

United States Institute of Peace  
Association for Diplomatic Studies and Training  
Iraq Experience Project

**ROBERT GOODWIN  
EXECUTIVE SUMMARY**

*Interviewed by: Mark Gribbin  
Initial interview date: August 26, 2004  
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Robert Goodwin, 31, is a graduate of the Air Force Academy and is employed by the Department of Defense. In Iraq, he worked in governance and reconstruction as he helped set up the Iraqi Ministry of Health (MoH) and the greater health care system in general. He was stationed in Baghdad for 11 months, from June to May of 2003, and mostly worked outside of the Green Zone at the health ministry. His Iraq-specific training, prior to taking up his post, consisted of a few briefings at the Pentagon.

Goodwin notes that prior to the US invasion the Iraqi health care system was deteriorating from neglect and was riddled with corruption. The Hussein regime used its medical system to support the regime, not necessarily to provide for the common good. Favored groups were given top-notch care, while the rest of society was neglected. There was also a focus on Hospitals over small local care facilities. Overcrowded conditions at hospitals and poorly trained staff resulted in disease epidemics. Medical facilities were operated for political convenience rather than greatest need, and were often used for propaganda purposes.

The Health Care system was highly centralized and inefficient. The UN Oil for Food program supplied the health care system with all of its needs, from pharmaceuticals to x-ray machines. Pharmaceuticals were often of low or varying quality and adequate dosages were hard to determine. Distribution of medical supplies was done through the state-owned medical corporation Kimadia. This distribution was highly inefficient, as all goods were funneled through central national warehouses in Baghdad, then out to provincial capitals, before finally being passed on to the local level end-use facilities. Many goods "disappeared" before ever reaching their final destination and were sold on the black market. The funneling also took time, meaning that supplies expired before reaching their end-use points or were improperly kept (i.e. IV fluid would be kept for months in a hot warehouse).

One of the new Ministry of Health's goals was to decentralize the health care system and provide adequate care for all Iraqis. The shift of emphasis was from the Hospitals and emergency treatment and prescription writing to local level clinics and preventative care. The new plan called for an end of the centralized distribution network. Instead, medical facilities were asked to begin budgeting and supplying their own medicines, equipment, etc.

The shift toward a decentralized system has proved difficult for several reasons; (1) There is a lack of trust in the quality of treatment available at local clinics, as hospitals have long been the foremost care provider; (2) doctors and administrators are not used to taking initiative, creating budgets, or obtaining supplies on their own; (3) nursing staffs are poorly trained, resulting in doctors performing the work of nurses; (4) there is a lack of "generalist" medical practitioners.

Despite the obstacles faced, Goodwin feels that the new ministry was very successful in moving towards accomplishing its goals. He gives the example of a national immunization program as well as an emergency vaccination program, both of which proved highly successful. He also notes that Iraq personnel continue to provide the lion's share of medical care in Iraq, supplemented by NGOs and coalition medical staffs.

Goodwin notes that the key to successfully rehabilitating the health care system is to provide better training to Iraqi administrators and medical professionals. Under the former regime, administrators were stymied by a stovepipe bureaucracy and medical professionals languished in intellectual isolation. Empowering these persons to develop their own capacities and to change their systems is essential. He argues that Iraqi involvement in developing new institutions and practices is essential if they are to take ownership of these institutions. Medical training programs are being conducted by international NGOs. Attempts are being made to rehabilitate indigenous training institutions.

One of the chief means that the MoH used to address the ownership issue was to create Iraqi working groups to discuss health care issues. The working groups included a diverse group of Iraqi medical professionals, educators, and administrators. Issues discussed ranged from the type of health care system to be developed (social or private) to how public health initiatives should be carried out. Working group recommendations heavily influenced MoH policy.

Other MoH outreach was targeted at including local clergy groups, civil society, and the public at large in the discussion on health care and public health. NGOs and the World Health Organization (WHO) have also made contributions to the reconstruction of the health care system.

Funding from the US supplemental bill promises to be helpful in refurbishing the physical infrastructure of hospitals and clinics and purchasing new equipment. However, the DFI (Development Fund for Iraq) and CERP money have to date been more useful, as spending guidelines for these monies fall outside of slow-moving US government contracting regulations.

Goodwin is largely optimistic about the future of Iraq and has faith in the diligence, intelligence, and courageousness of the Iraqi people to rebuild their country.

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*Q: Today is August 26th and this is an interview with Robert Goodwin being done on behalf of the U.S. Institute of Peace and the Association for Diplomatic Studies and Training as part of the Iraq Experience Project. I am Mark Gribbin. We've covered your basics, which will be provided on another sheet. When you arrived in Iraq, you were working for the Ministry of Health. What were your goals and objectives going in?*

GOODWIN: First and foremost, there was some confusing information as far as what was the real situation on the ground, what was happening. The folks that were there prior to us was a group of military members, with a civilian component, [which was what was left of] the original ORHA (Office of Reconstruction and Humanitarian Assistance), which was originally operating there. However, they were operating in a very emergency response mode, crisis action. They would meet for two hours in the morning from seven to nine and talk about what they were going to do that day. They would meet for two hours later that evening and talk about how did things go; everything from paying ministry employees to humanitarian deliveries. The first thing we did was to get on the ground and figure out, "What is the current situation down at the ministry with the staff," and then move on from there.

*Q: Were there Iraqi people in place at the ministry or was it essentially just Garner and his advisors forming the ministry? What was the structure?*

GOODWIN: When we got down there, there was very little structure. The place had been looted down to the electrical sockets. Trash was six feet high outside on the ground at the windows. There were no desks, chairs, anything, so pretty much all the ministry employees were hanging out outside in the parking lot waiting for someone to tell them what to do. It was clear to us very early on that we needed to get this place back up and running, so we established our team and moved into the Ministry of Health to start working there full time and then eventually got desks, chairs, things like that, and did a major project to refurbish the ministry building to get people back to work.

*Q: How did you get all those supplies? Did you work through American contractors or did you work with Iraqis?*

GOODWIN: Multiple sources. USAID helped very early on with what they called a "ministry-in-a-box" kit, which was 300 chairs, 100 desks, and things like that. We got several of those

kits. That had an immediate impact. Then we got some support from the World Health Organization. We also used some other funding that we were able to get through CPA in order to start the refurbishment of the ministry.

*Q: Was that from the supplemental or was that special emergency?*

GOODWIN: Not from the supplemental. There are two accounts there. One is what they call the DFI, Development Fund for Iraq, which are the Iraqi funds; seized assets, oil revenues, things like that. The supplemental, the \$18,000,000,000, was totally separate from that. The benefit of DFI type money is [that] it's Iraqi funds, so [DFI spending] didn't necessarily have to follow U.S. procurement law. Therefore, we were able to hire an Iraqi general contractor, who did a lot of work for us very quickly.

*Q: Are you talking about reconstituting the ministry building itself, or are you also talking about some of the other facilities, for example, hospitals and the public health centers?*

GOODWIN: Our first goal and objective was to get all the hospitals and clinics back up and running, which we were able to accomplish very quickly. Much of the original investment on that was done through military or "CERP" funding. Office of Foreign Disaster Assistance (OFDA) was doing some work there [too]. But through our team, we also started infusing money out into all the different governorates so that those director generals from the ministry themselves, the Iraqis, would have some funds at their disposal. The challenge was that under Saddam these people never had any access to funding. Second, they never had any decision-making authority, so our base challenge was getting them to spend that money and not think, "Okay, if I spend a dollar incorrectly or I overpay a little bit for something, I'm going to end up dead, in jail, or out of work."

*Q: You mentioned that you were sending out money to the governorates. Correct me if I'm wrong: Wasn't the health system highly centralized under the former regime, and what kind of problems did you encounter in trying to change that culture?*

GOODWIN: It was very centralized. We found some problems again with just decision making. Everything would go to the minister under the former regime for decision, even minor things. If you had a project that required both mechanical and electrical engineering, both plans from each engineer would have to go up to the minister for a decision. So everything took forever. You had people working warehouses that worked right next to each other for 30 years and had never met each other, because it was so stove-piped. That's part of the way that Saddam kept control of the people. So it really was a challenge just getting that empowerment. And those were some really key decisions that were made from the central level at the ministry, to shift from a centrally controlled system to a more decentralized execution mode.

