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using the medium to find sexual partners take more sexual risks[26] and, in the case of young people, start sex earlier.[27] Many good sexual health sites are already available. However for the young, protective filters on home computers sensibly bar access to pornography but incidentally often bar access to safer sex sites as well.[28] Parents can change web browsers to allow access to safe sex sites but this requires a sexual health dialogue between parent and child. All too often this dialogue is absent especially for those who have started sex or even an interest in sex early.[6]

In reality of course there is no specific promiscuous 10% as many individuals move in and out of polygamy, serial monogamy, long term monogamy, and even abstinence. However, meeting the needs of the most sexually active, whatever the terminology, lies in giving more consideration to their needs when planning educational curriculums, media campaigns, and health interventions. With some areas seeing one in ten young people with a STI[29] perhaps a greater level of statutory, pertinent, and timely sex education is now required despite the complaints of a few. More realistic portrayals of sex, condom use, and safer sex practice in the media may again upset a few but may also help counter the sexual innuendo that currently promotes promiscuity but provides no hint of safe sex behaviour. Perhaps even the occasional advert could suggest that condoms, not just aftershave or the right jeans, may help improve your sex life. The price for this will undoubtedly be complaints from a few individuals who find open discussion of sex and sexuality difficult to condone. However, with spiralling numbers of STIs and continuing unwanted pregnancies the price of ignoring the needs of the promiscuous 10% will be far greater.

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Iraq

Rebuilding health care in Iraq

Andrew S Furber, Paul Johnstone

Advocacy and technical support required to support professional colleagues in Iraq

The effects of three wars within 25 years,[1] a decade of international sanctions,[2] and a brutal regime have had tragic consequences on Iraq's health system and on the health of the Iraqi people.[3] While the scale of these problems is becoming clearer, it has been difficult in the current security situation to know how best to respond to requests for help.

A workshop organised by the International Committee of the Faculty of Public Health (FPH) in November 2003 has now addressed this very issue.[4] This paper describes the health service needs presented at the workshop by representatives from the Department for International Development (DFID), World Health Organisation (WHO), International Non-Governmental Organisations (INGOs) and, most importantly, Iraq's Ministry of Health. We will also consider current responses and how professional public health bodies from around the world might

contribute to the development of Iraq's health sector.

The priority health service needs of Iraq where professional public health organisations could usefully contribute fall into four broad areas: communicable diseases, primary care development, health management, and public health training. These areas were identified as being of key importance by the participants at the workshop with recent experience in Iraq and concur with the assessment of the Iraqi Ministry of Health[5 6] and findings of the donor meeting in Madrid.[7]

The potential for the outbreak of infectious diseases is clear and immediate. The cold chain for the delivery of vaccines has broken down in many parts of the country.[8] Primary care facilities are often not administering the immunisation programme in an efficient manner—and even where facilities are functional staffing remains variable.[9] Such disruption will also affect other communicable disease control programmes such as that for tuberculosis. Water supply and sanitation are poor, especially in parts of the country where fighting was the fiercest, resulting in episodes of watery and bloody diarrhoea. The incidence of diarrhoeal disease has been reported to have doubled in some areas of the country.[10] The causes of these cases are often unknown as laboratory facilities are still not functioning in a way that permits microbiological diagnosis. Laboratories have suffered from systematic looting and therefore lack basic equipment. Clinical reporting from primary care facilities remains inadequate to properly monitor patterns of infectious disease. However, despite all this there have been no major outbreaks of infectious disease reported, according to Tim Healing, a microbiologist working for WHO. This is probably attributable to the basic clinical skills of Iraqi healthcare workers and the prioritisation of communicable disease control by NGOs and WHO. While a public health catastrophe has thus far been averted, the dangerous conditions still exist that would allow for serious outbreaks of communicable disease.

While primary care facilities are improving, it is clear that many remained poorly staffed and inadequately equipped. At the FPH workshop, Linda Doull, Health Advisor from the INGO Merlin, described their programme for the re-establishment of primary care facilities. While this has had some success (showing that it remains possible to see improvement even in difficult security situations), there is still a long way to go. Merlin has been able to distribute emergency health kits, water storage equipment, chlorine tablets, and health promotion leaflets.[10] Although such process indicators are encouraging, outcomes are more difficult to measure. Good outcomes from such programmes will be reduced by the on-going security problems. Many parts of the country do not have similar primary care support programmes.

