.3%). Depression was reported in only 1.5% of cases and there were 9.4% of cases of co-morbidity (PTSD and depression) (Al-Jawadi and Abdul-Rahman 2007). In 2006, in Nassiriya, a city in southern Iraq, ADHD was found among 15% of school children (Sadik *et al.* 2008).

Box 14. Mental Healthcare Training

At the time of publication of this report, a postgraduate programme leading towards a full qualification in psychiatry (Iraqi Board of Psychiatry and Arab Board of Psychiatry) was available with 10 positions per year at five centres. A two-year MSc course in clinical psychology started in 1994 in Baghdad. There were 2 courses of training for psychiatric social workers conducted annually. As far as the teaching of paramedical personnel was concerned, graduates from the University Nursing College in Baghdad received good theoretical and practical training in psychiatry, but all other health workers (nurses from the nursing schools, medical assistants, and auxiliaries) only received theoretical training in psychiatry. All medical schools taught undergraduate mental health care during the 2 years of basic sciences. There were approximately 15 hours of lectures in psychology. During the 3 years of clinical teaching, there were around 30 hours of lectures in psychiatry. During the 5th and 6th years, some 60 hours of clinical training were given on the wards to groups of 8 to 10 medical students at a time. During the internship period (2 years), rotation in psychiatry was obligatory for 1 month, while a further 3 months in psychiatry was optional.

Source: WHO 2006 'Healing Minds'

In a study conducted at the child psychiatric department of the general paediatric hospital in Baghdad in 2005, the distribution of diagnoses included: anxiety disorders (22%), behavioural problems (hyperkinetic and conduct disorders) (18%), non-organic enuresis (15%), stuttering (14%), epilepsy (10%) and depression (1.3%) (Al-Obaidi *et al.* submitted for publication). Many reports have indicated the problem of drug and sexual abuse among children and adolescents in Iraq (Al-Obaidi *et al.* 2009b), but it is again difficult to know the real scale of this problem given the limited number of drug abuse cases registered in the clinical sample of children and adolescents in Iraq. Al-Obaidi *et al.* (submitted for publication) suggest that only 1.3% cases of drug abuse are registered.

7.4 CAMH Human Resources Of the approximately 100 qualified psychiatrists in Iraq, none has formal training in CAMH or Learning Disabilities. The following figures demonstrate the paucity of local mental health specialists, which in 2009 totalled seven general practitioners, 145 psychiatric nurses, 16 psychologists and 25 social workers (WHO 2009, Table 2). Two INGOs – Diaconia and International Medical Corps (IMC) – have run CAMH training programmes, the first in psychotherapy, primarily in northern Iraq, and IMC on

[20] DSM refers to the Diagnostic and Statistical Manual of Mental Disorders which is published by the American Psychiatric Association. It provides a common language and standard criteria for the classification of mental disorders. DSM-I was published in 1952 and DSM-III in 1980, DSM-III-R was revised and published in 1987.

orphanage rehabilitation and mental-health training programmes for primary healthcare doctors, primarily in Central Iraq. There is a general lack of mental health awareness in Arab countries, and low priority is given to mental-health within general healthcare policies, which is the case in the majority of developing countries (Al-Sharbati *et al.* 2003; Murthy 2008). The picture is even gloomier in countries like Iraq where there are almost no proper CAMH services, in spite of additional needs caused by wars and economic sanctions. Even for children, stigma exists around psychosocial needs (Catalyst, November 2007).

Khawla Khanekah again: *"There is a common view in Iraqi society that counselling is only for persons who are not mentally sound"* (ibid.) *…"There were psychosocial support centres established by the Ministry of Labour and Social Affairs, one in each governorate. But these efforts were not school-based, and they were handed over to the Ministry of Health two years ago – a further indication of the association between asking for psychosocial help and being considered mentally ill"* (ibid.).

8. The Role of the Voluntary Sector

Lack of funding reduces the effectiveness of NGO and CPO activities. However, in the mental healthcare sector it seems that voluntary organisations play a major role in providing and supporting state services.

Box 15. Conferences on Disability attended by Dr Al-Hashemy, Iraq August 2009

"Caring for People with Special Needs is a National Humanitarian Duty" 16-20 August 2009

Over 1500 individuals with special needs attended the 4-day conference held by The Republican Assembly for People with Special Needs which was also attended by specialised ministries and NGO representatives. Lectures and speeches delivered at the conference exposed the extent of the plight of the 4.5 million people with disabilities in Iraq.

Conference Recommendations:

1- National Forces, Political Movements, Parties and NGOs were urged to exercise pressure on decision-makers to pay special attention to the issues of people with special needs.
2- Establishment of an official body responsible for the disabled and legislation to protect them with branches in all ministries and governorates.
3- Health Establishments should provide precautionary, technological and health services to avoid anomalous births and reduce disability in society. This is to be achieved through provision of medicines that directly affect birth anomalies and other disabilities.
4- The media was requested to play a role in changing the negative social view towards people with special needs.
5- Provision of suitable employment and increasing rehabilitation opportunities to allow the disabled to function as a working force to serve the community.
6- Forming a committee affiliated to the conference to follow up the implementation of these recommendations. The committee should keep contact with societies specialized in tending people with special needs to achieve their demands. It should also coordinate and exercise pressure on parliament, government, international and local establishments to provide care and attention to this category.

"The Handicapped take part in the construction of New Iraq" August 2009

The conference was attended by The General-Secretary of the Ministers' Council, several Ministers, MPs, Red Cross & Red Crescent representatives, the UNAMI Mission in Iraq and academics.

Conference Recommendations:

1- Speed up the activation of constitutional article 32 which stipulates government care and rehabilitation of disabled people to allow them to be incorporated into society.
2- To speed up the establishment of the Independent National Body for Affairs of the Handicapped as stated in the constitution. The Body, as stated, should include the handicapped themselves. [The Prime Minister has confirmed support for a draft bill sent earlier to the State's Consultative Council on this issue]
3- Speed up signature and approval of the UN International Agreement for the Handicapped. The agreement signed by 142 countries includes 50 legal items securing indiscriminate and decent life for the handicapped.
4- Signature and approval of the Oslo Agreement banning the manufacture, use and handling of cluster bombs. Item 5 of the agreement secures the rights of cluster bomb victims and Iraq is considered as one of the most affected countries.
5- Activate the political participation of the disabled. Facilitate their participation in elections through convincing political blocs to grant them the opportunity to run for elections and represent the 4.5 million unrepresented disabled people in the country.
6- Facilitate and encourage marriage of the handicapped through facilitating government grants and by paying special attention to disabled women
7- Providing care for little people and drafting measures to incorporate them into society
8- Encouraging importation of special aids, such as sound computers, Braille writers and printers to prepare text books enabling independent study for the blind.
9- Increasing public awareness of sign language and encouraging its use.
10- Backing organisations in charge of the mentally disabled and encouraging voluntary work.
11- Application of suitable moral standards and providing decent living conditions for the disabled victims of war and veterans similar to those in other countries.
12- Launch of a national campaign to raise awareness of the rights of the disabled, shedding light on their points of strength and potentials to change prevalent views against them.

These organisations support children, the elderly, mental health patients, and care providers (WHO 2004-06). The MoH has established a bureau to liaise with them and coordinate their activities through partnership.

There are four identified mental health voluntary organisations: Heartland Alliance, Diakonia, Movimondo and Together (*ibid*.).

Dr Al-Hashemy met with a number of NGO and voluntary organisations (Tables 1-4, Annex 8), but further work will need to be done to clarify their true role.

9. Benefits: 'Social Salaries' in Iraq

The World Bank Iraq Household Socio-Economic Survey (2007) provides statistics on the per capita nominal income by income source and governorate, including benefits, or 'social salaries' (WB IHSES Part 2, Table 9-3). In Central/South governorates, the percentage of income derived from 'social salaries' was found to be highest in Baghdad at 6%, followed by 4.7% in Basrah and 2.7% in Najaf (*ibid*.).

10. The Iraqi Education System

The Iraqi education system was extremely well regarded in the 1970s and early 1980s following a period of purposeful investment that led to improvement at all educational levels and near universal enrolment in primary school by 1980 (MoH 2004 'Health in Iraq'). By the 1990s, however, the education sector had entered a period of steady decline. Initially the result of irrational policies and the politicisation of the education system, influencing the curriculum, teaching staff and admission policies (MoH 2004 'Health in Iraq'),and then the result of the economic impact of war and UN sanctions that between them devastated an already weakened infrastructure, with the final act following the 2003 invasion, when Iraq's educators, amongst other key professionals, became the target of a campaign of assassinations which left hundreds dead and drove thousands more into exile.

Two decades of wars and economic hardship have seen Iraq's schools fall into disrepair, enrolment drop, and literacy levels stagnate. Iraq's adult literacy rate is now one of the lowest in Arab countries; in 2007 UNESCO estimated literacy rates to be less than 60%, or 6 million illiterate Iraqi adults (*cf*. USAID 2007a). Rural residents and women have been hit hardest; only 37% of rural women can read, and 30% of Iraqi high school-age girls are enrolled in school compared with 42% of boys (*ibid*.).

The 2005 Iraq Constitution enshrines the right to free education for all across the education spectrum, but only primary school education is compulsory. Universal literacy is now a key goal.

Box 16. Levels, Grades & Entry Age

Pre-school	Grade 1	4years
	Grade 2	5years
Primary	Grade 1	6years
	Grade 2	7years
	Grade 3	8years
	Grade 4	9years
	Grade 5	10years
	Grade 6	11years
Secondary		
Intermediate	Grade 7	12years
	Grade 8	13years
	Grade 9	14years
Preparatory/	Grade 10	15years
Vocational	Grade 11	16years
	Grade 12	17years
Higher Ed.	Grade 13	18years
	Grade 14	19years

The education system caters for a national population of some 31.9 million (COSIT 2008) and comprises four separate levels: *Pre-school* (ages 4 to 5), *Primary* (ages 6 to 11), *Secondary* encompassing Intermediate (ages 12 to 14), Preparatory/Vocational[21] (ages 15 to 17) and *Higher Education* (ages 18 and above). The Ministry of Education (MoE) is responsible for pre-school, primary and secondary education, as well as teacher training institutes and the Open College of Education. The Ministry of Higher Education and Scientific Research (MoHESR) is responsible for higher education: universities and technical institutes.