*Q: We were talking about reconstituting the hospitals and the public health centers. Who was doing that? Were you working through or with the pre-existing infrastructure or with coalition forces and NGOs?*

GOODWIN: One of our biggest challenges when we first got there was there was no lead for health care. World Health Organization thought they were in charge, USAID thought they were in charge, NGOs thought they were in charge, and no one was hearing or coordinating with the Iraqis.

So our biggest thing was — and this is a fundamental thing that I think many people misunderstood from the State Department [and] the Department of Defense (DoD) — that CPA was not there to represent the U.S. government; they were there to represent Iraqis. I considered myself an Iraqi advocating for the ministry. We had a lot of conflict in the interagency process to kind of say, “No, the Iraqis are in charge, and it just so happens, temporarily until an Iraqi minister is in place, our team is the leadership of that Iraqi ministry.”

So there were multiple actors operating within country, NGOs, this and that. Our base challenge—it was a very painful process—was to get everyone on the same page of what needed to happen. For example, there were a lot of good things being done through NGOs and military units; however, sometimes you can do more harm than good. If you build a clinic and not think about long-term recurrent costs (staffing, supplying) then you just have an empty shell. It needs to be brought in within the Ministry of Health context. Or if you build a clinic right next to an already existing facility, then you’re again going to have problems.

[One of our] first [priorities] was kind of to exert that authority [in Baghdad, and] out to the governorates as well. It was a real challenge just because in the past everyone came to Baghdad, and we tried to change that by kind of saying, “You need to start making these decisions yourself out in the governorates.”

I’ll never forget one example: This guy came into the ministry, an Iraqi, and he said, “I want to do this project.” “Okay, well, go do it.” He said, “I need a piece of paper to be signed.” We said, “No, you don’t. Just go do it.” He said, “Well, can I have a piece of paper signed that says I don’t need a piece of paper?”

*Q: Do any specific examples jump to mind of how a specific clinic or hospital was refurbished?*

GOODWIN: I think you can look at Medical City, which used to be the Harvard of Iraq. It was the main place where everything was happening. This is a place that basically was supposed to have the nicest hospitals, but they didn’t have power, they didn’t have water, they didn’t have supplies, they didn’t have anything.

Part of it is that the Iraqis are conditioned to ask others for help. If they need a bandage, they would go to Coalition forces or NGOs or something and say, “We need bandages,” instead of looking at their own supplies for bandages. Originally a lot of NGOs and stuff were kind of filling those needs on an ad hoc basis.

So, we tried to get the Ministry of Health supply lines back up and running. When we first got there, the state-owned enterprise called Kimadia -- which handled all medical supply procurement, pharmaceutical supplies procurement, as well as distribution of all these items -- was not operating at all. There were all these medical supplies sitting in these warehouses and

not being distributed. We couldn't get the system working through the Iraqis, so we had to get the cooperation of Coalition forces to go and take over these warehouses and just start moving items out. [This was needed] because there were some severe shortages that were happening in Iraq.

*Q: I imagine there was a pretty sizable NGO presence throughout the country. Did that help in getting supplies out, or was everything still flowing through this central river?*

GOODWIN: What people underestimate about Iraqis is their capacity. These are very smart, very capable, very resourceful people, and too many people from the very beginning were still operating in the emergency response mode. They were seeing something that needed to get done and doing it themselves, versus empowering the Iraqis or trying to get them to do it themselves. [That included] everything from providing care directly to Iraqi citizens to supplies and everything else. So that was the biggest challenge.

With the NGOs, there was a lot of good work being done up until the Canal Hotel bombing, when most of those NGOs left the country. I just found it to be very ad hoc, very emergency response. You see something; you do it yourself. Whereas in a more reconstruction or transition-type mode you say, "Okay, here's what needs to get done. Let's step back for a second, see what others are doing, and then work a plan collaboratively with our Iraqi colleagues on getting something done."

*Q: Would you characterize the original response as throwing a band-aid on something when what was really needed was some treatment, something to actually heal it?*

GOODWIN: Reconstruction activities can go hand in hand with emergency response. You have to focus on those immediate needs that need a band-aid, and at the same time you need to focus on the longer term. Our job from the ministry standpoint was get people more focused on long term, and that is why in August we started a strategic planning process involving our Iraqi colleagues to start charting out, "Where is health care going to go after 2005," so that short-term inputs could fit into the puzzle which was the longer-term strategy.

For example, the health care system under Saddam was completely hospital based. There was no focus on primary health care, so people with minor infections would let them [worsen] and [worsen], and then finally go to a hospital when it got so bad that it really needed some serious treatment. There was not any focus on preventive medicine or public health.

*Q: Do you know if that was a staffing issue? Did they not have people qualified to do treatment in the smaller centers? Was the qualified staff all grouped together in the hospitals?*

GOODWIN: No, they had a model of primary health care prior to 1980. But so much of the resources under the regime were directed at hospitals, because Saddam would say, "How do I get my name out there? I want to build a new Saddam hospital." So many resources were going there because it's a big mark that you can make on society. [As a result,] primary health care was neglected.

Also, there were two health care systems in the country. There was the health care for the regime -- the senior Republican Guard officials and Saddam's family -- and there was [one] for everyone else. That was something that we saw evidence of.

Saddam [also] used to use the hospitals as propaganda. There was this hospital, Al-Iskan Children's Hospital, and all the children that were dying. He would wait and not let them be buried right away. He would build them up and then invite the press in and show the horrible conditions of the hospitals -- as well as parade all these dead children -- and use it as propaganda for sanctions. At the same time several blocks away there was this brand new Saddam hospital that had the latest equipment, that had foreign doctors, that provided a very high level of care, but it just wasn't open for the rest of the people. There were quite a few people, the Marsh Arabs, many people in the south, the Shia population that had no access to health care. We estimate that now access to health care has increased by over 30 percent.

*Q: Going in, initially, you said that there was not a plan in place on how to develop the Ministry of Health. Is that correct?*

GOODWIN: Well, I think there was a plan to try to deal with much of the humanitarian crisis: what happens if we have a cholera outbreak, a measles outbreak. But because we avoided those crises very early on, we were able to move much quicker into a longer-term reconstruction phase.

*Q: And that began with the August planning sessions?*

GOODWIN: Well, it started before that because we had to start identifying [the staff] that we can deal with. We're at a ministry with 100,000 employees. The senior-level Baath Party leadership had been removed from the ministry, and what was left were officials who were kind of "elected" by their peers in the ministries. So we started working alongside those Iraqis to start getting those things done: broad policy directives on how to get things done and how to work through some issues.

We saw very early on the need to involve the international community as well as the NGOs, all these people; just try to get a big-tent approach was really what we were looking at. On August 17<sup>th</sup> we invited the World Bank, the UN, WHO, UNICEF, the European Commission, DFID (UK Dept. for International Development), USAID, and a broad spectrum of Iraqis from around the country, from the north and south. We also invited Ministry of Health employees to be part of this group.

For the next three days we [separated into] nine work groups, [each of] which would focus on things like public health, pharmaceuticals and medical distribution, licensing and credentialing issues—there were nine different categories. We kind of said, "Okay, we need to lay out the outcomes we want [and figure out how to achieve them]." For three days, August 17<sup>th</sup> through the 19<sup>th</sup>, we kind of laid out "Here's the plan going forward in developing the strategic plan."

It was a wonderful three days of meetings, and unfortunately it ended at about three o'clock on August 19<sup>th</sup>. Several of the people that were attending that meeting went over to the Canal Hotel

to check their email and have some meetings, which then blew up around four o'clock. We spent the rest of the night evacuating patients, dealing with the wounded, things like that.

