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Republic of Iraq



Global AIDS Progress Reporting 2012

Country Progress report

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1. Overview of the AIDS epidemic in Iraq

Iraq can be characterized as a low-prevalence HIV epidemic, with a low number of officially reported HIV cases. The first HIV cases were reported in 1986 among hemophilic patients who had received contaminated blood products. In the period from 1986 to December 2011, 615 HIV cases were officially reported: 309 of which (50%) were Iraqi citizens, and 59 of which are still alive. The distribution of the cases is as follows:

- 85% males and 15% females;
- 66% were hemophilic by parental route;
- 17% by heterosexual route;
- 5% vertical transmission from infected mothers.

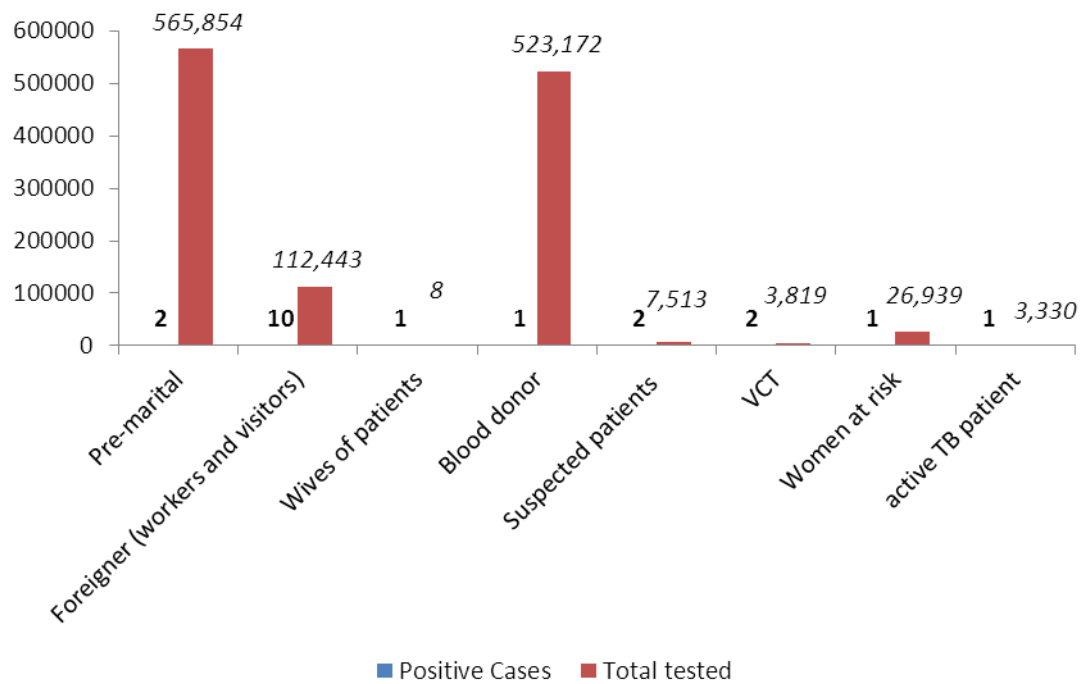
Apparently, no cases of transmission due to homosexual intercourses or exchange of infected needles were reported.

In the time span between March 2003 and December 2011, which marks the period after changing the political regimen of Iraq by foreign troops, 131 new HIV cases were reported, 51 (39%) of which among Iraqis citizens. Within this period, the transmission mode shifted towards the heterosexual route, as the government has put in place strict blood safety measures.

To date, the total cumulative number of HIV (mandatory + voluntary¹) tests carried out in Iraq in 2011 is 1,306,651. Out of these, 20 positive cases were detected. The disaggregation of these encountered positive cases, in relation to the number of tests performed by each category, is shown in figure 1:

Figure 1: Distribution of HIV positive cases from total number of mandatory and voluntary testing by category (2011)

¹ Screening of HIV risk groups include the following categories: Donated blood, Clinically suspected cases, STD patients, Hemophilic and Thalasemic patients, Active TB patients, Hepatitis B ,C cases, patients on hemodialysis, Pregnant women who are at risk of HIV infection, Babies of HIV infected mothers, Contacts of positive cases, Prisoners with sexual offences, Travelers to Iraq, Health workers, Long distance drivers, Workers in tourist places, Premarital testing, Clients to psychiatric centers, Special surgical operations, Foreign employees.