Overall enrolment and attendance across the school system have been in steady decline over the past two decades. Security factors have also impacted on teacher attendance. Family poverty has been another major cause of drop-outs, with girls particularly vulnerable in rural areas where female attendance has dropped to 50% in some areas (MoH 2004 'Health in Iraq').

The male to female pupil enrolment and attendance ratio varies according to education level and location, but urban enrolment and attendance rates are consistently higher than rural ones at all levels including pre-school and a direct correlation has been identified between the mother's education level and enrolment, again at all levels (MICS 2006).

[21] Offers a choice of Scientific, Literary, Commercial, Industrial, Teacher's Institution, Home Art, Agricultural, Teacher's Training Institution, Institute of Fine Arts

Transport to facilitate access to schools, in rural areas in particular, is another factor amongst a number of factors impacting on attendance and the extent of this and other security or social factors will be important to assess in Phase 4 of the study: the four governorate survey.

10.1 Educational Infrastructure There are approximately 15,000 schools nationally, thousands of which do not meet minimum health standards. Poor school stock is having an increasingly negative impact on the quality of education and attendance rates. A 2004 MoH report concluded that 80% of school buildings required significant reconstruction, over 1,000 required a total rebuild and a further 4,600 major repair (MoH 2004 'Health in Iraq'). These figures were confirmed in 2007 by UNESCO and UNICEF who found that 70% of school buildings were suffering from war damage or neglect (*cf*. Relief-Web/UCHO 2008).

It has been estimated that an additional 4,500 schools are required to meet the current demand, a shortfall that has led to the introduction of shift systems within schools, as well as the sharing of school buildings by 2 or even 3 different schools (MoH 2004 'Health in Iraq'). In 2004, almost 50% of schools were in double shift use and 2% triple shift use (UNESCO 2004). This extensive use of multiple shifts has a considerable detrimental effect on the learning environment and pupil's hours of study and presents a major challenge in the task of restoring quality education. The school visits undertaken by Dr Al-Hashemy in 2009 confirmed that the practice was ongoing and common.

Box 17. Rebuilding of the School Sector - Government & NGO Activities 2006-2009

(Information obtained by Dr Al-Hashemy from meetings with key ministries August-September 2009)

1. Two memoranda of understanding and mutual cooperation were signed between the government and the Ammar Charitable Organisation and the International Medical Association for the purpose of supporting the educational system with programmes and projects serving the educational process.
2. The work of local and international organisations has helped to rehabilitate damaged schools as well as maintain school buildings. New schools have also been built in Baghdad – particularly in Sadr City. UNICEF is currently implementing a project to build 25 new schools to replace the clay-built schools in the governorates of Mosul, Thiqar and Salahaddin.
3. International and local organisations have undertaken projects to furnish and equip schools suffering from lack of facilities like laboratories, play grounds, sport fields, computers and libraries in addition to drinking water systems, particularly in rural areas.
4. Local organisations have set up classes targeting illiteracy in addition to setting up health, psychological and educational awareness-raising courses in rural and marsh areas.
5. Governmental and non-governmental organisations have set up training workshops to raise awareness of human rights, democracy and children's rights, in addition to programmes and projects to reactivate Parent-Teacher Councils to form links between family and school.
6. Projects to improve the quality of education and the performance of teachers in the use of teaching aids have been done and include a UNICEF project to train teachers as well as training leaders to be trainers of teachers. The deanery of the Training & Educational Development Institute has adopted this programme in addition to the 'Social Self' project.
7. The Accelerated Education Programme has been set up to provide support for school drop-outs to allow them to obtain their elementary-school certificate within 3 years. The programme was implemented in Baghdad and other governorates.
8. Introduction of the Educational Information Systems (EIS) Project to prepare statistics on school and education facilities to allow comparison of the number of registered and drop-out pupils and the effects of planned educational projects by UNICEF on pupils. The project will also pilot state-of-the art technology to computerise educational data, and modernise school atlases amd some of the curricula.
9. UNICEF has introduced an e-learning program which focuses on:
    a. Providing learning opportunities for children and youth who face difficulties accessing schools.
    b. Flexibility in the teaching dates for displaced people.
    c. Locating learning opportunities for the inhabitants of rural areas.

    The anticipated results are: the preparation of 100,000 Iraqi children and youth to be educated through the internet; the building of 10 youth centres that use modern methods of continued education; the building of 10 libraries to provide e-learning to pupils and teachers, as well as training 300 teachers and employees to use modern information systems. The project is aimed for completion in 2010.

10.2 Curriculum Development The MoE High Committee for the Development of Curricula, Teaching Aids and Examinations is responsible for planning, designing, approving and revising the curriculum (UNESCO 2004). Composed of members from the Directorates of Education and subject experts from Iraqi universities, this Committee also approves textbooks and teacher guides (*ibid*.). This was the situation at the time of publication of the UNESCO report; the study research team will confirm if this remains the case.

Although universities and technical institutes used to develop their own academic programmes through their respective governing councils in consultation with the MoHESR (UNESCO 2004), a Temporary Advisory Committee on Curricular Reform has since been established as part of a long-term national process of curricula review and reform across all disciplines. The Committee's initial task was to develop a plan to conduct a comprehensive curricular review, suggest priorities, and identify avenues for international support of the review and revision process.

10.3 Pre-School Provision Information on pre-school provision in the 2000 MICS report (there is no data on this topic in the 2006 MICS report) indicates extremely low provision and an extremely low take-up rate, confirming the lack of ECD programmes within the formal educational system. Only 3.7% of children aged from 36-to 59 months (3.8% males to 3.6% females) enlisted in nurseries or kindergartens (MICS 2000, Table 7). Table 7 also shows that 5% of children enrolled are between 48-59 months as compared to 2.6% of younger children (*ibid*.). Pre-school enrolment is 5.2% urban against 0.9% in rural (*ibid*).

In 2007, Iraq's population of kindergarten age children (0-4 years old) was estimated at 4,970,829 (COSIT 2007; see Table 1, Annex 1). The number of kindergartens, children admitted and teachers by governorate for the academic year 2006-07 is provided in Table 2 (COSIT 2007; see Annex 1). The highest number of kindergartens was in Baghdad (145), followed by Basrah (59), Nineveh (49) and Babylon (39). The number of male pupils enrolled was higher than female pupils in all of these areas, but this was not the case across the board. In Kirkuk, Diala and Al-Muthanna the reverse was true. The ratio of teachers vs. the number of pupils was highest in Baghdad (6.7%), followed by Nineveh (5.2%) and Basrah (4.4%).

10.4 Primary and Secondary School Provision In academic year 2006-7 the total number of primary schools was 12,141, of which 6,260 were mixed, 2,646 were female only and 3,235 were male only (COSIT 2008; see Annex 1, Table 4). The highest number of primary schools was in Baghdad (1,876), followed by Nineveh (1,328), Thi-Qar (1,109) and Salah el-Din (939) (*ibid.*). The lowest number of primary schools was in Al-Muthanna (351), followed by Kerbala (413) and Najaf (476) (*ibid*.).

In 2006-7, 4,150,940 pupils were admitted in all grades of primary education, of which 1,825,317 girls and 2,325,623 boys, a boy girl ratio of 1.8 to 2.3 (COSIT 2008; see Annex 1, Table 5). The highest number of admitted pupils was in Baghdad (1,025,993), followed by Nineveh (458,014) and Basrah (377,952) (*ibid*.). The lowest number was admitted in Al-Muthanna (101,228), followed by Maysan (122,372) and Wasit (158,572) (*ibid*.). In the same academic year 775,168 pupils were enrolled in the first year of primary education, of which 364,858 girls and 410,310 boys, a boy to girl ratio of 1.1 to 1 (*ibid*.). The highest number of pupils were enrolled in Baghdad (190,199), followed by Nineveh (82,939), Basrah (74,050) and Thi-Qar (53,991) (*ibid*.). The lowest number was enrolled in Al-Muthanna (18,690), followed by Maysan (25,765) and Kerbala (28,425) (*ibid*.).

In 2006-7, there were 236,968 primary school teachers of which 163,067 were female and 73,901 were male, a female to male ratio of 2.2 to 1 (*ibid*.). The total number of drop-out pupils in primary schools in 2006-07 was 123,177, of which 56,137 were female and 67,040 were male, a boy to girl ratio of 1.2 to 1 (COSIT 2008; see Annex 1, Table 6).The highest number of drop-out pupils was in Baghdad (38,186), followed by Nineveh (18,134), Basrah (9,631) and Al-Anbar (8,951) (*ibid*.). The number of male drop-outs was higher than female drop-outs in almost all governorates except in Nineveh and Kirkuk – where the reverse was true – and Babylon and Al-Muthanna where the number of males and female drop-outs were almost equal (*ibid*.).

Secondary Education begins with the Intermediate general education level (grades 7 to 9) leading to the Third Form Baccalaureate, followed by Preparatory level (grades 10 to 12) where there is a range of options (see Box 16). Pupils can continue general secondary education opting for either literary or scientific studies leading to the Sixth Form Baccalaureate, or move to a vocational school or teacher training institute (*ibid.*).

In academic year 2006-7 the total number of secondary schools was 4,109, of which 765 were mixed, 1,419 were female only and 1,925 were male only (COSIT 2008; see Annex 1, Table 9). The highest number of secondary schools was in Baghdad (983), followed by Basrah (371) and Nineveh (347) (*ibid.*). The lowest number of secondary schools was in Al-Muthanna (76), followed by Maysan (106) and Kerbala (136) (*ibid.*).

In the same academic year, 1,491,933 pupils were enrolled in both general and vocational secondary education, of which 608,964 girls and 882,969 boys, a boy to girl ratio of 1.5 to 1 (COSIT 2008; see Annex 1 Table 9). The highest number of pupils were enrolled in Baghad (479,762), followed by Nineveh (135,646), Basrah (120,659) (*ibid.*). The lowest number were enrolled in Al-Muthanna (23,769), followed by Maysan (30,893) and Kerbala (49,333) (*ibid.*).

In 2006-7, there were 113,556 secondary school teachers of which 63,185 were female and 50,371 were male, a female to male ratio of 1.3 to 1 (*ibid.*). The total number of drop-out pupils in secondary schools in 2006-07 was 62,187, of which 25,846 were female and 36,341 were male, a boy to girl ratio of 1.4 to 1 (COSIT 2008; see Annex 1, Table 12).The highest number of drop-out pupils was in Baghdad (26,152), followed by Basrah (8,884) and Nineveh (4,839) (*ibid.*). The number of male drop-outs was higher than female drop-outs in almost all governorates except in Al-Najaf where the reverse was true (*ibid.*).