*Q: I hate to ask this: You don't happen to know what those nine categories are off the top of your head?*

GOODWIN: Off the top of my head: primary health care; public health; pharmaceuticals; licensing and credentialing; doctors, nurses, and medical personnel; human resources; information technology; and health information systems. It was generally the broad spectrum of where we wanted to go. But I have to talk a little bit about this work group process.

Originally as it started out, our staff -- along with some contractor support from USAID -- was really driving the discussion. We had gotten an even broader group of Iraqis to sit around the table with us.

*Q: What was the make-up of the Iraqis who were involved?*

GOODWIN: There were a lot of medical professionals, doctors, nurses, pharmacists, but at the same time, too, we tried to have a broader perspective, that of educators, thought leaders....

*Q: Administrators?*

GOODWIN: Well, administrators didn't really exist in Iraq. That was one of the challenges of the health care system. Management skills are really lacking.

*Q: Were these mostly educated people, then, rather than just kind of the farmer from the south representing his village?*

GOODWIN: One of the ways that we tried to drive more input was [through] the strategic planning process. It came out with a document and quite a few recommendations for how to change the health care system. Then we took [those recommendations] kind of on a road show. Several members of the Ministry of Health went around to different parts of the country and said, "Hey, here's what came up in the strategic planning process. Here's a form for you to fill out, a questionnaire." A lot of people participated in that —there were several thousand people around the country that participated in this process. The purpose was to (1) inform them of what was going on; and (2) to try to get more input into health care and how it works.

For example, [one question was] "Do you have more confidence in a hospital for care or a primary health care facility?" Something like 60 percent said they have more confidence in hospitals. So, if we're shifting to a primary health care model [in Iraq, which we were], it's going to require education, training, and resources going down to the primary health care level for the populace to have more confidence.

*Q: So a lot of the road show was gauging public opinions and public needs.*



GOODWIN: This was something that did not exist in Iraq: an everyday person's input into the plan. It was normally dictated to them: "Here's what you're going to do, and if you don't like it, then we'll get rid of you." But this was a real collaborative process, and that's what I was going to kind of touch on. Originally we were driving a lot of the process, but it was just amazing to see the transformation over the next couple months in the Iraqis in the work groups and even in senior management of the ministry.

The women, for example. The ministry was 80 percent women. When I think about it—I spent some time in the Middle East—the strength of the Iraqi women, I think, is going to be something that really helps drive that country towards the future. They are very strong, very capable, and they showed it very much so in the work group process. It was just interesting.

But the funny thing was that we would sit around a table and talk about an issue, whether it's pharmaceuticals or primary health or what to do with nursing, and the Iraqis had all the answers. They knew how to fix their system, but they were never allowed to have any input before. Now the challenge is that it's going to take some time, it's going to take some resources, and it's going to take some kind of empowerment and training for them to kind of learn how to implement. They know where [the effort] needs to go, but it's just a matter of kind of the implementation.

*Q: How were the work groups broken up? Were they topical, i.e., you had a work group working on each of the nine areas?*

GOODWIN: We didn't have specific work groups focusing on those specific topics, but later in the process we identified crosscutting issues and then a combination of work groups would be formed to talk about, for example, master planning. If you're going to look at a certain configuration of a clinic requiring certain numbers of nurses and certain numbers of doctors, it's clear you're going to have human resource implications. So then, how do you deal with that given the strategy of human resources?

*Q: So some of it was project based. You were looking and saying, "We need to build a new public health center. How do we do that? What will we need? What resources will be required?"*

GOODWIN: No, not really project based. I think what you have first is your rough strategy: where is health care going to go? Will it be centralized or decentralized? How are you going to do general procurement? How is the ministry going to function? How is licensing and credentialing going to work? What is the role of the public and private sector in health care? We got to the broader strategies, which the Iraqis worked on in cooperation with us.

Take the nursing strategy, for example. They have a very detailed plan now as far as how to improve nursing in the country. Some of that is through curriculum reform and working with the universities. Some of it is the length of training for courses. Some of it is the resources that they're going to put towards those efforts in the future. As time goes on, as the new Minister of Health continues to carry on this process, they're getting more and more detailed as far as how they're going to do specific things. That will eventually get down to the project level.

*Q: The Minister of Health, is that Doctor Alwan?*

GOODWIN: Doctor Alwan is the new interim minister. When we were there, around September 2003, is when Doctor Khudair Abbas became the Minister of Health.

*Q: About how many people were involved in the work group process all in all?*

GOODWIN: We tried to keep the work groups under 15 people. Again, we had a table that sat about 12 people, two of them—we set up some rooms at the ministry to do this—and then we had kind of chairs around the back that other people could come and participate.

*Q: Were those members of the general public?*

GOODWIN: It was open to members of the general public, but for the most part it was just mainly Ministry of Health people or people from the Ministry of Higher Education or university professors. A lot of times we would kind of invite people. I would invite a lot of representatives from DFID, from USAID, to kind of participate in that process. But normally fewer than 15 was how we liked to keep it. Every once in a while there were the work groups and then there was the steering committee, and it was really the steering committee that ran the meetings. The group that got together from the 17<sup>th</sup> to the 19<sup>th</sup> was the steering committee that laid out the plan for the work groups. Then the work groups would feed information back to the steering committee, which Doctor Abbas was chairing, in order to approve and move things forward.

*Q: Most of these people who were involved in the process were somehow involved with the health care system in whatever city or region that they lived in?*

GOODWIN: Right. And I'd say hundreds of people, hundreds of Iraqis, were involved in that process.

*Q: Getting down to the local-level facilities, who are the people who are running the centers, and are they doing it in conjunction with any Coalition people on the ground? I know, for example, Coalition had certain funds and local commanders had money they could give out, so were they working with local military? What was kind of the generic make-up of a local health facility? How's it being managed?*

GOODWIN: The local health facility is normally staffed by Ministry of Health personnel. There are private clinics as well as public. Most of the time, though, there was a certain moonlighting aspect. A Ministry of Health official would have their normal job during the day from eight to two and then they could run a private clinic in the afternoon. They did that under the former regime because salaries were so low. A doctor got paid \$10 a month; nurses would get a dollar a month. So they had to find new ways of kind of getting additional income. So there is cooperation happening.

The thing that's interesting is that health care being delivered by the Iraqis. The military and Coalition forces and NGOs at this point are simply helping to fill some of the gaps, because as

the ministry changes, as personnel change over, you have different spikes of problems, whether it's a shortage in [supplies] or a public health outbreak.

For example, we had a measles outbreak recently back in March, and UNICEF supplied the vaccines to be used, but the Iraqis did everything. They're the ones that ran the clinics, they're the ones that got the public in, they're the ones that immunized, and they reached 90 percent of the target population, which is unheard of in our own country let alone in a post-conflict situation.

*Q: That is very impressive. So the entire reconstruction of the ministry is very Iraqi driven?*

GOODWIN: Yes. That was part of the reason why we left the Green Zone every day. We would go down [to the ministry] around seven or eight in the morning and leave at three or four. We would work seven days a week. The ministry's only open six days a week, but we would be down there with [the Iraqi staff] because we wanted that input. Some people tried to run things from the Green Zone, and it just didn't work. Our whole mission was to get down there and create sustainable solutions that would ultimately benefit the Iraqi people. It's like what a lot of people have seen from development: If you build a bridge somewhere in some country and the local populace wasn't involved, then when something happens to that bridge, they would be like "Well, you built it. You fix it."

*Q: There's no ownership.*

GOODWIN: Right. So our whole goal exactly was to get Iraqi ownership. When Doctor Abbas came on board, it took us a little bit of time to build that strong relationship, but we were hand-in-hand on every single thing that we did. We felt, when he came on board, [that] we were working for him and we were supporting him in accomplishing objectives for the ministry. I think because we had such a close relationship with our Iraqi colleagues and worked down there every day, it allowed us to be the first ministry to transition fully to the Iraqis.