Source: Iraqi MoH

1.1 Potential drivers of the epidemic

Although there have been very few officially reported HIV cases to date, certain factors may be driving the HIV epidemic in Iraq. While there is virtually no reliable research data to provide a comprehensive understanding of the HIV/AIDS situation in Iraq, the recent history of the country provides evidence that there are many factors that may contribute to an increased spread of HIV, currently and in the near future. These potential drivers of the HIV epidemic include structural, socioeconomic, political and cultural factors that are not easily measured, and which increase people's vulnerability to HIV infection.

a) The Impact of Poverty and War on Women's Survival Strategies and HIV Risks

Many years of armed conflict and violence have marked the recent history of the country, resulting in the displacement of large groups of people, both internally displaced persons, as well as refugees to neighboring countries – such as Syria and Jordan. In the aftermath of the years of conflict, many Iraqi citizens have been returning, and continue to return, from years of exile under often very hard circumstances. The war has led to enormous social, psychological and economic

problems, including poverty, unemployment and the disruption of families and communities, which have had an enormous impact on the lives of millions of individuals, families, communities, and society as a whole. Women and young people are particularly vulnerable to the consequences of war and poverty. The impact of the war in Iraq has been visible in neighboring countries as well, not only through the large numbers of refugees, but also through the many unprotected Iraqi women who lost their husbands and families and were often left to fend for themselves and their children alone without the support and protection of their own families or communities.

b) A Large Young Population with Shifting Sexual Norms and Practices

Another potential driver of the HIV epidemic may be the large young population: 42% of the Iraqi population is between 10 to 30 years of age. The impact of the armed conflict on the social fabric of society may have had an *accelerating impact on shifting social and sexual norms and behaviours among these young people*. In the absence of scientific research in this field it is impossible to identify to what extent this may have increased the risk of HIV/STI infections.

However, young people's rapidly increased access to the outside world through TV, cell phones and the Internet may have contributed to more liberal sexual morale, norms and practices, which may contribute to higher HIV risks as well. Of all young people, more than half (51%) has a cell phone; 35 percent know how to use a computer, and 13 percent uses the internet. At the same time, only 46 percent are employed, thus more than half is unemployed. While alcohol use is low, it is on the increase.

c) Risk of drug use

The combination of violence and instability, a large group of young people and high unemployment rate might bring additional risk through the fact that there is a lot of drug trafficking in the region, especially from Afghanistan and Iran particularly in bordering districts of Sulaymaniyah. While oral use of prescription drugs appears to be common, it may also be converted to injected. The addiction treatment services in Baghdad and Erbil primarily cater for alcoholics and prescription drug addicts. Anecdotal report shows that the governorates of Sulaymaniyah, Erbil, Baghdad, Karbala and Najaf would have higher number of drug marketing since they are big cities often visited by travellers and pilgrims.

d) HIV-related Stigma and Discrimination

HIV/AIDS-related stigma and discrimination may also contribute to the spread of HIV: due to stigma and discrimination, few people, especially MARPs groups, will go for voluntary counseling and HIV testing (VCT) to avoid the negative societal consequences of being diagnosed with HIV. As a result, most people living with HIV

are not aware of their HIV status and may thus unknowingly pass on the virus to their sexual partners. In addition, HIV-infected persons who are unaware of their status will not be able to timely access effective treatment, care and support, including antiretroviral treatment, thus further exacerbating the risk of HIV infection..

2. National response to the AIDS epidemic

The National HIV/AIDS/STD Programme (NAP) was established in 1987 under the Ministry of Health (MOH) in response to the first HIV cases that were identified in 1986 among hemophilic patients who had received contaminated blood products. In this context, a policy of registering and HIV testing all hemophilic patients was first put in place.

2.1 HIV/AIDS structures, policies and programmes

The HIV/AIDS/STI Control Program is part of Iraqi Ministry of Health / Public Health Directorate, with a link to other programs (MCH &TB). During the year 2000, an administrative structure was established to include all the activities of the program (AIDS Research Center/National AIDS Center):

- a) Information, Education and Communication (IEC);
- b) HIV/AIDS;
- c) Sexually Transmitted Infections (STI);
- d) Immigrant Health and Residency Applicants;
- e) Administrative.