10.5 Primary & Secondary School Attendance The UNESCO and UNICEF 2008 finding that 1 in 5 primary school-aged children were unable to go to school (Relief-Web/UCHO 2008) is consistent with the MICS 2006 attendance figures of 5 in 6 (or 83%) (MICS 2006, Table 16). The urban/rural attendance ratio is 89% to 75% (MICS 2006).

The ratio of girls to boys attending primary and secondary education is provided in Table 17 of the 2006 MICS report, with figures on gender parity for primary school at 0.91 (91 girls per 100 boys). The indicator drops to 0.79 for secondary education (79 girls per 100 boys). The disadvantage of girls is particularly pronounced in the rural areas where the gender parity for primary school is 0.83 and 0.44 for secondary school. Gender parity also increased with the mother's education.

Box 18. Iraq Education in Transition: Needs & Challenges

Levels of pupil enrolment were affected by an increased incidence of poverty during the period of economic sanctions.

Curriculum and textbooks are outdated and politically biased.

The education sector is under the authority of the central Ministry in Baghdad, but the semi-autonomous Kurdish ministries hinder development of uniform education policies.

Loss of experienced teachers due to the dramatic decrease in the salaries during the sanctions period, to $5 - $10 per month.

Shortages of textbooks, teaching-learning materials, equipment.

Poor condition of schools and educational infrastructure.

Isolation from the international academic community prevents access to contemporary scholarship & modern teaching methods.

Source: UNESCO 2004

School attendance again increases in line with the mother's education: 92% for mothers with secondary or higher education, 84% for mothers with primary education, and 72% for mothers with no education (MICS 2006). Boys have a higher school attendance (87%) compared to girls (79%) (*ibid.*).

10.6 Primary School Completion & Transition Rates The standard graduation age from primary to secondary school is 11 years. Table 18 of the 2006 MICS report presents the *primary completion rate*, the number of children of *all ages* who are completing the final year of primary education, as a percentage of the population of the official primary school graduation age and the *net completion rate*, ie. the number of children of *primary school completion age* who are completing, as a percentage of the population of the official primary school graduation age. The primary completion rate is given as79% but varies within sex and area. Boys have a higher rate (90%) than girls (68%) and urban areas have a higher rate (88%) than rural areas (65%). The primary completion rate also increases with the mothers' education.

About 30% of children of primary graduation age attend grade 6 at age 11years (MICS 2006). There is no difference in the rate between boys (30%) and girls (30%) and the difference observed in the primary completion rate is due to the fact that the majority of children over 11 in grade 6 at the time of the survey were boys (*ibid.*). The net completion rate is greater in urban areas (36%) compared to rural areas (21%) and the rate increases markedly with mothers' education. The variation between the primary completion (79%) and net completion rate (30%) indicates children in grade 6 older than 11 years at the time of the survey (*ibid.*).

The transition rate to secondary education is also shown in Table 18 of the 2006 MICS report. 78% of children in primary school grade 6 in the preceding year attended the first grade of secondary school the year of the survey. The percentage is higher for girls (82%) than boys (76%) and for urban (82%) than rural areas (70%).

10.7 Special Needs and Inclusive Education As noted in Section 3, the right to education for all is enshrined in Article 34 of the Iraq Constitution, care and rehabilitation of the disabled and persons with special needs in Article 30 '*…The State shall provide them housing and special programmes of care and rehabilitation …'.* and Article 32 '*The State cares for the handicapped special-needs people and ensures their rehabilitation for their reintegration into society. This shall be regulated by law.'*

Article 9 (modified) of the 1976 Mandatory Education Law No.118 *'The Ministry of Education will work to develop special-needs classes in standard schools at the elementary education level for people with learning difficulties, visual impairments, hearing impairments and all those who are not categorised as handicapped and fall within the modified 1980 Social Care Act No. 126, to guarantee their education, care, orientation and enhanced abilities to the stipulated level.'* addresses the provision of primary school special needs classes in standard schools – inclusive education, which is covered explicitly in the new 2010 Disability & Special Needs Care Act, Article 3, Clause 4 *'Providing public and private education opportunities as well as vocational and higher education for the disabled and special-needs people.'*

Deteriorating security post 2003 has had a tremendous negative impact on the educational system in Iraq in general (De Santisteban 2005). Children suffering disabilities have been unable to access adequate care and education, and despite the legislation, the Iraq education system has consistently failed to make inclusive or even parallel special-needs education a reality. The final approval of the New Disability Act by the Council of Ministers (pending) would indicate an important shift in understanding of the issues and the political will to act.

National Inclusive Education Strategy In 2009, prior to the drafting of the New Disability Act, a strategic plan was put into place to support the development of a dedicated national inclusive education programme (see Annex 3). Evaluation of the progress of the 2009 national inclusive education programme strategy will need to form a core part of the current study, a strategy that includes special-education teacher recruitment and training targets, the expansion of current provision to primary school years 5 and 6, the establishing of a dedicated special needs body, development of special-needs curriculum, and a media awareness raising campaign amongst other initiatives (see Box 19).

A critical development in the move towards a National Inclusive Education Programme came with the issue on 26th June 2009 of *Instruction Reference 4785* (see Annex 4), by Ghazi Mutlaq Sakhi, Acting General Director, Directorate of Special Education, at the Ministry of Education.

The Instruction was issued to: *'The General Directorates of Education in Baghdad Governorate: First Karkh; Second Karkh; Third Karkh; First Rasafah; Second Rasafah; Ninawa; Karbala; Babil; Al-Anbar; Department of General Education; Special Education Section'* with the subject heading

'Instructions for comprehensive educational inclusion and complementary stage (parallel education)

Agreement was granted to apply the instructions of the comprehensive educational inclusion for the fifth class primary, and for the complementary stage of the fifth and sixth classes for children with special needs (parallel education), to be applied in the beginning of the next academic year 2009-2010. We, herewith attach a copy of these instructions.

Inform us of the schools that will be included in the complementary stage (of the parallel education) for the two mentioned classes and male and female teachers who work therein before 15/9/2009 in accordance with the instructions aforementioned.

Follow up receiving the text books for the aforementioned classes in coordination with the General Directorate for Administrative Affairs – Administration of Central Stores, so that pupils will have sufficient copies.

Send us a detailed report on the practical implementation of the instructions and on the parallel education stage – fifth class, in the first half of the academic year; and another report in the second half of that year on the qualitative and quantitative aspects and clarify the suggestions and the obstacles so that they can be overcome.'

As noted, early 2010 has already seen preliminary approval of the New Disability Act and implementation of a number of allied components. In January 2010, Dr Al-Hashemy obtained a number of the newly developed special needs text books for the Grades 5 and 6 special needs pupils.

10.8 Special Needs Education Statistics The following analysis draws on MoLSA 2009 statistics for academic years 2007-2008 and 2008-2009 (see Tables 7 and 8, Annex 1). In 2007-08, a total of 903 primary schools catered for special needs pupils, of which 559 were pupils with special needs in their first year at the school (*the first diagnostic year*). Of the 903 schools, 715 provided separate special-needs classes (grades 1 to 4) for a total of 7,190 special needs pupils, taught by 1,079 teachers and supervised by 37 educational supervisors. The ratio of male to female special needs pupils is 1 to 1.2. Table 7 (2007-08) provides a detailed breakdown by governorate (MoLSA 2009; Annex 1).

In 2008-09, a total of 1,107 primary schools catered for special needs pupils, of which 691with special needs pupils in their first year at the school (*the first diagnostic year*). Of the 1,107 schools, 883 provided separate special-needs classes (grades 1 to 4) for a total of 8,095 special needs pupils, taught by 1,445 teachers with 36 educational supervisors. The ratio of male to female special needs pupils is 1:1. Table 8 (2008-09) provides a detailed breakdown by governorate (MoLSA 2009; Annex 1).These figures demonstrate an 18% rise in primary school special education capacity across Iraq, and the target set for special-needs class expansion in academic year 2009-10 is 433. However, the process of expansion will require a concomitant expansion in the provision of special teaching aids and technologies and qualified special needs teachers.

Box 19. Towards A National Inclusive Education Programme: 2009-10 Targets

(Information obtained by Dr Al-Hashemy from meetings with key ministries)

- ***Qualified Special-needs Teacher Recruitment Targets***
  2008-09: appointment of 260 fully qualified special-needs teachers (male/female).
- ***Coordinated Approaches to Diagnosis of Special Needs Pupils***
  Coordinated MoLSA and MoH (and its governorate-level institutions) examination and diagnosis of special-needs pupils by special-education committees to assess the level of need in academic year 2009/2010. Printing of Examination & Diagnosis forms & distribution plan (see Annex 5)
- ***Extension Existing Primary School Grades 1 to 4 Special Needs Provision to 5th & 6th Grades.***
  Following the Director of Special Education issue of *Instruction Reference 4785* work has begun to establish parallel 5th and 6th grade, academic and vocational special needs classes. This will include:
  a. Drafting of special textbooks for the 5th and 6th grade special-needs classes
  b. Preparation of Workshops and Handicraft Guides including:
    - Principles of Weaving and Handicrafts and their Application
    - Principles of Ceramics and Drawing and their Applications
    - Principles of Carpentry and their Applications
    - Principles of Computing and their Applications
  c. Publication of text books following tender process
  d. Development of a distribution plan for delivery to selected governorates.
  e. Issue of instruction to education directorates (see Annex 4 and Section 10.7 above).
- ***Policy & strategic developments***
  a. Creation of special-needs units within the Directorate of Education.
  b. Seek approval of Minister of Education for the National Inclusive Education Programme.
  c. Gain support of State Directorate for Public Relations via UNESCO.
  d. Organise a media campaign to disseminate information on the inclusive education programme and the concept of educational inclusion in coordination with civil society organisations.
- ***Centralised Approach to Special-needs Teacher Training and Continuing Professional Development*** to keep teachers and supervisors up to date with developments in the field of special needs education.
- ***Field-study*** to evaluate admissions of special-needs pupils across elementary, intermediate and secondary level education, with preliminary results showing an increase in admissions to schools. The aim of the national project is to meet special-needs pupils' requirements in line with global directions and the MoE's responsibility to guarantee the right to education.
- ***Approval of National Body for Care of the Disabled*** In coordination with the MoH and concerned ministries the proposal was submitted to the State Shura Council for approval (see Annex 2).
- ***Approval of the Disabled and Special-needs Care Act*** was prepared in coordination with the General Secretariat of the Council of Ministers/Councillors and the concerned ministries and referred to the State Shura Council for approval (see Annex 2 and Section 3 above).