*Q: I looked at the Iraq Ministry of Health website and noticed that the key issues they're currently looking at are facility rehabilitation and development of public health programs. I was wondering if you could kind of run through what your priorities were when you were setting this up and how those issues were addressed.*

GOODWIN: First, the budget under Saddam for Ministry of Health was \$16,000,000. That's less than 75 cents a person. The budget for 2004 is approximately a billion dollars, \$571,000,000 of which is for pharmaceuticals. [That is] primarily because, now that the Oil for Food Program is over, [the ministry] has to do their own procurement of supplies. There is no money in the Iraqi budget for refurbishment of the facilities that have been neglected essentially for 30 years.

All that we had money for were salaries and basic operating costs to keep those hospitals and clinics up and running. We had a little bit of funds to try and work on some new training initiatives, some basic improvements to some facilities. We put a lot of money out to the governorates so that those facilities would have more operating costs, so they could fix their own

problems. In the past, if you have something that costs five bucks, if it was a minor leakage in a sewage pipe in a hospital, it never got fixed because they had to go to the minister himself to fix that minor problem, to spend those five dollars. We've tried to get them into the mindset of get out there and....

*Q: Find a local plumber, have him come in, and just reflect it in your budget.*

GOODWIN: Exactly. So that is why the supplemental was so important, because this is the first opportunity for a major infusion of resources in order to refurbish facilities and buy new equipment.

The CERP funds helped out. They repaired quite a few clinics as far as painting, cleaning them out, helping with small generators to provide power. One of the things we were able to do through the ministry is we found \$36,000,000 in our budget in order to do a major generator project, because when we first got there many of the facilities did not have power and, therefore, it was 130 degrees [inside the clinics and hospitals]. Also, if there's no power and incubators go out, children are going to die.

*Q: I understand that the power is on an average of maybe eight hours across the country.*

GOODWIN: Well, the thing is that many places that now have power never had power. Saddam took all the resources in the country and focused them on two areas: Baghdad and Tikrit. CPA had a policy that when we first got there we would spread power more equally. So, yes, Baghdad went from having almost continuous power to intermittent power, like you said, eight hours on, eight hours off. Sometimes it's much better. But other places, in Basrah in the north, that never had power before now have power, and you can see that that's affecting their economy, too, in that there are all these new refrigerators showing up, satellite dishes. Things that were absolutely banned under Saddam are now showing up. But it's causing some larger problems in that demand is outpacing supply, because they're not charging anything for power at this point.

*Q: I understand that's one of the subsidies. Getting back to the facilities, you said most of the facilities were worn down from neglect except for those that Saddam chose to prop up. Did you find that any were impacted by conflict? Were public health centers being used as ammo depots? I know, for example, a lot of primary schools were used as ammo depots. Also, were there any effects from looting? For example, people stealing medical equipment and trying to sell it on the black market?*

GOODWIN: I don't have figures, but I think it was around 30 percent of the facilities were affected by looting, not so much bomb depots although at some of the hospitals in Baghdad there was actually fighting going on in the hospital themselves because anti-Coalition forces were using them as bases of operation. I don't know about the ammo dumps and things like that.

*Q: You were talking about how the supplemental had a big impact on facility repair. Was it strictly focused on facilities repair, or did it also help you to, for example, infuse pharmaceuticals, buy medical equipment, and pay salaries? How exactly was that money being used?*

GOODWIN: It's not being used for salaries; that's in the Iraqi budget. As I said, there's \$571,000,000 for pharmaceuticals in the budget. Of the \$794,000,000 that health got in the supplemental requests, \$300,000,000 of that is for equipment for facilities and the rest of the money is for new construction or refurbishment, and then there's a small part that's for a new hospital in Basrah; a new 50-bed hospital. The supplemental was supposed to build between 200 and 250 brand-new primary health care clinics all throughout Iraq to (1) show immediate impact to every governorate; and (2) to kind of help kick-start that shift from a hospital-centric model to a primary health care model.

*Q: I imagine that the shift from centralization to decentralization is one of the big obstacles. Is there kind of a driving plan on how to do this? You're talking about major cultural reforms and funneling money out to the smaller areas. What other things are you doing to help foster this change?*

GOODWIN: There was a major emphasis in the plan for the ministry that involved training. [The security situation] has not allowed for a lot of trainers to come into the country to train in methods of decentralization, management, administration. Many Iraqis have left to go to Jordan for training, to go to other countries for training.

The Iraqis know what they need to do. What they really need is a kind of encouragement to take risks in making some decisions and not worrying about potentially making mistakes. So I think our role, the coalition and the many people who are still working there, [is to help with that.] Our mindset has to shift to "Hey, we believe in you, [the Iraqis]. You can do it. We know you're going to be successful, and we're here to help provide advice, provide help with implementation, but ultimately it's going to be you owning these projects and owning these plans."

*Q: To backtrack just a minute or two to the facilities: who's rebuilding these? Are you contracting out to the big American companies, and are they subcontracting to Iraqis? How's that coming together?*

GOODWIN: Supplemental funds have to be, for the most part, contracted through U.S.-type companies, or [those of] coalition [members]. There are a number of countries that are eligible for that; I think there's like 50 countries or something that can actually win those contracts, but then have to use Iraqis to implement those contracts. Now, the challenge is to make sure that those companies are utilizing Iraqi people as much as possible, because that will help with unemployment, that will help with building their [indigenous] capacity. Expat salaries are [also] much higher, clearly, than Iraqi salaries. So that's the supplemental.

Also, through the ministry we used a lot of Iraqi contractors to do certain work, whether it's building a security fence for the ministry, doing repairs, or helping with the hospitals. In a minor sense, we were using Iraqi companies to do that work, and it just kind of depends on the funding source. We did provide [enough funds] in the operating budgets -- for the different hospital directors and director generals of the different governorates -- so if a facility needed to be painted or [whatnot], they will always use an Iraqi company in order to get that done.

So it's just the supplemental that has to be done through U.S.-type contractors.

*Q: Did the fact that that money was being funneled through the U.S. contractors—I know there's a lot of bureaucracy that gets involved—do you think that slowed things unnecessarily, or was it just something that you have to do?*

GOODWIN: I think there's a fundamental lack of understanding -- or an underestimation -- of the capacity of the Iraqis. They can do work very quickly. They need some help as far as building standards; they need some help as far as quality control work. But for the most part -- as far as moving dirt, getting things painted -- they can do it. They're competent and capable enough to do that.

I was frustrated with the speed. Whenever you try to put U.S.-type contracts and rules on things, it just takes months, where when we use Iraqi companies, stuff that would have taken a year or two years for the U.S. company took us months.

*Q: I understand that there's a database in Baghdad of Iraqi contractors. Would it have been easier just to go through those people in all cases, just do the local companies?*

GOODWIN: Well, it's a difficult situation. If it's U.S. government money and there's a certain responsibility to Congress—and it's tough to tell who of these Iraqi contractors are good and who are bad. That's why, I think, much of the money could have been funneled through the ministries with some oversight and then the ministries could have helped with the selection of contractors to implement.

*Q: Did the inflow of assistance money, like the supplemental, shift the emphasis [of reconstruction] overly to construction?*

GOODWIN: Well, the purpose of the supplemental was to kick-start things that generally the other donors probably weren't going to kick in right away, and it was to do a lot of things like construction and equipment, getting those longer lead-time items started now versus waiting two years and then starting them. This is a country that has the potential of being a first world country, and it's an absolutely rich country. Not just oil and agriculture. [There is] intellectual wealth, water resources, and the religious sites. This is a very wealthy country that is just temporarily poor. So it's got this huge dip. It was kind of like, okay, if we can make these investments now, you can kind of minimize that big dip that's going to happen. Money right now exists in the Iraqi budget to do public health initiatives, to buy all the pharmaceuticals, to do a lot of training, things like that, but it's just hard to get them to spend money. They just lack some of the capacity.