The Center provide activities through 19 focal units & 98 HIV testing centers (18 of them in Baghdad, the capital), with 15 socio-medical facilities for PLWHA.

Furthermore the NAP counts on:

- I) 19 focal units, one in each governorate and two in Baghdad (Kharch and Rusafa);
- II) 98 centers for HIV testing (18 of which in Baghdad);
- III) 15 Socio-medical facilities for PLHIV and tested close to 1.2 million people annually.

To date, around 460 individuals are working with the NAP. Their distribution is as follows:

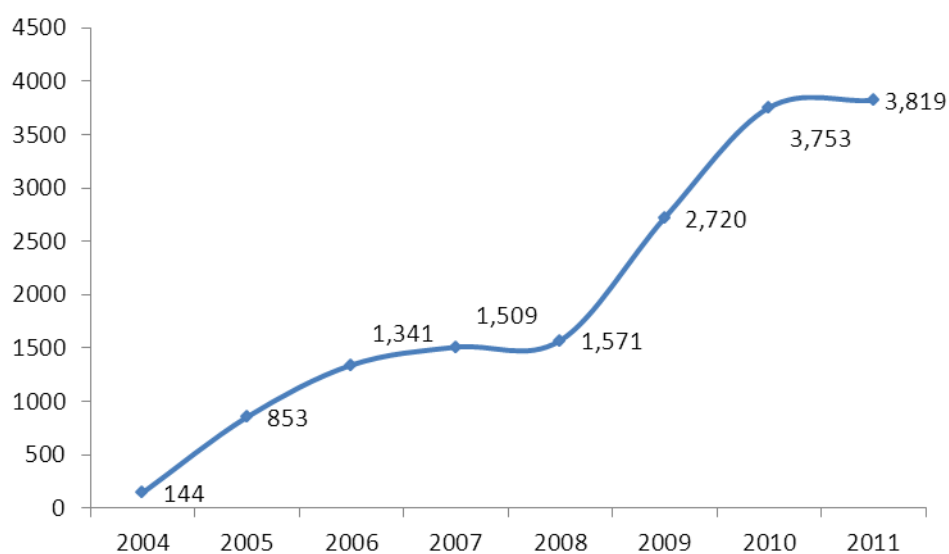
| At Central Level | At Provincial Level |
|--------------------------|---------------------------|
| Professionals: 10 | Professionals: 129 |
| Supportive: 44 | Supportive: 277 |

The first National Strategic Plan for HIV started in the late late '80s with the approval of the higher committee, which counts on several Ministries. A National Plan of Action is put in place and revised and updated on annual basis, and it is based on the "three-ones" principle: *One* National Action Framework, *One* National Coordinating Authority and *One* National M&E System.

The objective of the national strategy for HIV is to maintain a low prevalence in the Country, and it is based on seven pillars:

- 1) HIV Surveillance**, with the objective of scaling up testing for population at higher risk, surveillance through VCT centers and implementation of second generation surveillance systems; As an example, the total number of VCT centers has been constantly increasing since 2004, with an average annual increase of 97%

Figure 2: Annual cumulative number of VCT clients in Iraq



Source: Iraqi NAP

- 2) **Early detection , diagnosis and treatment of STIs**, whose targets are the scaling up of syphilis testing among high risk groups, increase diagnostic capacity for the STIs and strengthen the skills of the service providers;
- 3) **Prevent transmission of HIV**, which aims at ensuring the blood safety, HIV testing, and increase condom availability;
- 4) **Provide care and support for PLHIV**, with the objective of providing free medications, free health services, free condoms, counseling & awareness, as well as decrease stigma and discrimination;
- 5) **Health education**, which aims at conducting lectures and events, producing brochures, articles, and undertake media activities;
- 6) **Training health workers**, with the target of enhancing their skills through *ad-hoc* trainings and field visits;
- 7) **Research & studies**, which include KAP studies and a wide range of other surveillance activities.

In 2005, the NAP, in close collaboration and support from several UN partners (WHO, UNICEF, WFP and UNFPA) developed a first Strategic Plan Framework after war. The framework was intended to serve as platform for all stakeholders and a basis for all interventions in the HIV/AIDS response with focus on prevention of HIV infection, reduction of personal and social impact of AIDS and capacity development for the national institutions. However the framework was not operationalized because of the political instability. Following the workshop no actions plans were developed; and no costing or resources mobilization was conducted, therefore the country was running the previous strategy. At present, the country is updating the NSP.