10.9 Phase 1 School Visits (2009) As part of Phase 1, over a period of two months, Dr Al-Hashemy undertook visits to 49 state primary schools in the four study governorates: 28 in Baghdad Governorate, 10 in Basra Governorate, 6 in Najaf Governorate and 5 in Erbil Governorate. The purpose of these visits was to allow preliminary verification of the level of implementation of *Mandatory Education Law No.118 (modified) Article9* for primary school grades 1 to 4 (see Section 3 above); to hold informal interviews with headmasters/headmistresses and teachers, including special-needs teachers and supervisors; to gauge the

condition of school buildings and facilities therein; to observe teaching sessions; to review the level of training of teachers in charge of special-needs pupils and special-needs classes; to review the number of inclusive education classes; to record the number of special-needs pupils, and generally gauge attitudes towards the concept of inclusive education and issues arising.

The selection of primary schools visited was random, but incorporated a balance of 'boys only', 'girls only' and 'co-educational' (mixed boy & girl) schools in both rural and urban areas (see Annex 6). Dr Al-Hashemy had no prior knowledge as to whether these schools had inclusive education programmes or separate special-needs classes. Full details of the visits are in Annex 6.

Between them the schools had 814 special-needs pupils enrolled and employed 66 special-needs teachers. Dr Al-Hashemy's visits highlighted universally poor building stock, eg. windows without glass, door frames without doors, uneven flooring etc. and a lack of qualified special-needs staff. A majority of the 49 schools also lacked basic facilities such as access to potable water and suitable washrooms. None of the schools visited had 'social' rooms, specialist areas or special needs equipment.

The average special-needs teacher to special-needs pupil ratio was 1:8, although 14% of the schools visited with special-needs pupils had no special-needs teacher. The remaining 86% had at least one special-education teacher, the majority of whom were female. Most of the special needs pupils were not integrated within standard classrooms. Special-needs classes observed were held away from the main classes, and often located in unsuitable areas within the school building, eg. in a storeroom without windows and under a school stairwell. The curriculum being taught was the standard curriculum.

It was found that a large proportion of special-needs pupils (up to 80% in some directorates) were excluded or had dropped out of school due to poor transport, lack of specialist skills and expertise, lack of specialist equipment/materials, a lack of accessible washrooms and generally poor facilities. Dr Al-Hashemy also found that pupils with disability were not receiving their annual medical assessments following the first year diagnosis on initial enrolment to the school.

Special-needs teacher training was identified as a major concern. Few of the special-needs teachers interviewed by Dr Al-Hashemy had received in-depth formally accredited special-needs training, most having attended 1 to 2-week courses delivered by trainers whose own special-needs qualifications were unclear. This will be a critical area of enquiry for the study.

The majority of schools visited also operated a shift system compromising teaching hours and the quality of education being provided to all pupils.

The resistance to inclusive education encountered amongst standard teaching staff in Kurdistan at the outset of the KIEP yields an important lesson. Although the maximum quota of special-needs children in any one standard class was maintained at 12, in reality, there were rarely more than two special needs pupils in a standard class of 30, breeding resentment amongst standard teaching staff who received lower salaries than their special-needs counterparts (see Box 23 for further information on the KIEP).

There is no doubt, however, that one of the biggest constraints to the development of an inclusive education and special-needs education programme in Iraq has been the lack of political will, most clearly demonstrated through the lack of dedicated budgets. A number of Phase 1 respondents cast doubt on the extent to which senior players within the Central MoE had embraced the concept of inclusive education. Even in Kurdistan, where the Kurdistan Inclusive Education Programme (KIEP) has been being implemented under the auspices of the KRG MoE since 2006, there remains opposition from some members of the Erbil Provincial Council, who view KIEP as pushing a Western 'construct'.

Measured against the enormous reconstruction task faced by Iraq to restore and grow its basic school building stock and the fact that the current system does not meet the educational needs of Iraq's non-disabled children, it is not surprising that developing education opportunities and facilities for children living with disability has been sidelined. The study's awareness-raising role will be crucial.

Phase 1 findings specific to each of the study governorates are summarised under Section 11 below.

10.10 Teacher Training including Special Needs Teacher Training[22] As noted, the MoE is responsible for Iraq's teacher training institutes and the Open College of Education. These provide two distinct standard professional teacher training routes (not special needs), the first, starting at the Preparatory/Vocational level, lasts five years (grades 10-14). The second follows on from the 2nd General Education Baccalaureate Exam, and provides a two-year higher education teacher training programme (grades 13-14).

Box 20. Kurdistan Inclusive Education: Special-Needs Teacher Training
(training partner in brackets) TOT = training of teachers

14/12/06	Training for 24 teachers (ACORN)
21/01/07	Training for 20 teachers (Intersos)
	2.5 months Inclusive Education training for 73 teachers
30/08/07	Awareness-raising training (Mercy Corps)
24/11/07	10-day training for special-needs teachers delivered in Syria (Deaconia)
21/05/08	Training to help children to speak for 30 teachers (KSC)
	TOT for 22 special-education teachers and supervisors
01/08/08	30-day training course for 227 teachers on integration
27/02/08	3-week training on autism and child mental health delivered in the Lebanon for 10 teachers (Sociohabil)

The above have been supplemented by a number of additional special-education teacher training courses delivered locally in Kurdistan.

The Phase 1 school and institutional visits undertaken by Dr Al-Hashemy highlight that the training route available to those wishing to obtain professional qualifications as special-needs teachers is not so clearly or systematically formulated and reveal the current dearth of qualified and experienced special-needs teachers. On the face of it, current training provision in special needs appears to be ad-hoc and unfit for purpose. The Kurdistan inclusive education programme does, however, encompass a considerable training dimension (see Box 20), to be reviewed as part of this study.

The lack of formal provision for continuing professional development training amongst teaching staff in general and special-needs teaching staff in particular presents another major area of enquiry for the study.

11. Study Governorates: Key Characteristics

As noted in Section 1, the four study governorates have been selected to capture Iraq's geographic and demographic diversity, to provide a comparative basis for data analysis and to introduce characteristics that are specific to each governorate. Most importantly, Phase 1 data indicates that these four governorates contain the largest proportion of children with disabilities within their respective populations. The following governorate specific information gathered in Phase 1 will inform the development, design and methodology and sampling for the Phase 4 survey.

11.1 Baghdad Governorate Situated in the centre of Iraq, Baghdad Governorate covers an area of 4,555 sq. km (1.5% of Iraq) with an estimated 7,145,470 inhabitants, 24% of Iraq's total population (WFP VAM 2007 *cf.* IAU/OCHA [2009] Baghdad Governorate Profile). Predominantly occupied by Bagdad City, Iraq's capital and seat of government, Baghdad Governorate is Iraq's most densely populated. According to GoI COSIT 2007 statistics, the geographical distribution is 13% Rural: 87% Urban and the gender distribution is 50% Male: 50% Female (*cf.* IAU/OCHA [2009] Baghdad Governorate Profile). Baghdad Governorate comprises 9 districts, many of which are linked to Baghdad City. Population distribution is outlined by district in Table 1.

Table 1. Baghdad Governorate: Districts and Population Distribution

Al-Karkh District	1,624,057	Al-Sadr District	1,316,583
Al-Risafa District	1,312,052	Al-Adhamia District	842,310
Al-Kadhimiya District	832,759	Mahmudiya District	496,053
Al-Mada'in District	332,883	Abu-Ghraib District	326,626
Al-Tarmiya District	62,147	*(WFP VAM 2007 cf. IAU/OCHA [2009] Baghdad Governorate Profile)*	

In Baghdad, 52% of households live in slum conditions with occupancy of more than 3 persons per room in 27% of households (IHSES 2007, *cf.* IAU, the Housing & Shelter in Iraq Fact Sheet, 5 October 2009). 84% of households have unstable water supply, while 2-7% of houses are not connected to the water network (*ibid.*). Most households in Sadr, Risafa, Adhamia, Karkh and Kadhimiya have infrequent or no connection to the

[22] New Disability Act: Article 3, Clause 5. 'Developing the cadres and staffs working in the field of the disabled and special-need people care as well as building and updating a special database thereon.'

electricity network and all these districts have significant levels of chronic disease and children with chronic malnutrition (IAU/OCHA [2009] Baghdad Governorate Profile). Unemployment rates are 8% for women and 9% for men, with a 24% Female: 81% Male labour force participation (WFP VAM 2007 *cf.* IAU/OCHA [2009] Baghdad Governorate Profile).

According to the IAU/OCHA Iraq Pockets of Vulnerability Map 2009, the districts and neighbourhoods with the highest proportions of people and households in need are Al-Risafa, followed by Mahmudiya, Karkh, Mada'in and Taji. The IAU/OCHA, Iraq Humanitarian Action Plan Priority Districts Map November 2009, lists the Karkh district of the governorate of Baghdad as a priority for humanitarian action.

Governance Baghdad constitutes a new 'capital territory' whose structure differs from other parts of the country (USAID 2007b). A Governor appointed by the Governorate Council heads the Governorate. The Baghdad Governorate Council is composed of 57 directly elected representatives and oversees the entire governorate as well as the City of Baghdad. The City of Baghdad is also overseen by a mayor (*ibid.*).

Baghdad City is divided into Kati', or districts, which are headed by a Qa'im Makam elected by the Kati' Council. Members are chosen from among neighborhood council representatives. The number of members on each Council varies according to the population. The members choose a chairperson to head the Council. The Councils have next to no money and must ask – not order – the Governorate Council, Beladiyas or Amanat (service entities, see below) to undertake projects. One of the Kati' Council's responsibilities, is the monitoring and evaluation of education in the Kati' (*ibid.*).

Box 21. Phase 1 Preliminary Survey in Baghdad Governorate

In January 2010, to inform selection of Phase 4 survey localities in Baghdad, Dr Al-Hashemy and members of the Iraq Study research team conducted a 4-day household survey in 9 of the poorest known sub-districts in and around Baghdad City: Hay Tareq, Al-Maamil, Shaaireh and Umm Jider, Al-Husseinieh, Abu Ghreib, Al-Taji, Al-Nahrawan, Al-Madaain, Al-Mahmoudieh.