*Q: They're so used to going to the top level before they can write a check for something?*

GOODWIN: Right, and they've created their own bureaucratic problems that will eventually get sorted out, but it's hard for them to get things done at this point.

[END SIDE]

*We were talking about the working groups and convincing people to buy into this decentralized system, especially with regards to procurement as just one example. Was there buy-in? What were the issues discussed? Did people intellectually understand it but just couldn't put it into practice?*

GOODWIN: First and foremost, [the question was] can [the Iraqis] agree with the concept, does the concept makes complete sense to them? But again, it was that implementation part where they have challenges.

I just want to kind of step back. I think it's great we're going to talk about the strategic planning process. That's where the key future is going forward, but some of that is going to take time for them to fully get it out to where the entire population has had kind of input into where they're going. This is kind of like a first step. That plan needs to be refined, and that's what they're kind of doing. You've got the broad plan, but then you have to get kind of [get into the details].

For example, we've had some discussion on facilities, but there was no rhyme or reason in Iraq for where a clinic or hospital was located. Everything was focused for the most part in Baghdad [which was not necessarily where it was actually needed most]. That's not an effective way to meet the needs of the population. [The Iraqis] have to look at where these places are. They need a [new] population-centered master plan.

That's where they're going with the future of the health care system, but right now it's kind of like they had to get their existing system back up and running. The next step is figuring out where investments go in the future. It happened very quickly that we were able to get existing facilities back up and running. Now it's kind of like "How do we shift to this new Iraq that just does things completely different than what they did before?"

One of the biggest forms of torture in Iraq was the intellectual isolation. Saddam did not like doctors because he saw them as an intellectual threat. Therefore, he would not let them have any training and no new textbooks. The latest textbooks we saw in the Harvard of Iraq, Medical City, were from 1996. And those were photocopies that were smuggled in from Jordan, and there were only a few of those. The latest medical journals were 1993. So the majority of the doctors, their techniques and methods, were stuck back in the late '70s or early '80s, and there's been tremendous improvement in medicine since then.

[We want to promote] access [to new materials], as we set up some learning centers around the country and others. Military units and other people have really done a lot to bring in new textbooks. We had an initiative which brought in about \$2,000,000 worth of new textbooks and medical journals from the American Medical Association that we distributed all around the country. But it's now that access to new information that's really going to create some links into where the health care system goes in the future.

I think it's important to focus on some of the facilities but more it's that human capacity that's really going to make them successful in moving forward. We saw that with things like public health immunizations. The nosocomial infection (infections caught in the hospital) rate in Iraq is

between 80 and 100 percent; that means people that go into a hospital with no infection have a very high chance of catching an infection from someone else in that facility. Those are the type of things [that need to be addressed].

Every medical professional in Iraq was a specialist -- a neurosurgeon, an oncologist -- but there are very few general practitioners. So now you have people that want to learn liver transplants but can't get basic needle safety right. So it's those types of basics that will have major implications.

Infant mortality and term mortality rates are some of the highest in the world with 131 per 1,000 children under five dying. Term mortality is something like 360 per 100,000. These are tremendously high numbers. The ministry has a goal to reduce those numbers in half by the end of 2005. That strategic plan will create the roadmap where they're going to go, but it's the type of things outside the facilities that are really going to get them there, especially the training.

*Q: When you say that everybody's a specialist, is that on down the line? For example, there's a special type of nurse for this and a special type of nurse for that? Or was the specialization focused at the higher levels?*

GOODWIN: Really, doctors ran the show. Nurses were completely neglected, treated like slaves, and that is something that [is being addressed]. There's a whole new strategy that will incorporate nurses, like in our country and in the UK, into the actual delivery of health care. [After all,] these are the people that spend the most time with patients. There are approximately 30,000 nurses; only 300 of them are college-equivalent trained nurses. [The nursing corps] was totally decimated. Most of the resident doctors had been fulfilling the function that nurses would normally provide. A "nurse" was the person you'd see cleaning the floor. Then [they would] go and change a bandage.

In general there are two ways of fixing the nursing program. One is to provide better training so these people develop [the] skills [they need]. The second is to change the mindset of most doctors in Iraq of how nurses are treated and how they are utilized. [This way the doctors] can focus on different aspects of medicine versus [spending their time] taking blood pressure and doing other things that well trained nurses can do.

That is a key factor. There was some money for training in supplemental for that. It's a key focus of the minister to improve that, and it's a key focus of international donors in order to improve that.

*Q: You've alluded to some training programs. Do you have any specifics of what is being done on the ground or what you did on the ground?*

GOODWIN: There are quite a few training courses that are set up that handle this specifically. Some were done through USAID grants, and some were done by contractors. WHO did quite a bit of nurses training in Jordan, and there are ongoing programs that were being done.



*Q: Is there any effort being made to develop Iraqi institutions to train people? For example, refurbishing medical schools, redoing curriculums, establishing more nursing schools?*

GOODWIN: There are. Many of those fall within the Ministry of Higher Education, so we were working alongside them to do those types of things. There were [originally] something like 15 nursing schools in Iraq, and many of them were focused on basic-level training, [but at] something like the ninth grade level. So [graduates] had no skills. What they've done [since] is close down quite a few of the nursing schools, [and they] are creating new programs that will train new staff to be much more capable and have much different skills than the nurses that currently exist.

That is going on through international training programs, but the ultimate goal --where you have the most impact -- is to do it indigenously. And that is going on. It's going to take some time, but there already have been quite a few courses within Iraq. The nurses have formed their own associations that are helping them to work through some of these issues. The minister recently signed a strategy, very detailed, on how they're going to get to that new plan for nursing.

*Q: Are a lot of these training programs being run through hospitals and medical clinics, trying to reach the people there, or are you bringing staff out to training locations?*

GOODWIN: I would say there've been both sides. There has been some kind of classroom training on methods and things like that, especially emergency medicine, for a lot of those personnel, but there's also been at the clinic level: here's how you do things, here's the practical aspect. That's one of the strengths of a lot of the military medical teams. Their mission primarily is to support Coalition forces, but many of the civil affairs units -- that have medical professionals -- would also go into those hospitals and do cases with those doctors. Many of them are nurses who would kind of go through different techniques with them. The Iraqis generally are very smart, capable people and they learn very quickly, so when they have access to that information, they just absorb it very quickly.

*Q: So a lot of the training is practically oriented, as opposed to discussing "best practices" in a seminar room.*

GOODWIN: Right. Like I said, they have basic needle safety that they've got to handle before they get into the more complex methods.

*Q: I guess this is being carried out by medical professionals with Coalition forces as well as with organizations like WHO and American Red Cross?*

GOODWIN: There are some NGOs doing this, but there are Coalition forces doing it kind of on an ad hoc basis. There are quite a few programs going on through the ministry itself using some of its budget to do that. Most of the training I've seen from WHO [is done out-of-country] because they have not been allowed to have international staff since the Canal Hotel bombing (when the UN presence left). They've had to bring a lot of people to Jordan. They've done some training within medical facilities there, but the goal again is to push all that inside Iraq's borders.

*Q: If I am a nurse and I've received my basic needle training, for example, is there any kind of certification that I'm getting? Is there some kind of standardization to say "This person got needle-safety certified at location X in class Y," and that means the Iraqi Minister of Health says they're okay to handle needles?*

GOODWIN: Generally there is not a good credentialing program. That is one of the work groups and it is something that the Ministry of Health is struggling with. It is covered as far, as nurses go, in that new plan. Once someone completes this course, they're credentialed at a given skill level. Many of the existing Ministry of Health staff that are nurses are going to have to go through retaining in order to validate their own skills. That's a goal, to [credential] a known commodity, "This person is qualified to do this," and set up programs of continuous training and improvement for those individuals.