Retaining the central role of primary care is part of the challenge of managing Iraq's health system.[11] A health system based on primary health care remains an effective approach in resource constrained settings.[12] The Ministry of Health in Iraq has yet to set a vision for the future of the country's health system, according to Jürgen Schmidt, Health Advisor with DFID. While broad targets have been set in terms of, for example, electricity and water supply, it seems that no objectives have been set for reconstruction within the health sector. This leads to reluctance from the donors to become involved in long term investment in this sector and is compounded by weak management capacity within Iraq, both at central and governerate levels.*

The causes of this lack of management capacity are complex, but it is clear that there is a key training need[11] and a priority area identified by WHO.[13] The effects of the wars, the sanctions, and the restrictive regime have meant that most health administrators and healthcare workers who have remained within the country have had little professional development over the past 15 years or so.[14] Medical libraries, where they still exist, are stocked with out of date journals and text books. Internet access remains poor for most health professionals resulting in limited access to online resources. Postal and courier services are either unreliable or absent making it difficult to mail resources. Providing training within the country currently represents a significant security risk for both trainer and trainee.[15] While there are important training needs within all specialist areas, it is clear that during a postwar period of development and investment the need for skills in public health and health systems management are particularly urgent. Another pressing need is for a rapid expansion of nursing capacity, which is currently inadequate at all levels. There is an important opportunity for professional nursing organisations to ensure this area is not neglected.

The expectation of the people of Iraq for the rapid development of health services is important and needs to be recognised. However, it is unlikely that these expectations will be met in the short term. It is also possible that these aspirations are distorting the donor response. There is evidence, for example, that funds have been allocated to the reconstruction of metropolitan hospitals ahead of primary care development.[2] This is probably in part attributable to the need to have some highly visible health projects both for the Iraqi people and the international media. In reality Iraq must aim for the health system of a middle income country in the short term and leave ambitions for an expensive technology based service until a later date. Managing these expectations and demonstrating important health improvements achieved through primary care development will be an important role for public health practitioners.

A major issue that affects existing health services and any efforts to develop them is that of security. While acknowledging the extreme difficulty faced by the occupying forces, it is nevertheless lamentable that health services were not better protected.[16] The maintenance of essential services is a responsibility of the occupying powers. A political solution is required to bring the long term stability required to fully develop the country's health services. Making this link clear to governments and pressing them for action will be an important advocacy role for health professionals. The current security situation makes travel to Iraq for expatriates extremely hazardous and in most cases inadvisable. Therefore, while not ideal, most training initiatives for Iraqi health professionals will need to be done either remotely or out of country.

Given these pressing needs and the important constraints we have described, what is the best way to support professional colleagues in Iraq? The FPH International Committee's Workshop identified two broad areas for action: advocacy and technical support. Advocacy from professional organisations can be an important influence when there is a widespread public perception that government actions may be driven more by domestic political considerations than the needs of the Iraqi people. Particularly in the period before a democratic government becomes established in Iraq, advocacy can be a way of ensuring that the human rights of the Iraqi population are given the highest priority by those in authority. The Faculty of Public Health and other professional bodies can have an important role in influencing the response to postwar Iraq. In particular it needs to be made clear that there is a humanitarian duty to ensure that the

*There are 18 governerates within Iraq, each having a director of health services.

health of the Iraqi people remains central. While it remains vital to secure the broader determinants of health, such as security, employment, and water supply, the Iraqi Health Ministry needs to work with the Interim Iraqi government with support from the international community to build a vision for health sector development. The FPH needs to join with similar bodies to lobby governments to ensure this happens.

In terms of practical support there is a need for more professional and technical connections. Poor access to journals, training, and continuing professional development are key issues for many Iraqi professionals, many of whom were trained in the UK. International exchanges and provision of information will be important drivers for improvement. However, caution needs to be exerted. Inappropriate ''study tours'' to technology based health systems may create more dissatisfaction and increase emigration by professionals from Iraq. The FPH hope to establish a post to help carefully coordinate training exchanges to ensure that they are appropriate. Exposure to academic training and service National Health Service work for short periods will be valuable in updating public health competencies and emphasising the centrality of primary care, as well as establishing longer term supportive partnerships.

Despite the concern that many public health professionals may have over the decision to go to war in Iraq, we are now faced with an important opportunity to help meet major public health needs. Within the UK the FPH will provide one channel for such work, but many more will be required throughout the world.

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THE *JECH* GALLERY

''5-a-day'' may be harder to achieve in more deprived areas

Increasing the public's intake of fresh fruit and vegetables is a major public health objective. Pronounced differences between social groups in fruit and vegetable intake have been observed and lack of access may contribute to patterns of consumption.[1] In our study of socially contrasting localities in Glasgow, we have noticed differences in retail outlets that may contribute to lower consumption of fruit and vegetables in the more deprived locality.[2]

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