The criteria for selection of sample households was population groups living on or below the poverty line, including homeless and internally displaced persons (IDPs). Selection was facilitated by tribal, municipal and council leaders allied to each sub-district referring to local tax records.

An initial random survey of 215 out of a total of 18,750 households within the 9 localities led to the selection of 45 children with disability, and was followed by one-to-one interviews with a parent using simple 1-page survey instrument addressing the following 7 areas of enquiry:

- Educational status of mother and father
- Employment status of mother and father
- Total number of children in the family
- Number of disabled children (as identified by the respondent)
- Whether the disabled child attends school
- Whether the disabled child receives official healthcare
- Whether the family or disabled child receives NGO support

Resulting data revealed: 45% of the special needs children surveyed were attending school and receiving some form of healthcare. Of the children not attending school, just over 50% were in receipt of healthcare. Equal numbers of mothers and fathers were in employment, while fathers were on the whole better educated than mothers. 44% of fathers compared to 29% of mothers received primary education and 29% of fathers compared to 4% of mothers attended intermediate schools.

School attendance amongst children improved with the mother's education. 22% of the mothers of children attending school had attended at least primary school in comparison to 16% of the mothers of children who did not attend school. Receipt of healthcare also increased with the parents' education with 33% of mothers and 64% of fathers of children receiving healthcare having attended at least primary school in comparison to 6% of mothers and 9% of fathers for children not receiving healthcare.

Kati' are further subdivided into Muhallas, or neighbourhoods, and are the smallest administrative units. Neighborhood Councils are the closest elected officials to the people. Again, the number of members is based on the population. They have no spending money and primarily handle lower-level administrative functions such as initial approval of fuel or food rations and initial verification of residents returning home after fleeing (*ibid.*)

There are two service entities in Baghdad, the Amanat and the Beladiya. The Amanat is Baghdad's public works department responsible for improving Baghdad's infrastructure and overseeing the city's essential services. Money for large-scale, Iraqi-funded projects typically originates at the Amanat. It has no

responsibility for electricity, which is overseen by the central Ministry of Electricity. The Amanat is headed by an 'Amin', the principal executive official, chosen by the Governorate Council (*ibid*.).

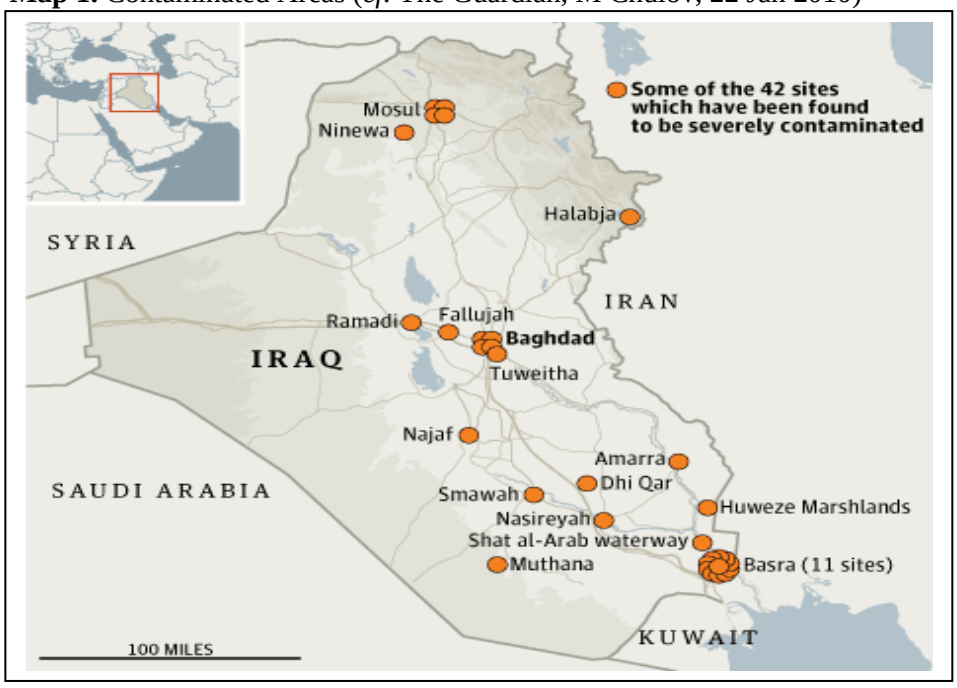
Baghdad's 13 beladiyas can be considered the administering arm of the Amanat. They maintain the city's distribution systems and perform other administrative tasks such as governing water, sewage, roads, public lands and zoning. Beladiyas have significantly less money than the Amanat. This typically limits them to maintaining existing infrastructure and performing low-level improvements such as landscaping or street cleaning. Beladiyas must turn to the Amanat or Governorate Council for the creation of any significant new infrastructure. Beladiyas also control money collected by the kati' councils. The Deputy Amin for Beladiyas appoints a Deputy Mayor to head each Beladiya, but most of the remaining employees are workers hired for specific jobs, such as engineers or street cleaners (*ibid*.).

Impact of War Baghdad City has borne the brunt of much of the fighting both during and after the 2003 invasion. It remains one of Iraq's least secure cities, with the highest level of security incidents whether bombings, targeted assassinations or kidnappings. There are 8 returnees and 77 internally displaced persons per 1,000 in Baghdad (IOM September 2008 *cf.* IAU/OCH [2009] Baghdad Governorate Profile).

The Baghdad City district of Sadr, one of the most overcrowded and poverty ridden districts in Baghdad City and the whole of Iraq and a stronghold of the Shi'ite leader Moqtada Al-Sadr and the Al Mehdi Army saw intense fighting when confronted by the joint Iraqi Security Force and MNF-I forces in March/May 2008 (IAU/OCH [2009] Baghdad Governorate Profile).

Environmental Factors/ Contamination A recent joint Ministry of Environment, Health and Science report found that scrap metal yards in and around Baghdad contained high levels of ionising radiation, which is thought to be a legacy of depleted uranium used in munitions during the first Gulf war and since the 2003 invasion (*cf.* The Guardian, Martin Chulov, 22 Jan 2010). It lists four severely contaminated sites in Baghdad Governorate (see Map 1, *ibid.*).

Map 1. Contaminated Areas (*cf.* The Guardian, M Chulov, 22 Jan 2010)



Industry Local industry includes an atomic energy facility, military industrial facilities as well as manufacturers of batteries, electrical goods, bicycles, clothing, cement, vegetable oil, tobacco, dairy produce, bricks and ammunition.

Baghdad Governorate also contains a number of universities, amongst which the University of Baghdad, and has major commercial area (bazaar) in the south. Tourism provides income to the governorate as people come to see Baghdad's park and experience the city's culture – poets, artists, literature. There are also agricultural activities in the rural areas of the governorate.

Schools Baghdad Governorate has approximately 2,769 schools (COSIT 2006-7), split across 6 Education Directorates, each with its own Director. Three of the Baghdad Governorate Education Directorates are located north of the Tigris in Al-Risafa District and three South of the Tigris in the Al-Karkh district. All six of the Education Directorate Directors are based at the Central MoE in Baghdad (see Annex 6).

Care Institutions The most recent MoLSA figures show that Baghdad has 29 MoLSA run Child Social Care establishments (educational and vocational), catering for 1,502 children between ages of 2 and 16 years and a

total of 884 employees providing a staff to child ratio of 1:2 (Source: Dr Al-Hashemy 17 August 2009 meeting with the Minister of Labour & Social Affairs, see Table 1, Annex 8).

Third Sector Dr Al-Hashemy visited 3 of the Baghdad-based NGOs catering for people with disability: the Civil (Al-Madaniyah) Association for the Handicapped, the Imam Al-Mahdi Association for the Handicapped and The Republican Assembly for People with Special Needs, the first two of which have no defined policy regarding inclusive education, no training capacity due to lack of funds and are primarily lobby groups.

The third, The Republican Assembly for People with Special Needs has some training capacity. Although it also lacks funds, it is collaborating with international organisations such as the World Development Fund and UNAMI to deliver courses teaching reading and writing to the blind using a specialist computer programme. Although it owns a small number of computers, it lacks transport to help beneficiaries attend its courses.

Box 22. Baghdad Schools: Initial Phase 1 Findings (full details are included in Annex 6)

Dr Al-Hashemy's Baghdad school visits encompassed schools in 5 of the 6 Baghdad Education Directorate Districts the 6th district, Karkh 3, being excluded due to lack of time. The selection of schools was entirely random with each school visited referring Dr Al-Hashemy on to the next. Of the 27 schools visited, 6 were girls only, 7 were boys only and 14 were co-educational.

The 27 schools contained a total of 63 special needs classes, 476 special needs pupils and 20 special education teachers. 4 of the schools visited who were catering for special needs pupils had no special-education teachers. The survey also found that in 4 schools, the number of special needs pupils in 2009 had dropped by more than three-quarters from the previous year due to the poor facilities and lack of transport for the pupils. Overall, facilities for special needs pupils were found to be very poor and lacking in teaching equipment, suitable teaching spaces and qualified teaching staff.

The Republican Assembly for People with Special Needs also lacks a clear policy on integration, but has filed a request for the construction of a school through which it aims to develop a model for inclusive education for schools across Iraq. Concerns were expressed about the MoE's Special Education Programme in terms of the lack of efficiency and well trained teachers.

11.2 Basrah Governorate Situated in the south eastern corner of Iraq, with Iraq's only stretch of coastline and borders with Kuwait and Iran, Basrah Governorate covers an area of 19,070 sq km (4.4% of Iraq) with a 2007 GoI COSIT estimated population of 1,912,533 or 6% of Iraq's total population (*cf.* IAU/OCHA [2009] Basrah Governorate Profile). The gender distribution is 50% Male: 50% Female and the geographical distribution is 21.8% Rural: 78.2% Urban (GoI COSIT 2007 *cf.* IAU/OCHA [2009] Basrah Governorate Profile). There are two major, densely populated cities, Basrah, the governorate capital and Zubiah, as well as three ports Fao, Abu Al-Kasib and Umm Qasr (WFP VAM 2007 *cf.* IAU/OCHA [2009] Basrah Governorate Profile). Basrah Governorate comprises 7 districts whose population distribution is outlined in Table 2.