*Q: I read an interview with a Civil Affairs officer who worked at the Iraqi Assistance Center in Baghdad. One of his tasks was organizing for Iraqi children to go out of country for surgery. That indicates (at least initially) a shortcoming in the Iraqi medical capacity. What was your impression of the capabilities of the health system when you arrived?*

GOODWIN: The tendency of Iraqis was "I want to get my child the best care possible," the normal thing any parent would do. Many of them thought, "Okay, I need to get my child out of the country in order to provide this care." Most of the time, I'd say 90 percent of the time, when people would go to the Iraqi Assistance Center, the services that were needed for that child were able to be provided within Iraq. That's preferable because then you don't have to move the family, you don't have to worry about logistics; paying for them to live abroad, dealing with separation, to have that kind of support and work within the country.

At the same time, for cases that could not be treated, first and foremost, we would look at countries that border Iraq—Jordan, we'd go to Saudi Arabia, other countries right around—and then you kind of do rings out from there. If that didn't exist, maybe somewhere in Europe, and if that didn't exist, then we would try to look at the United States for care. Again, there's a lot of logistics and expense whenever you're going to send those people in and out of the country. It's not just getting them out; it's also getting them back in.

*Q: The Iraqi healthcare system: what type of shape was it in? Was it better than it was under Saddam? Was it about equal? How has it developed since the war?*

GOODWIN: I would say, across the board, health care is better now than it was under Saddam. Access to care has improved. [So has the quality of drugs].

Under the Oil for Food Program, drugs were bought from Sudan, from sources that couldn't be confirmed. You couldn't confirm the quality of many of those drugs. I remember an anesthesiologist telling me a story of how he would decide how much anesthesia to use; they would just keep turning up the dial and watch the patient, because they could never know what the actual purification was of the anesthesia that they were using. So there's a new drug formulary for the whole of Iraq to kind of insure that there's standardization for the different medical facilities.

As operating budgets have increased, they have included money for [clinic and hospital] directors to go and get medical supplies themselves in order to fix certain things, to improve the food that patients are getting while in the hospital, in order to prove cleanliness. So across the board health care has improved. [The] \$16,000,000 [budgeted by Saddam] for a population of 27,000,000 just doesn't go very far.

*Q: How is the health care system set up? Can anybody walk into a hospital and say, "I'm sick. I'm an Iraqi citizen and you must treat me"?*

GOODWIN: Currently health care is free in the country. There's a small charge, something like 250 dinar, or approximately 13 cents, per prescription that is charged. Sometimes there's also a small fee for a visit, like 250 dinar sometimes is charged per visit for Iraqis, but for the most part services are free. At the same time, there's also a thriving private sector, so if people want to go off and feel like they need some type of more specialized surgery or things like that, then if they can afford it they'll go to the private sector to get those services.

*Q: We've glossed over Oil for Food a lot. How exactly did Oil For Food feed in when you first went into Iraq? What was the nature of the relationship between Oil for Food and health care?*

GOODWIN: The Iraqi ministry depended upon the Oil for Food Program for all its supplies.

*Q: Pharmaceuticals, equipment, everything?*

GOODWIN: Everything. And it was the most corrupt system you could ever imagine. It was never designed to provide care for Iraqis. It was simply designed to make money for the regime. So many times these brand-new machines, Phillips' latest x-ray [device], all these things were bought, but no one ever worked out the long-term maintenance costs: spare parts, things like that. So much of this equipment just sat around and wasn't working.

If you wanted to get drugs, it wasn't necessarily something like, "Oh hey, this clinic needs this much every month and here's what they're going to get." It was the clinic asking for things and maybe, if they cut a deal with the warehouse manager, they might get something or they might not. They could never know exactly what they were going to get.

*Q: When they cut the Oil for Food Program, what impact did that have? Did that liberate the system? I know you said there were problems with the distributor for all the pharmaceuticals. Was that an outgrowth of cutting the Oil for Food?*

GOODWIN: The Oil for Food Program, they would order stuff for a year-long basis and it would come all at once. So there was tremendous waste, because if you're trying to warehouse a year's worth of supplies—they had 147 warehouses....

*Q: All that stuff, it expires.*

GOODWIN: Right, and it's not just expiration. As you know, much of it has to be controlled as far as heat and things. There was no shelf-life analysis being done, and so much of the product was terrible. It would sit out in the sun. IV fluid sitting out in the sun! And that would be what they would give their people.

The other thing is that, with it being such a hospital-based system, Iraqis would go to the hospitals and there would be one doctor seeing 100 patients. Well, if you're a doctor seeing 100 patients, you can't really provide that much care; you're simply there writing prescriptions. So the Iraqis had a mindset of "prescriptions equal care".

The Oil for Food Program was stopped, and then it was up to the Iraqis to create the [new] systems. We helped them do this, to create a system of procurement and things like that, but it's been a real challenge in getting them to spend money, as well as dealing with corruption within the distribution aspect.

There was an analysis done on trucks that were coming in through the Oil for Food Program. [A truck would] make 19 stops and offload cargo before it even made it to the Ministry of Health warehouse. There was stuff going out the back door all the time. If you look at the private market, much of the product that they're selling in the private pharmaceutical market is Ministry of Health supplies.

*Q: The Ministry of Health didn't have regional warehouses, they just had one central warehouse in Baghdad?*

GOODWIN: Much of it was done through Baghdad. Everything came into Baghdad. They had a system where everything came to the center and then it was shipped off to regional warehouses. So there was a lot of loss that happened between [the Baghdad] warehouses and the regional warehouses. Then the regional warehouses would send [supplies on] to local warehouses, and again you've got that other logistics chain where stuff was lost. Additionally, they didn't have any type of customer focus on supplying. The hospitals and clinics themselves had the burden of getting trucks together and going to the warehouses themselves to get their stuff and bring it back.

Some of it was cultural, too; not only cultural but conditional. If you're a nurse making a dollar a month -- in order to keep your family alive and survive -- many times you would go and steal trucks. So would the doctors. So now, even though salaries have increased so much, that habit is a little bit ingrained and will take time for them to kind of get out of that business.

*Q: With the move towards decentralization, is the Ministry of Health still going to try and bring everything in through their one funnel and then disburse it, or will it move toward a more American system where the hospital itself buys what it needs?*

GOODWIN: That is the ultimate goal, for hospitals and facilities themselves to have a formulary, have a budget, and eventually they'll be able to order what they need. Several things are going to have to happen before that.

One of the major decisions that happened right before I left was the new minister, Doctor Abbas, gave control of the governorate warehouses to the governorate director generals. Supplies from those warehouses [now] have a good chance of actually making it to those facilities because all politics is local; and once you get down to the local level it's harder for it to disappear. I shouldn't say the Ministry of Health had these warehouses; the state-owned enterprise, Kimadia, had all those warehouses, and that was a corrupt company. The head of that company [nominally] reported to the minister, but they were [only] part of the ministry when they wanted to be. They were a separate company entity....

*Q: Kind of a front for the Hussein family?*

GOODWIN: There was a lot of money for the Baath Party being made out of that. The funny thing was, they did some crazy math. They would buy something for \$80 and sell it for \$20, because they would supply the private market as well. All this stuff would come through the Oil for Food Program. So in order to supply the private market, they would sell it. They would always sell it at a loss, but at the end of the year they would say they made a profit and then the employees would get a profit sharing of that.

*Q: Do you have anything else to add about the decentralization effort?*

One of the things that we worked very closely with Doctor Abbas on -- prior to Jim Haveman and I leaving -- was a new structure for the ministry. As I talked about before, you had people working right alongside each other for 30 years and never knew each other. The ministry itself was designed in "silos" or "stovepipes" that didn't allow for any crosscutting issues, so Doctor Abbas created a new structure.

One of the key things we did was dismantle the state-owned entity that was Kimadia. We kept a logistics arm within the ministry but took out the procurement end and set it into two new offices. One was for the procurement of pharmaceuticals; the other was for procurement of medical supplies. So we brought in some teams of pharmacists and logistic-specialists to work alongside those Iraqis in those new offices to come up with new ways of doing business. As we were leaving, they were doing some drug procurements that were very different than the way they did it in the past.