All institutions involved in the national HIV response report directly to NAP through their respective HIV focal persons at the governorate level on a regular basis (monthly, quarterly, 6 monthly and annually). Data collation and analysis are done by NAP at the national level.

With technical and financial support from UNDP and WHO, NAP developed a HIV/AIDS communication strategy, and conducted various awareness activities for vulnerable groups, including young people. NAP also worked with UNFPA, WHO and UNICEF on surveys including the National Youth Survey in 2009, and the National Survey on Women Health and Social Status.

To date, however, strong levels of stigma and discrimination of key populations at higher risk have thwarted the development of targeted interventions for these groups, and to date no special services have been established. Therefore, stigma and discrimination against PLHIV and key populations remain significant challenges for strengthening the national response to HIV.

Similarly, HIV/AIDS plays a very limited role in the post-conflict rehabilitation plans. E.g., there is no reference to HIV/AIDS in the key planning and policy documents of the post-war Iraq such as National Development Strategy (NDS) and the International Contract with Iraq (ICI). NAP's priority focus remains health-sector oriented, with limited linkages to the private sector. Moreover, the role of NGOs in the national response is still limited due to limited capacity and prioritization issues.

HIV testing and counseling

After the first HIV cases had been identified in Iraq, the government gradually introduced HIV testing for a large number of categories, such as blood donors, clinically suspected cases, STI patients, patients with hemophilia and thalassemia, newly diagnosed TB patients, patients with hepatitis B and C infections, patients on hemodialysis, pregnant women who are at risk of HIV infection, premarital testing, newborn of HIV infected mothers, contacts of HIV positive cases, prisoners with sexual offences, travelers to Iraq, health workers, long distance drivers and workers in tourism.

HIV testing is mandatory for prisoners convicted for sexual offences, travelers to Iraq, blood donors, newly diagnosed tuberculosis cases and those who are getting married. HIV testing in prisons involves those prisoners detained/imprisoned for sexual offences. There is systematic regular testing of prisoners. Other than counseling and testing, the prison system does not offer specific HIV services to inmates.

Voluntary counseling and testing (VCT) services were introduced in 2004.

HIV services in prisons

Iraq has 64 prisons and detention facilities: 20 only in Baghdad and six in the Kurdistan region. The male prison population has a good proportion of men engaged in sexual and drug-related offenses; while women's prisons have a sizable proportion of inmates engaged in commercial sex. Three types of prisons exist in Iraq:

1. *Adult prisons* (male and female), which are usually under the jurisdiction of the Ministry of Justice. There are medical health facilities inside each prisons run by MOH and there are social workers managed by the Ministry of Justice;
2. *Juvenile Rehabilitation and Reform prisons*, which are under the jurisdiction of the Ministry of Social Affairs. These facilities also all have primary health care, and provide counseling and psychiatric

counseling. The prisoners are usually street children incarcerated for offences such as prostitution, theft or violent crimes;

3. *Detention and deportation centers*, which are under the jurisdiction of the Ministry of Interior and are used to keep suspects for not more than 14 days before their trial or release.

There are some health care programs in prisons and detentions facilities for inmates and prison staff.

HIV services for drug users

Most clients of psychiatric hospitals and drug-treatment centers are alcoholics and those addicted to prescription drugs (inhalers, oral and injectable). However, the number of patients with narcotic drug addiction is also slowly increasing (sniffed, inhaled and injectable). This is more so in private psychiatric practice where patients seeking more anonymity go. Psychiatrists providing care agree that patients come for consultation when their family forces them to seek help or when they are referred from the police after they have been sent to prisons for drug addiction. In addition, most drug addicts (alcoholism, prescription drugs) tend to engage in risky sexual behavior. Part of the reason for drug use is reportedly to increase sexual drive and enhance sexual experience.

HIV treatment and care services

All 59 HIV positives cases are under care. 8 of them are on ART and the remaining are under pre-ART care. The MOH provides medical, social and economic support to those under pre-ART care; and provides financial support (a monthly salary), free medical evaluation and treatment, prevention services and counseling, as well as housing support to ensure that PLHIV have a place to live (for those who have no place to live or evicted because of stigma and discrimination) and coordinates with relevant agencies to provide support to orphans, if needed. Despite the range of services offered, PLHIV still suffer from marginalization and discrimination in relation to access to health, education, and social services. NAP has been working on intensive advocacy to ensure equal access for PLHIV and their families to health and social services within a supportive social environment.