Table 2. Basrah Governorate: Districts and Population Distribution

Basrah District	951,655	Al Zubair District	320,523
Al-Qurna District	194,216	Abu Al-Khaseeb District	162,740
Al-Midaina District	160,420	Fao District	18,890
Shatt Al-Arab District	104,089	*(WFP VAM 2007 cf. IAU/OCHA [2009] Basrah Governorate Profile*)	

Unemployment rates are 20% for women and 12% for men, with 11% Female:83% Male labour force participation (WFP VAM (2007) *cf.* IAU/OCHA [2009] Basrah Governorate Profile). Female labour force participation outside Basrah City is low compared to the national average, and female unemployment is particularly poor in Fao, Al-Midaina and Al-Zubair districts (IAU/OCHA [2009] Basrah Governorate Profile).

In Basrah governorate, 54% of households are living in slum conditions, with more than 3 persons per room in 36% of households (IHSES 2007, *cf.* IAU, the Housing & Shelter in Iraq Fact Sheet, 5 October 2009). 88% of households have unstable water supply, while 2-7% of houses are not connected to the water network (*ibid.*). According to the IAU/OCHA, the Iraq Pockets of Vulnerability Map 2009, the districts in Basrah Governorate with the highest numbers or proportions of people and households in need are in Basrah City/District, followed by Fao. Basrah performs well according to other infrastructural indicators, eg. sanitation and electricity access are significantly better than the national average across the governorate (WFP VAM (2007) *cf.* IAU/OCHA [2009] Basrah Governorate Profile). None of the Basrah districts are listed as a priority for humanitarian action by the IAU/OCHA, Iraq Humanitarian Action Plan Priority Districts Map, Nov. 2009.

The IAU 2009 Basrah Governorate Profile describes it as the socio-economic hub of southern Iraq of great strategic importance due to its coastline, with a significant amount of oil and the Shatt al-Arab waterway. It also contains part of the Marshlands on its northern borders that have been an important source of support for Shi'a political movements.

Impact of War A government crackdown in March 2008 on militia groups operating in Basrah and the subsequent declaration of a ceasefire by Al-Sadr led to a much-improved security environment in the second half of 2008 (IAU/OCHA [2009] Basrah Governorate Profile). There are 1.4 returnees and 18 internally displaced persons per 1,000 of the population (IOM September 2008 *cf.* IAU/OCHA [2009] Basrah Governorate Profile). An unusually high proportion (85%) of Basrah's IDPs – most of whom come from Baghdad – would like to settle in the local community (*ibid*.).

Vulnerable Groups In 2003, the UN Environmental Programme reported that about 90% of up to 20,000 sq.km of marshlands had been lost due to targeted draining by the Saddam Regime and upstream damming since 1991 leading to the internal displacement of up to 1 million Marsh Arabs primarily into Basrah City. Although the group has diversified and is now relatively economically settled, it is nevertheless a group still perceived as 'other' by the local population.

Environmental Factors/Contamination The upstream damning of key water flows by Turkey and Syria has led to reverse flow from the sea and to major salt contamination of fresh water sources and surrounding agricultural land in southern Basrah. Access to potable water has become a major problem in the area, with piped water only fit for washing and cleaning. Drinking and cooking water is usually purchased from tankers or local markets.

A recent joint Ministry of Environment, Health and Science report again found that scrap metal yards in and around Basrah contained high levels of ionising radiation, which is thought to be a legacy of depleted uranium used in munitions during the first Gulf war and post invasion. The report lists 11 severely contaminated sites in Basrah Governorate including the Shatt al-Arab and the Marshlands (*cf.* The Guardian, Martin Chulov, 22 Jan 2010). Depleted uranium is seen as a major cause of contamination and congenital deformity and birth defects, although a correlation between the increase in child and adult cancers and increasing birth defects has yet to be scientifically proven. This study will need to be sensitive to any apparent correlation between known areas of contamination and an abnormally high ratio of disability and birth defects amongst the local population.

Industry Basrah Governorate is a major oil producing area with oil refineries and chemical and fertiliser industries. It has three electricity power stations, two of which are situated near Basrah City, three ports – Fao, Abu Al-Kasib and Umm Qasr – and a university. Other industry includes factories manufacturing iron and steel, cement and thermostone. Its paper industry, active from 1950s through to 1990s, has ceased.

Schools Basrah Governorate has approximately 1,239 schools (COSIT 2006-7). Of the sample of 10 schools visited by Dr Al-Hashemy in Basrah, 3 were girls only, 4 boys only and 2 were co-educational. The schools had a total of 27 special needs classes, 124 special needs pupils and 9 special-education teachers, providing a teacher to pupil ratio of 1:14.

As with schools visited in Baghdad, there were extremely limited facilities and teaching staff available for special-needs pupils. Three schools with special-needs pupils had no special-education teachers. Eight of the visited schools had at least one special-education teacher, although with questionable qualifications and again teaching the standard curricula (see Annex 6).

Care Institutions The most recent MoLSA figures show that Basrah has 6 MoLSA run Child Social Care establishments (educational and vocational) catering for 206 children between the ages of 2 and 16, and a total of 77 employees, providing a staff to child ratio of 1:3 (Source: Dr Al-Hashemy 17 August 2009 meeting with the Minister of Labour & Social Affairs, see Table 1, Annex 8).

Third Sector Dr Al-Hashemy visited 3 of the Basrah-based NGOs catering for people with disability in Basrah Governorate: The Al-Rawabi Association for Disabilities, The Centre for the Development of Women and the Iraqi Media Forum (see Table 2, Annex 8). Their impact is currently limited by lack of clear policy and funds.

11.3 Erbil Governorate Situated in the north of Iraq, the Governorate of Erbil combines with the governorates of Dahuk and Sulaymaniyah to make up the semi-autonomous region of Kurdistan and includes the regional capital of Erbil, seat of the Kurdish Regional Government (KRG). Erbil Governorate covers an area of 15,074sq km (3.5% of Iraq) and borders with Turkey to the North and Iran to the East. Since World War I, Kurdistan has been divided between several states (Iran, Syria, Turkey and Iraq), in each of which Kurds are minorities. From a political standpoint, since the end of the First Gulf War, Iraqi Kurdistan is the only region which has gained official recognition internationally as an autonomous federal entity.

Erbil Governorate has a 2007 GoI COSIT estimated population of 1,542,421 (*cf.* IAU/OCHA [2009] Erbil Governorate Profile), 15-20% of the total Iraqi population (CIA 2010). Gender distribution is 50% Male: 50% Female and the geographical distribution is 24% Rural: 76% Urban. Erbil Governorate has 9 districts with the population distribution outlined in Table 3.

Table 3: Erbil Governorate Districts and Population Distribution

Erbil District	808,600	Dushty Howleer District	216,759	Makhmour District	50,927
Soran District	181883	Shaqlawa District	150,659	Juman District	37,074
Khabat District	90,531	Kwesinjak District	81,199	Merkeh Soor District	50,316

(WFP VAM 2007 cf. IAU/OCHA [2009] Erbil Governorate Profile)

38% of households are living in slum conditions with more than 3 persons per room (IHSES 2007 *cf*. IAU, the Housing & Shelter in Iraq Fact Sheet, 5 October 2009). 82% of households have unstable water supply, while 15-25% of houses are not connected to the water network (*ibid*.). According to the IAU/OCHA Iraq Pockets of Vulnerability Map 2009, the districts in Erbil Governorate with the highest numbers or proportion of people and households in need are Erbil, followed by Juman, Kwesinjak and Merkeh Soor. The IAU/OCHA, Iraq Humanitarian Action Plan Priority Districts Map November 2009, lists Makhmour District as a UN priority area for humanitarian action. Unemployment rates are 21% for women and 11% for men, with 16% Female: 78% Male labour force participation (WFP VAM 2007 *cf.* IAU/OCHA [2009] Erbil Governorate Profile).

Although poverty is not overly prevalent, Erbil Governorate performs less well against other human and developmental indicators (IAU/OCHA [2009] Erbil Governorate Profile). Illiteracy rates are generally above average; female labour force participation is low; infrastructure is poor and the majority of households in all districts except Koisnjaq suffer from prolonged power cuts, with few able to access an alternative electricity source (*ibid*.). Sanitation is also poor in all districts except Erbil, Dushty Howleer, Kwesinjak and Makhmour. Most households in Shaqlawa, Juman and Merkeh Soor are not connected to the water network (*ibid*.).

Governance The KRG is the official ruling body of the predominantly Kurdish region, referred to as Iraqi Kurdistan or Kurdistan. The KRG consists of a parliament with 111 seats known as the Kurdistan National Assembly (KNA). The cabinet is selected by the majority party or list who also select the prime minister of the Kurdistan region. The President of Kurdistan is directly elected by the regional electorate. He is the head of the cabinet and chief of state who delegates executive powers to the cabinet. The prime minister is traditionally the head of the legislature body, but also shares executive powers with the president. The President is also the commander-in-chief of the Kurdistan Armed Forces. Parliament creates and passes laws by a majority vote, and the President has the power to veto any bill. The KRG government has 19 ministries.

Impact of War Although Iraqi Kurdistan has remained relatively unaffected by the 2003 invasion in terms of security, it has experienced massive inflows of internally displaced persons from other parts of Iraq and, in particular, Baghdad and Nineveh. There are 40 internally displaced persons per 1000 of the population (IOM September 2008 *cf.* IAU/OCHA [2009] Erbil Governorate Profile). Unlike the rest of Iraq, Erbil Governorate has been a place of refuge, rather than flight.

Industry There are many oil and mineral resources in Kurdistan. KRG-controlled parts of Iraqi Kurdistan are estimated to have around 45bn barrels of oil reserves making it the sixth largest in the world. As of July 2007, the Kurdish government invited foreign companies to invest in 40 new oil sites, with the hope of increasing regional oil production over the next half decade by a factor of five, to about 1 million barrels per day (160,000 m^3/d) (Iraq Updates 2007). Gas and associated gas reserves are in excess of 100 TCF (KDC 2010). Other underground resources that exist in significant quantities in the region include copper, iron, zinc and limestone which is used to produce cement. The world's largest deposit of rock sulphur is located just Southwest of Erbil (Howleer). Other important underground resources include coal, gold, and marble (*ibid*.).

Schools Five co-educational schools were visited in Erbil in late 2009, and were found to be suffering from much the same dilapidation and lack of investment as the school buildings and facilities from the other three governorates (see Annex 6). The higher percentage of special-needs teachers with formal special-needs training identified during Dr Al-Hashemy's visits points to the growing effectiveness of the Kurdistan Inclusive Education Programme (KIEP). Launched in 2006 with the support of UNICEF it has, in regional terms, placed Kurdistan ahead of the game, although Kurdistan still faces a considerable struggle to embed and normalise inclusive education within the region.