For example, the Kimadia organization would talk to 1,000 different vendors, order all these different drugs. The drugs would arrive at the ministry and would have to be sorted, packaged, and sent out to the regional warehouses, then sent to local warehouses. You're talking months and months by the time any products would ever get out there.

We came up and worked with them on a new system that worked with distributors. You say, "Here are the different drugs that I want. Here's how much is supposed to go to each warehouse," and they actually procured them and within a month those drugs were in the country. Instead of coming centrally and then going out to the local warehouses, they went directly to those local warehouses, so we bypassed the whole challenge of the logistics in the past.

But on the other side of that, those at the local level [doctors and administrators] said, "Oh, you used a new system that I'm not familiar with. I'm not going to accept these drugs." [Our response was,] "Well, they're EU- or FDA-approved drugs." [They would say,] "Well, they haven't been through the Kimadia testing that we used in the past." Nothing is easy in Iraq, unfortunately.

*Q: One of the other things besides Oil for Food that had a big impact was de-Baathification. I know they did take out the top four layers, I believe, and I'm assuming that includes a lot of the top administrators. Did that have an impact on the health care system? Was it hard to hit the ground running with those people out of place, or did it have no impact whatsoever? How would you characterize it?*

GOODWIN: I think there was a need to remove those people. Unfortunately, many medical professionals were involved in some real atrocities. Medical professionals were present at most interrogations so that the interrogators could get inflict the most pain and still keep people alive. There's evidence that executions were timed in such a way that things like corneas were taken from the dead bodies and then the next day they were implanted into patients that needed cornea transplants. So that Baath party leadership needed to go. Some of those medical professionals that were involved in such crimes needed to be gone out of the ministry.

That being said, I think just in general it was tough to find good, competent people from an administrative standpoint. But the team would exist there, like Doctor Shakir al Anachi and Doctor Nima al Said. Some of these people are so sharp that they could be senior officials in our own health and human services.

*Q: Other interviewees have noted that a lot of Baath party members were members because that's the only way you could get promoted. Were any of those people reintegrated into the process, or was it kind of "You're in the Baath Party and we don't want anything else to do with you"?*

GOODWIN: Well, for the most part, people that have Baath Party affiliation, as long as they weren't involved in any crime, there was no problem with them participating in the reconstruction of the country. But if you were Furkha or above, you couldn't participate, and most of those people, in order to reach that level, had to be involved in something heinous. There were many people that were part of the Baath Party because you had to join if you were going to school and things like that, but most of those were not [real Baathists].

*Q: In this big effort that you're undertaking, especially at the local level, were there indigenous civil society groups or political groups getting involved?*

GOODWIN: New governance institutions are coming together all the time, and there are mayors, city councils, and legislators who get together. There are civil society groups. It just depends where and what. But some of the things that the governance teams -- that were around the country -- were working on was providing funding. I think quite a few of the city councils had actually like \$1,000,000 or something that they could prioritize for specific projects within

that area, whether it was fixing the road, a clinic, or whatever else. But they had a lot of oversight into those funds.

*Q: So not all the money for these public health systems is trickling down through the Ministry of Health; it's also coming at them from a variety of sources.*

GOODWIN: Right. Civil affairs units are still out there doing a lot for public health. For example, in Sadr City they had a recent problem. In the longer term, they're supposed to fix the water purification plants and things like that, but in the short run [those plants] aren't [operational] and so they don't have access to clean water. So they have been drinking unclean water and there are a lot of public health implications that can be solved with an intervention such as jerry cans with chlorination tablets.

We did many of those projects for public health. I think we did 500,000 jerry cans around the country. Many of them had a very significant impact, and it was the Iraqis in the Ministry of Health that were running those interventions (with our support). Culturally, a lot of people were using those, but then again other people saw these five-gallon jerry cans and would say, "Oh, what a perfect thing for me to carry gas around in. I can go down the side of the road and sell gas and make money." [So they would do that] versus using it for its real purpose, which was to purify water.

*Q: One of the issues that we haven't really gotten into is public health, and I know that's a Ministry of Health mandate. Was that a priority going in, or was that kind of subdued to getting the health system, providing basic care to people?*

GOODWIN: Public health was key to our intervention. One of the major things we did was restart the immunization program. They hadn't had any immunizations for months, so we restarted that program first by having a "national immunization day", and then we had a national immunization day once a month from then on. But we were also doing other interventions on a weekly basis. Now not only is immunization available daily at most public health facilities, but it's available on-demand. Someone can bring their child in and say, "I need this immunization," and, boom, it happens.

*Q: How are those programs being carried out? Were you running them through the clinics?*

GOODWIN: Most of it is done through clinics, some of it's done through schools, some of it's done through other facilities. In the very beginning Coalition forces were involved in helping to get the word out, [helping to] get people in the right location, and also in working right alongside the Iraqi doctors in doing immunizations.

Now it's a program that's just phenomenal, what the Iraqis themselves have done. UNICEF, for the most part, has been providing a lot of the vaccines, and then the Iraqis are the ones that implement the program.

*Q: How did you raise public awareness about the vaccination program? Was it word of mouth through people out on the streets or were you using the media? One of the things I would be*

*concerned about is that the population is not exactly 100 percent trustful of the coalition. For example, in many third-world countries vaccination programs have often been eyed suspiciously...*

GOODWIN: We did see some of those kinds of reports: "Don't take these vaccines because it's going to cause you problems versus solving them for you."

The Iraqis have a tremendous way of being able to communicate. If you tell one Iraqi something, within hours it will probably be around, the story, because they're just very kind of communicative people, and it's like they have [their own kind of] carrier pigeons. They would send out trucks, people would get in their cars with letters, whatever. That's how things were delivered. They would go out to those different governorates and say, "Here's your letters for the day, and here's the information."

We also did use Coalition forces as well as other media outlets, such as Radio Sawa, to let people know that these immunizations are happening. And we also used the normal broadcasts to put out information about hand washing, put out information about breast feeding, things like that. Under Saddam they discouraged breast feeding. They wanted this formula [used] instead of breast feeding, and some people were using tainted water sources, so it really had a negative implication on the infant mortality rates.

*Q: For these more basic awareness initiatives such as breast feeding or nutrition, how are you going about relating that to the people? Is that being done just at the local level, at the local clinics?*

GOODWIN: The Iraqis and the Ministry of Health, they're the ones that got these messages out, they're the ones getting people involved in the program. We helped facilitate it, but for the most part they had the capacity to do it.

*Q: How would you rate the success so far of these various programs?*

GOODWIN: I think a huge example is what we saw with the immunizations when they had that measles outbreak. To reach 90 percent of the population just shows the capacity that they have. At the same time, they're trying to focus more on community-type medicine, to get mosques involved, to get information out to people on the basics of public health and preventive medicine.

*Q: It seems that working with religious organizations would be a very good way to gain public trust in the system. Were there a lot of outreaches made to those and other civil society groups, or is that just something that will come to pass on its own?*

GOODWIN: No, they did. I can't recall the specific examples, but I know that the Iraqis within the ministry would do that outreach to multiple groups in order to get the word out on different initiatives. I believe they did make announcements in the mosques, or in quite a few of the mosques, about the national immunization day the first time.



*Q: Do you think that the security situation had negative impacts on the health care system, or was it left largely untouched? I know, for example, that schools largely haven't been bothered by the insurgents. Has that been the experience with the health care system as well?*

GOODWIN: I think what's affected the health care situation are just the mass casualties of certain events. It just has put a strain on the supplies as well as the personnel in the facilities. But for the most part, it was evident that the 240 hospitals and the 1,200-plus clinics got back up and running pretty quickly.

Iraq is the type of place to where normal life is going on, businesses are running. It's normalcy with very small instances of extreme chaos. But even with some major bombing and two or three people died, it's a tragic event, it's horrible, but the streets get cleaned and then, boom, people are back going to work and driving and doing all the things that they would normally do. The threshold of pain that the Iraqis have as well as their inner strength is pretty amazing.