Prevention and control of STIs

STI control is part of the HIV/AIDS programme and run by the National AIDS Center. Although STI services are available in the public health-care sector, most STI patients seek care in private clinics and pharmacies. Systematic data collection, reporting and

analysis on STIs in the public sector are done on monthly basis, and private sector involvement is limited. All STI patients are reportedly screened for HIV, but no HIV-positive cases were reported.

TB/HIV collaborative programme

As part of TB-HIV collaboration, all newly diagnosed TB patients are screened for HIV. Some HIV cases have been detected in TB patients.

Prevention of HIV transmission in health-care settings (blood safety, infection control etc.)

There are regional blood banks in all of the 18 governorates, blood is usually collected from family or directed donors with occasional campaigns for voluntary donation of blood in schools, universities, government offices and military barracks. For those patients who require regular blood transfusion such as haemophiliacs, blood is usually collected from family or directed donors.

Donated blood or donors are screened for HIV, HBV, HCV and syphilis. This is followed by all public health facilities. The practice in private sector health facilities needs to be explored. From 2007 to 2010, laboratories in Kurdistan region reported 380, 276, 1370 and 1211 HBV positive cases; and 129, 140, 446 and 334 HCV positive cases. Though we do not have denominators, i.e., the total number of people tested each year, the absolute number indicate possible breaks in infection control measures in health care settings.

3. Main challenges

Impact of the war: the war that started in 2003 led to a prolonged period of violence, insecurity and instability, which resulted in the breakdown of the health-care system and the destruction of many health-care facilities. In this context, most of the programmes and facilities of the National AIDS programme (NAP) were disrupted and/or destroyed, including the counseling center at the Ibn-Zuhur hospital and VCT centers in other Governorates, as well as many laboratories where HIV testing was done (MOH/INAP, 2005). These events have clearly affected the effectiveness of HIV testing and counseling in the last decade, but recently health system is rehabilitated & reconstruction efforts is running accordingly.

Lack of HIV data on Key Populations at Higher Risk: the main source of HIV data is routine HIV testing among a certain groups, including blood donors; clinically suspected HIV cases; STI patients; hemophilia and thalassemia patients; newly

diagnosed TB cases; persons with HBV or HCV infection; patients on hemodialysis; pregnant women who are at risk of HIV infection; premarital testing; new-borns of HIV-infected mothers; contacts of HIV positive cases; persons convicted of sexual offences; travelers to Iraq; health-care workers; long-distance drivers; and workers in tourism. Testing is mandatory for sexual offenders, travellers to Iraq, blood donors, newly diagnosed tuberculosis cases and those who are getting married. While large numbers of – mostly mandatory – HIV tests are conducted among these groups each year, no (systematic) HIV testing is done among key populations at higher risk, such as sex workers, men who have sex with men (MSM) and injecting drug users (IDUs). Widespread stigma and discrimination, extreme social marginalization, as well as sometimes (severe) physical violence against these groups keeps them from seeking HIV testing for fear of being exposed. Thus, reliable data on these groups is not available and those groups are severely underrepresented in the national HIV/AIDS statistics.

VCT services:

Few HIV cases were identified in the last seven years through voluntary counseling and testing. However, experiences in neighboring countries such as Jordan and Syria show that VCT services can play an important role in identifying new HIV cases. Despite the fact that the absolute number of VCT sessions was very low in both countries, VCT accounted for more than 50 percent of newly found HIV cases in Jordan: out of a total of 15 new HIV cases in 2009 in Jordan, eight were found among only 220 VCT clients, while the remaining seven were found among almost 200,000 persons tested for blood donations or other tests. This indicates that persons who identify themselves as having been exposed to high HIV risks are more likely to go for VCT services.

Financial resources:

The cost of the national response is primarily covered by the Government of Iraq. The UNDG Iraq trust Fund provided resources to provide technical assistance in strengthening/generation of strategic information (surveillance) and supporting policy and strategy formulation. Other UN agencies have obtained funding to work on HIV and related issues in Iraq (UNFPA, UNICEF, UNESCO etc.).