Box 23. Education in Erbil: the Kurdistan Inclusive Education Programme (KIEP) Model

KIEP Programme Principles The concept of inclusion is based on the principle of equal educational opportunities for all and aims to meet the special education needs of disabled children within a regular schooling framework, in line with internationally recognised special needs education and learning methods, curricula and tools, delivered by trained special-needs staff and overseen by the Special Education Directorate.

At the time of its inception, the KIEP gained its legal authority from Article 32 of the Constitution *'The State cares for the handicapped special-need people and ensures their rehabilitation for their reintegration into society. This shall be regulated by law.'* There is, however, no legislation or regulation covering the delivery or quality of special-needs provision. Schools are not allowed to refuse admission under existing legislation although realities are somewhat different.

Pre-school Education The KIEP caters for children from ages 0 to 18 years. Pre-school level caters for children up to 6 years of age, 0 to 5 being considered the most critical years in the learning life of a child. It is an 'early intervention' teaching programme for children and parents.

Inclusive Primary School Education Participating schools cater for children with varying disabilities with four or more per standard classroom. Although they are educated within the standard classroom, each classroom is allocated a special-education teacher to support the learning needs of special-needs pupils using appropriate tools and materials with those unable to learn directly from the class teacher due to learning difficulties. The importance of inclusion is that it improves learning outcomes through the influence and proximity with non-disabled peers. Individual files are kept on each special needs child that includes medical reports, relevant information and evaluation forms recording improvements in performance.

Educational supervisors make regular visits to schools with special-needs pupils to observe the class and monitor the children's progress and the special-needs teaching. Supervisors also interact with the children and send monthly evaluation reports to the Special-Education Directorate. When problems arise, including lack of progress, a case meeting is called by the Special-Education Directorate in which the child's special needs teacher and Karen Chesterton (a UNICEF funded expert in the field) are able to develop new strategies.

By the final quarter of 2009, KIEP had been implemented across the region: districts and sub-districts and towns. Erbil now has 34 inclusive schools, 35 special-needs teachers and two Early Learning Centres, where there are eight children and three teachers.

Training Of the teachers included in the KIEP training, a number had existing special-needs experience whilst others had none. A number of the teachers were trained in the Portage System[(1)] and another group in the Small Steps System[(2)]. The training was delivered in coordination with the Portage Indian Network and South Asia Network following adjustment of the curriculum and teaching materials by the Portage Institute to reflect local cultural norms prior to translation into Kurdish. Local and Arab organisations involved in the training of special-education teachers

Two additional Dutch education experts were introduced through ACORN[(3)] to deliver practical training in 5 schools in Dahuk and Halabjah governorates and the programme initiated in Erbil and Sulaymaniyah in the academic year 2007-2008. The maximum of 12 special needs pupils per standard class has been maintained. Enrolment age is 6 years and admission to an inclusive education class follows formal diagnosis by both a medical committee and a special needs educational committee. In 2007-08, the standard curriculum was used for all. A special needs curriculum is due to be developed and introduced in academic year 2009-10.

Issues Arising Two major issues arising from the Kurdistan programme: the lack of any regulation on the delivery of special needs education programmes and the lack of a dedicated budget for the development and delivery of a special needs programme. The programme also relies extensively on the support of UNICEF and other international organisations from The Netherlands and New Zealand.

Future Challenges The KIEP is in the early stages of implementation and will need to gain considerably more support if it is to be accepted within the wider community. Although welcomed by parents of special-needs children and the Chair of the Committee for Women & Children, as noted above, it has received a mixed reception from other members of the Erbil Provincial Council, some of whom see it as a Western imposition. There has been little media interest or awareness-raising in support of the programme, but the Minister of Education is extremely supportive.

(1) The Portage System is a programme for children with disabilities that originated in the United States in the 1970s and which has since been adopted by over 100 countries;
(2) Small Steps is an Australian designed developmental steps programme for children with disabilities.
(3) ACORN is a Dutch community-based organisation operating primarily in children's rehabilitation in Northern Iraq

Care Institutions
During Phase 1, Dr Al-Hashemy visited three Erbil-based KRG institutes for the disabled: the *Institute for the Deaf and Mute* that caters for 166 children between the ages of 6-17 years, where the children face a number of difficulties including a lack of well-trained teachers and access to suitable transport to allow them to attend the institute; the *Institute for the Blind* that caters for 210 children between the ages of 4-15 years, which has experienced staff although they are not up-to-date with modern teaching methods, including the use of computers; and, the *Institute for the Mentally Disabled* that caters for 235 children between the ages of 2-16 years, most suffering from severe mental disability, requiring expert care. Admission to this last institute is based on a diagnosis by a medical committee and a special committee based at the institute. All three were in desperate need of additional funds, modern educational aids and qualified teachers.

Third Sector There are a number of Erbil-based NGOs and societies with either a disability mandate or special-needs teacher training capacity. All are reliant on funding from international organisations working in Kurdistan (eg. the Kurdistan Development Organisation, Kurdistan Handicapped and Save the Children of Kurdistan). Their impact is currently limited by the lack of legislation, policy, or clear regulation on inclusion in schools (see Table 3, Annex 8).

11.4 Najaf Governorate Najaf Governorate is situated between Anbar and Muthanna Governorates on Iraq's southern border with Saudi Arabia. Its landscape is dominated by desert. It covers an area of 28,824 sq km, 6.6% of Iraq (IAU/OCHA [2009] Najaf Governorate Profile). The Governorate capital is Najaf City and both it and Al-Kufah City are holy sites for Shi'a Muslims (*ibid*.).

The estimated population of Najaf Governorate is 614,997, 4% of the total Iraqi population (GoI COSIT 2007 *cf*. IAU/OCHA [2009] Najaf Governorate Profile). The gender distribution is 50% Male: 50% Female and the geographical distribution is 31.4% Rural: 68.4% Urban (GoI COSIT 2007 *cf*. IAU/OCHA [2009] Najaf Governorate Profile). The governorate has 3 districts with the population distribution outlined in Table 4.

Table 4. Najaf Governorate Districts and Population Distribution

Najaf District	567,340	Kufa District	288,255	Al-Manathera District	225,608

(WFP VAM 2007 cf. IAU/OCHA [2009] Najaf Governorate Profile)

In Najaf Governorate, 64% of households are living in slum conditions with more than 3 persons per room in 51% of households (IHSES 2007, *cf*. IAU, the Housing & Shelter in Iraq Fact Sheet, 5 October 2009). 84% of households have unstable water supply, while 8-14% of houses are not connected to the water network (*ibid*.). According to the IAU/OCHA, the Iraq Pockets of Vulnerability Map 2009, the district with the highest proportion of people and households in need is Najaf, followed by Kufa and then Al-Manathera. No Najaf districts are listed as a priority for humanitarian action by the IAU/OCHA, Iraq Humanitarian Action Plan Priority Districts Map, November 2009.

Unemployment rates are 15% for women and 11% for men, with 17% Female: 86% Male labour force participation (WFP VAM 2007 *cf*. IAU/OCHA [2009] Najaf Governorate Profile).

Najaf district (which contains the governorate capital) performs well according to many humanitarian and development indicators. However, areas outside Najaf District perform relatively poorly (IAU/OCHA [2009] Najaf Governorate Profile). Access to electricity supplies is relatively reliable in Najaf, and average elsewhere. Relatively few households outside Najaf have access to a secondary source of electricity when the network fails (*ibid*.). Sanitation and access to safe water are poor in Al-Koufa and Al-Manathra. However, levels of chronic malnutrition are low across the governorate (*ibid*.).

Governance The study research team is currently obtaining more detailed data on this topic.

Impact of War The security situation in Najaf governorate has been relatively calm (IAU/OCHA [2009] Najaf Governorate Profile) although there were bombings in the lead up to the March 2010 elections (Washington Post, 7 March 2010). There are 53 internally displaced persons and 3 returnees per 1000 of the population (IOM September 2008 *cf*. IAU/OCHA [2009] Najaf Governorate Profile). Around 85% of IDPs in Najaf are from Baghdad, and almost all are Shi'a (IAU/OCHA [2009] Najaf Governorate Profile).

Environmental Factors/Contamination A joint Ministry of Environment, Health and Science report lists Najaf City as a severely contaminated site (*cf*. The Guardian, Martin Chulov, 22 Jan 2010).

Industry Local industry include an oil refinery and a power station (situated outside Najaf City), in addition to cement, tyre and clothing factories. There are agricultural areas; a notable product is Anbar rice. Najaf has two universities (Najaf and Kufa)

Schools Najaf Governorate has approximately 659 schools (COSIT 2006-7). Of the 6 Najaf schools in Al-Ashraf visited by Dr Al-Hashemy in Phase 1, 2 were 'girls only', 2 'boys only' and 2 'co-educational'. These schools had between them a total of 13 special needs classes, with 165 special-needs pupils and 7 special-needs teachers (see Annex 6). The visits to state primary schools in Najaf emphasised again the overall lack of facilities for pupils with special needs. The average special needs teacher to pupil ratio in Al- Najaf was by far the worst encountered over the 4 study governorates standing at 1 teacher for every 26 pupils.

A recent Committee for Women & Children's Affairs report to the Najaf Governorate Council, failed to make any reference to children or pupils with special needs either in the context of schools or care institutions, highlighting again the need to raise awareness of the situation of disable children within the educational context and teh major task involved in delivering a national inclusive education strategy.

Care Institutions The most recent MoLSA figures show that Al-Najaf has 5 MoLSA run Child Social Care establishments (educational and vocational) catering for 204 children between the ages of 2 and 16 years, and a staffing level of 32, providing a child to staff ratio of 1:6 (Source: Dr Al-Hashemy 17 August 2009 meeting with the Minister of Labour and Social Affairs, see Table 1, Annex 8).

Dr Al-Hashemy also visited a number of special needs institutions providing care facilities for the disabled in the Govenorate of Najaf. These included: *Al-Nur Institute for the Blind* (The Light) catering for 25 pupils (formerly 80); *Al-Raja Institute for the Mentally Disabled* (The Expectation) catering for 60 pupils; *Al-Bara'um House(The Buds)* catering for 13 children; *Al-Ajyal 1 House (The Generations 1)* catering for 120 children; *Al-Ajyal 2 House* catering for 52 children; and *Al-Amal Association for the Deaf and Hearing Impaired (Hope)* catering for 136 pupils between 3-15 years of age.