*Q: As an American who's going outside the Green Zone, what were your experiences? Were you ever targeted? Did you feel that the security situation hindered your ability to do your job?*

GOODWIN: When we first got there, the resistance wasn't that organized and there weren't as many problems. I think the Canal Hotel bombing really changed that. Then, towards December, there were more and more attacks. We were targeted several times. I was in an IED (improvised explosive device) attack. I've heard of several other instances. One of our staff was killed, several others were very close to getting killed, and some were shot. We had eight Purple Hearts on our team. It's definitely a dangerous situation.

At the same time, I found that Iraqis are some of the best people that I've ever met, and it was worth the risk going down there, and we would take precautions. One of the things we did is, instead of using CPA-type vehicles that had CPA markings on them, we went and got some vehicles off the local market. We procured weapons for our teams to use. We would always go with at least two vehicles and at least two people with guns in each vehicle. We were able to procure some armored vehicles and eventually we got some private security teams to help augment our own team's security. But, you know, it was a dangerous place, but we had to take risks to get the job done.

*Q: Was there any targeting of Ministry of Health officials because of they were "collaborating" with the occupation?*

GOODWIN: That was the other aspect of it. In many ways, the Iraqis that chose to work with us took a great risk than we did working with them. Several of the staff we worked with very closely were assassinated as they were coming out of their house or in different situations.

*Q: Were these high-level people or just local doctors and administrators?*

GOODWIN: Some of these were lower-level, just kind of worker-bee types, but at the same time recently both the Deputy Minister and the Minister of Health have been targeted for

assassination and narrowly missed some attacks. Those are kind of the tactics right now that are being used.

*Q: So for even the lower-level people you believe that was a targeted assassination, not just random violence?*

GOODWIN: Right.

*Q: Okay. What challenges do you see the ministry facing now? There's the issue of funding and how are they going to self sustain. I know in many sectors of the governing economy, a lot of it's heavily subsidized. For example, medical supplies are probably subsidized. What's the outlook there? How are they going to make this transformation?*

GOODWIN: I think they're going to make it. The two real benefits of us ramping down our staff and transitioning fully to the Iraqis are; (1) [the Iraqis] understand how much work we were doing for them; and (2) they have a better understanding of the challenges that they face in order to get things done.

When we were doing it for them, it was very easy for them to say, "Oh, well, we don't have drugs because you're screwing things up." Now, when they see the stovepipes that exist, the bureaucratic hurdles, it gives them a better perspective on how they have to change the way they're doing it. Also, many Iraqis have gone outside Iraq and seen new ways of doing business. They are now coming back to their own country saying, "Why don't we do things this way?" But again, it's going to take them learning that new way of [doing] business and being able to take some risks and make some decisions and spend money. That's really the challenge that they have.

Other than that they have to really work on building their capacity as administrators, their technical skills, but I just perceive that their improvement is going to become exponential in the near future. I really feel that we're ripe for a spike. We've made some key investments in public health, in some of the facilities for operations and maintenance, and now they're starting to get access to information through the Internet. They're really going to make some changes.

One of the frustrating things has been that the only thing the Iraqis knew about our country [, the United States] was from the movies. The Husseins used to pirate all the latest movies, and the Iraqi population would see them. Because of that, they thought we had troops that could kill 1,000 people all by themselves, that we have technology that can see through walls, that we can get rid of 30 years of neglect within a year. So we would never be able to meet any of their expectations, which has caused a certain amount of anger.

*Q: Is this in general or just the public health expectations?*

GOODWIN: No, this is across the board. Iraqis just fundamentally don't understand Americans as well as many of the other countries that were there. At the same time, Americans don't understand Iraqis. They think that there's no infrastructure over there even though they have all kinds of buildings, a highway system.

The Iraqis are also very smart. They were doing kidney transplants back in 1968 in Iraq. The women there already drive. So there's that kind of clash from our media and from the Iraqi perspective that's really difficult. And they still depend upon Al Jazeera for most of their media, which gives them a very biased perspective as far as what's going on.

In general I think we spent the last year or so creating the foundation. It's kind of like if a house in your neighborhood is going up, people are working on it and working on it, and you're going, "Gosh, it's taking them forever. What are they doing on that house? It's going so slow," and then, boom, one day the walls and the roof come up and you're like, "My gosh, look how much progress they've made on that." I think within the next year the walls and the roof are going to come up, the Iraqi people are going to start seeing that real progress is being made, not just in the political arena but also in the reconstruction of the country, and then it's going to kind of all gel from there.

[END TAPE]

*Q: You were Iraqi discussing expectations.*

GOODWIN: I think the Iraqis had unreal expectations. They want to be able to have any service at any time, and I think ultimately [that will change] when they start figuring out what things cost. Much like anything, if things are free, it gets abused. [They need to work on] what type of tax base system that they [should] have. [They] should [ask if] the government [should] reimburse for specific services or just provide services across the board.

I think that's going to be some of the challenge: how to make the private and public sector work together in the future, as well as how do expenditures work and decide what are the basic services that should be provided [by the government]. But right now they just kind of want it all. They want a new country to happen right now, and it's going to take some time to learn the aspects of [making] that [happen].

*Q: What critical lessons did you draw from the experience and what advice can you pass on for people who are going in to work with the Ministry of Health or the health system in general?*

GOODWIN: For me this was probably the hardest thing I've ever done in my life but the best thing that I've ever done. This type of situation provided a unique opportunity. If you were willing to get outside your comfort zone and push the limits, you were able to accomplish quite a lot in a short period of time.

Something that I've talked about is that Iraq has no legacy systems so you can essentially go from no phones to a fully wireless environment. They would probably do very well in that because they haven't gone through having a normal telephone and then a cell phone that doesn't have very good capability. They can go right to the latest technologies. So there's some real opportunity for rapid involvement.

The other thing I would say is that from what I saw, not to get political, really if you look at “Have we found weapons of mass destruction?” Well, we found them in Saddam and his sons. They killed over 600,000—we’ve seen the mass graves. They targeted certain populations by either neglecting them or specifically targeting them for killings. It was just a bad place, and I personally believe in what we’re doing there. I also think, if you take the intelligence of the Iraqi people, their resourcefulness—these are people that kept cars going using bubble gum and reengineering parts and things like that....

*Q: Battery packs and generators with duct tape.*

GOODWIN: Right, exactly, and they are very resourceful and very apt to learn. So I think that lessons learned are (1) go in there very early and get an assessment of what the capacity of the people is; and (2) do what you can to incorporate as much of that capacity as possible.

I think some people within the military, CPA and others were kind of thinking of things like [they were in] Afghanistan, where the capacity of the people was so basic that they couldn’t run their [own] health care system. NGOs and other groups are kind of bringing the Afghan people along and, for the most part, are providing the services for them. The Iraqis could do [take control over their own systems] early on, and we just needed to kind of empower them more, as we need to do right now. I think there are still quite a few people that don’t quite understand just how intelligent these people are. This is [the place] where Hammurabi’s law came from. This was the center of civilization for thousands of years, and Iraqis will take that place again as a leader in the world.

*Q: Thank you.*

Interviewer’s note: The following is information gathered from Mr. Goodwin post-interview.

1. Mr. Goodwin worked primarily on the Macro-level, so he is hazy about the specifics of initiative implementation.
2. One of the biggest problems he notes was getting Iraqis out of a “crisis-management” mentality and have them start thinking about long-term initiatives.
3. Another challenge Mr. Goodwin noted was the challenge of being a young man (31) working with Generals and Colonels.
4. He gave three examples of the specific types of problems that were examined by the Ministry of Health working groups:
  - a) In developing the national immunization program, the working groups looked at the immunization programs which were being run in the Kurdish regions of Iraq (by the Kurdish authorities). The Kurdish program served as the model for the greater vaccination effort.
  - b) The issue of regaining respect for the nursing profession was also heavily debated and a major concern of the working group.

c) The nature of the health care system (public/social on the Canadian model or private/reimbursement on the United States model) was largely debated