Although this last caters for both the deaf and children with lesser hearing deficiency they are catered for in the same classroom and only taught to use sign language. There is no special curriculum for the deaf and hearing impaired, although the MoE is scheduled to develop a special syllabus for academic year 2010-11. The other major constraints to achieving international standards in special needs education is the lack of trained teachers and the lack of modern educational facilities and specialist teaching materials and aids, coupled with the fact that in the Amal Institution, deaf and hearing-impaired children share their building with sewing and carpentry workshops.

Although all of the institutions visited have good relations with the Al-Najaf Governorate Council, the Council itself lacks disabled funding in general. All lack experience and have received no financial support or formal training from international organisations. The service they provide falls well below required standards.

Third Sector Dr Al-Hashemy visited 5 of the Najaf-based NGOs catering for people with disability in Najaf Governorate: The Imam Shia of the World, The Centre for Human Rights Observance, The Iraqi Association for Disabled Rights, The Iraqi Farmer's Association and The Tamooz Association (see Table 4, Annex 8). Their impact is currently limited by lack of clear policy and funds.

12. Healthcare System

Box 24. Current Iraqi Healthcare Structure *Source: WHO 2005*

Iraq healthcare structure encompasses 10 Directorate Generals (DG) with responsibilities as follows:

i. *Public Health and PHC* preventive health; some promotive health programmes; PHC policies.

ii. *Planning & Human Resources* planning MoH budgetary and human resources needs and nursing programmes.

iii. *Administration, Finance & Legal Affairs* legislation, administrative and financial instructions for DOH governorate implementations and specialist departments.

iv. *Engineering* health facility engineering projects including construction, rehabilitation and renovation.

v. *Technical Affairs* management of curative care, dental and oral care, pharmacy and medical laboratories.

DG of Operation & Specialist Services: emergencies, ambulance care, and preparedness and response actions.

vi. *Kimadia* state company for procurement/distribution of medicines and medical supplies and appliances

vii. *DG of Public Clinics* a semi-official independent department: curative care in network of clinics, monthly drugs delivery to chronic disease patients.

viii. *DG of Medical City* the biggest provider of secondary/tertiary medical care in all medical/surgical

Iraq's current healthcare system is hospital-oriented and capital-intensive, requiring large-scale imports of medicines, equipment and health workers (WHO 2005). It is inefficient and access is inequitable; health professionals are also unevenly distributed (*ibid*.). GoI COSIT 2006 statistics show that there are 78 hospitals in Baghdad (36% of the total number), 8 in Najaf (3.7%) and 17 in Basrah (7.8%) (see Table 13, Annex 1). In addition, there are 109 public health clinics and 340 other health establishments in Baghdad (29% and 21% of the total number respectively), 15 public health clinics and 60 other health establishments in Najaf (4% and 3.7%) and 33 public health clinics and 151 other health establishments in Basrah (8.8% and 9.4%) (*ibid.*).

12.1. Health Care Structure In 2005, the MoH had sole responsibility for the provision of healthcare in Iraq. Funded through the MoF post-2003, funds were barely sufficient to meet staff salary costs let alone other expenses, leaving the MoH increasingly reliant on UN and INGO funding. Following the 2003 dismantling of the army, thousands of military medical and health staff were transferred to the MoH, and military health facilities connected to the MoH as fully integrated MoH Public Health System institutions.

Kurdistan established two regional MoH located in Erbil and Sulaymaniyah which since 2003 are also centrally financed through the MoF in Baghdad to meet staff salaries. There are 16 Departments of Health (DoH) in 15 provinces in the centre and south of Iraq (2 in Baghdad), each in the centre of each province. The process of devolution of authority was endorsed by the MoH to delegate some limited responsibility and authority to the DoH level as a pilot. In doing so, it was noticed that there was a need for capacity building at DoH level, strengthening management and methods to enhance multi-sectoral collaboration. Moreover, this pilot study did not work properly since the DoHs had responsibilities but did not have the means to implement them (funds). (WHO 2005)

Box 25. Iraqi Health Care System: Overview

The history of the health system in Iraq begins in the early 1920s. The first government in Iraq at that time saw the establishment of the Ministry of Health (MoH) which, after a couple of years, was part of the Ministry of Interior until 1939 when it was merged with the Ministry of Social Affairs. This existed until 1952, when a new MoH was established which continues today. Since the early decades of the last century, the MoH has gone through different organisational structures. The newest structure was adopted after the 2003 invasion and has recently been subject to further modifications.

During the 1970s and early 1980s, Iraq experienced improvements in several critical health outcomes. Infant mortality rates decreased from 80 per 1000 live births in 1979 to 40 in 1989. In the same period, under-5 mortality rates fell from 120 to 60. However, capacity and performance started to deteriorate during the 1980s—the decline was exacerbated as a result of both wars and of political and economic sanctions. During this period, health policy choices were inappropriate, especially in relation to health care financing. The per capita spending on health was extremely low; indeed, current analysis by the MoH suggests that during the 1990s the funds available for health were reduced by 90%. One significant consequence of all of these factors was a serious decline in indicators of population health outcome.

At the same time, many health professionals left the country. The health care system became increasingly politicised, centrally controlled, and poorly suited to respond to changing population health needs. The result was that health indicators, at least in the centre and south of Iraq, fell to levels comparable to some of the least developed countries in the world. From 1990 to 1996, infant, child, and maternal mortality rates more than doubled.

Health outcomes are now among the poorest in the region. Maternal and infant mortality and malnutrition are high; certain communicable diseases have re-emerged to join non-communicable conditions in a double burden of disease. Malaria, cholera, and Leishmanisis are endemic in several parts of the country. The registered number of cases of HIV/AIDS is relatively low; however, all risk factors are present for increased rates of transmission. In the aftermath of conflict, general insecurity and gender violence have prevented women from seeking health care for themselves and their children. During the 1990s, there was a trend of increasing vulnerabilities for

12.2 Infrastructure As with schools, years of neglect and underinvestment, followed by extensive looting and wanton destruction post-2003, have destroyed much of Iraq's medical infrastructure. Hospitals and Healthcare Centres lack reliable water and electricity supplies and patients preparing to undergo medical procedures are given shopping lists to purchase the necessary medical supplies, including the most basic such as syringes, gauze, suture gut etc. due to lack of central supplies (WHO 2005).

12.3 Private Healthcare The private healthcare sector is powerful and has the capacity to supplement the weakness of the public sector especially in curative services. Private clinics are distributed nationwide in addition to private hospitals mostly located in Baghdad and to a lesser extent in the centres of provinces.

12.4 Third Sector There is very limited provision of healthcare by NGOs. There is one hospital in Baghdad run by the Iraqi Red Crescent Society (IRCS) as an almost entirely independent for-profit hospital, but which provides some medical and surgical care at a relatively low price compared to the private sector.

13. Conclusion

The Phase 1 work to raise awareness of this study, to gain the support of key players, and to establish the status quo, although extensive, is by no means exhaustive and will continue throughout the study period.

Iraq remains an extremely fragile and fluid environment so that information captured can often only provide a snapshot in time. There will need to be constant re-verification of secondary data to ensure its continued relevance and reflection of the latest developments in policy, legislation, planning and practice. The 2009 elections in Kurdistan led to changes at ministerial and local government levels so that new links and relations have had to be forged by the study team in Kurdistan. Likewise, the January 2010 national elections will result in new incumbents in key positions within central and local government in Central/South Iraq, so that the task of bringing key players on board will also continue throughout the study.

Although we are delighted that Phase 1 respondents have all declared their support, nevertheless, ongoing dialogue will also be required to ensure that these in-principle commitments translate into realities. In addition to the vital importance of such support to the study's outcomes and impact, it is also crucial to the successful implementation of the Phase 4 study survey, as demonstrated in the small Phase 1 pilot in Baghdad, itself facilitated by the governor's deputy and council, municipal and tribal leaders.

This direct engagement of local representatives should also prove invaluable to the study's efforts to highlight the importance of educational opportunities for disabled and special-needs children and youth, to increase understanding of the concepts of inclusive education and early childhood development, of realities on the ground, and of the centrality of early childhood development provision in mitigating against the consequences of disability during a child's first critical five years of life. It will equally help to reveal attitudes and hopefully allow the study to give voice to those frustrated by poor provision and by the lack of financial investment and dedicated budgets.

The lack of human, as well as financial resources is clearly another major constraint to providing effective education opportunities to disabled children and children with special needs, so that the question of specialist training and the development of appropriate teaching resources are equally major considerations for the overall study. Institutional care echoes much the same failures as identified in the education sector: lack of investment, poor building stock, poor teacher/pupil ratios, a dearth of specialist and experienced personnel. Dr Al-Hashemy referred to the ineffectiveness of 200 social workers due to lack of training.

Phase 1 also confirmed not just the difficulty of accessing up-to-date reliable data, but the difficulty of comparability across data sets that have been captured using different criteria and definitions. The study will to some extent have to echo certain of the criteria identified simply to be able to verify its own findings against official data, eg. COSIT and MoLSA.

A multiplicity of social and cultural factors, including a lack of accessible single sex schools in rural areas and the social status of girls in Iraq, coupled with ongoing security concerns etc. have impacted most negatively on girls and girls in rural areas in particular. Understanding fully the more subtle variables that impact on one particular group over another will be a further important area of focus for the study.

Limited collaboration between ministries – MoE, MoH, MoLSA etc. – with responsibility for education and care for the disabled, for local infrastructure including school buildings and transport, for teacher training including special-needs teacher training, for the development of curricula including specialist teaching curricula and materials, for diagnosis and ongoing evaluation etc, is yet another major area for consideration.

Phase 1 has highlighted the chasm between positive legislation, in some instances dating back 30 years, and realities on the ground, in great part the legacy of three decades of conflict and economic deprivation, but also of attitudes towards disability and a lack of political will that is still evident today. This is in no way to deny the achievement of, and optimism engendered by, the New Disability Act, nor of the June 2009 instruction that heralded a National Inclusive Education Strategy. However, the problematic associated with introducing education opportunities for children and youth with disability and special needs within an education system that is failing its non-disabled children is all too evident, as is the failure of past legislation to impact meaningfully on realities on the ground. Both are stark reminders that there is little room for complacency.

Phases 2 and 3 (survey design, pilot and training) are scheduled to complete in early April 2010 with implementation of the Phase 4 survey due to start in late April 2010 and complete in mid to late June 2010.

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