IRAQ WATCHING BRIEFS

HIV/AIDS

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SOCIAL SECTOR WATCHING BRIEFS

HIV Prevention

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AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
DUs	Drug Users
HIV	Human Immune – deficiency Virus
GIPA	Greater Involvement of People living with and affected by HIV/AIDS
GONGO	Government Organized Non-Governmental Organization
IDUs	Injecting Drug Users
IEC	Information, Education, Communication
KABP	Knowledge, Attitudes, Behaviour and Practice
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NAP	National HIV/AIDS Control Programme
NGOs	Non-Governmental Organizations
PLWHA	People living with HIV/AIDS
STI	Sexually Transmitted Infection
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
VCCT	Voluntary and Confidential Counselling Testing
WHO	World Health Organisation

Vulnerability of Iraq to HIV/AIDS

The MENA (Middle East and North Africa) region is experiencing a doubling in the number of HIV cases year on year for the last three years, according to WHO/UNAIDS. Sexually transmitted infections in the region were estimated by WHO to be approximately 10 million in 2002. Young people are starting to have sex outside marriage and at younger ages. Drug use, including injecting drug use is escalating. Having been severely isolated from neighbouring countries and the international community for over a decade, Iraq is currently experiencing the early stages of the HIV/AIDS pandemic.

With only 267 reported cases of HIV/AIDS, and an estimated HIV prevalence of less than 0.01% of the total adult population (of ages 20 to 49) in 2001. According to the Ministry of Health of Iraq, 84% of reported HIV cases in 2001 were through contaminated blood or blood products. The next most frequent modes of transmission of infection were related to sexual transmission comprising 11%, bisexuals (9%) and mother to child transmission (5%). Moreover, 73% of the reported HIV cases have been found in men of whom most (61%) are aged between 20-49 years, while 37% are aged 5-19 years. There were no detected cases on injecting drug user, men having sex with men, and male and female commercial sex workers, due to denial and stigma, as well as an official ban of commercial sex work in Iraq. There is however a real danger that in the current context, this scenario of low prevalence is going to change drastically. Though the number of detected HIV cases in Iraq has been extremely low in number, the current collapse of the nation's health system, looting of medical supplies (including testing kits), absence of strict screening for all travellers at the border, active sexual behaviour and increasing drug use among young people makes Iraq very vulnerable to the rapid spread of HIV.

National and International Response

Over the past two decades the number of HIV+ cases has risen by more than 30% (from 152 HIV+ in 1990 to 222 HIV+ in 2001) in Iraq. The former Government of Iraq had launched the National Aids Control Programme (NAP) as early as the late 1980s. It was developed on religious and "cultural doctrines of delimitting extra-marital relationships". It has well established objectives, such as preventing the transmission of STIs, dissemination of health information through the formal education system, blood and blood product safety, infection control, and care and support for people living with disease. Moreover, the Ministry of Health also invited some non-governmental organisations such as the Union of Iraqi Women, Union of Youth and Students along with other NGOs (Red Crescent) to implement HIV/AIDS preventive activities in their programmes. Mother and care centres also played some role in delivering HIV preventive education initiatives. However, in actual practice, the NAP was extremely limited in scope. The virtual absence of a comprehensive and realistic social perspective in the conceptualisation of the programme and the adoption of a narrow medical approach led the NAP to ignore various issues that could have provided a real solution to HIV prevention.

HIV preventive education was integrated, albeit in a very limited manner, into biology and health subjects in the Iraqi school curriculum at elementary, intermediate and secondary levels. Teacher training institutes could not offer HIV preventive education in their curriculum due to lack of knowledge and resource material development. Other limiting factors included an absence of general public awareness of HIV/AIDS. Mass media and other communication means were rarely used for providing HIV prevention messages. The very limited publication of educational materials and the lack of professional development for

health workers on how to deal with the issue of HIV have all contributed in making the NAP laudable in its objectives but weak in both perspective and implementation.

Recommendations

A. STAFFING & RESOURCES

1. Need for professionals with **full time HIV responsibility,** especially **GIPA** (**greater involvement of people living with and affected by HIV/AIDS**).
2. Greater government allocation for HIV.

B. INCREASE IN THE KNOWLEDGE BASE

3. Review of legislation
4. Behavior
5. Evaluation of Previous NAP Programs and Projects
6. Best practices / Lessons Learnt:
7. Review of School curricula:

C. HIGH IMPACT AND STRATEGIC INTERVENTIONS

8. **Advocacy**
9. Development of a **comprehensive** multi-year, multi-media, multi-target group **communication strategy.**
10. **Operational Action Plan via Strategic Planning**:
11. **HIV prevention in children/adolescents/young people, through:**
    a. **GIPA** capacity building
    b. **Peer education activities** related to young people's sexual and reproductive health and rights.
    c. **Voluntary Confidential Counselling and Testing (VCCT)**.
12. **Prevention of HIV transmission from fathers to mothers to children** (vertical transmission) [3].

D. **IRAQ EXPANDED THEME GROUP (ITG) on HIV**

13. Increased **coordination among international and national players.**
14. **HIV in the Workplace**

E. ACTIVE PARTICIPATION OF YOUNG PEOPLE

15. HIV prevention should be carried out through active participation of high risk behaviour groups.

F. GENDER MAINSTREAMING

16. As over 71% of all new HIV infections in young people in MENA is in young females, issues related to gender mainstreaming have to be promoted.

[3] These programs are erroneously called Prevention of Mother to Child transmission, however, the vast majority of women are monogamous, and are infected by their husbands, who either have extramarital relations, usually with sex workers or other men, are drug users, or all of the above.

1. Introduction

MENA OVERVIEW [4]

The limited and incomplete data indicates that despite the appearance of social and religious conservatism, the Middle Eastern and North African (MENA) region has an **estimated 0.3% HIV infection of the adult population**, ranking higher than Australia & New Zealand (0.1%), East Asia and the Pacific (0.1%), and being on par with Western Europe (0.3%) (UNAIDS/WHO) – albeit 80% of the MENA HIV caseload is in Sudan. While globally young women (15-24 years old) account for 60% of all new infections, in MENA countries young women account for 71% of all new infections. MENA has the **2nd highest rate of increase of HIV in the world** (after the former Soviet Union and Eastern Europe), having more than a 300% increase in the number of estimated HIV cases in the last 3 years (WHO/EMRO), being the fastest growing disease in the region, and this latter aspect is valid for all MENA countries. By 1998, HIV/AIDS was the **3rd leading cause of morbidity** among people 14 to 44 years old in the low and middle-income countries of the region.

2. PRE-2003 WAR SITUATION [5]

2.1 LIMITED EPIDEMIOLOGICAL AND BEHAVIORAL INFORMATION

Iraq has a population of 23 million. Since the first case was detected in 1986, a cumulative number of **267 people** were detected and confirmed with HIV/AIDS **by January 2003.** Over the past two decades the number of AIDS and HIV+ cases has risen by more than 30% (from 152 HIV+ in 1990 to 222 HIV+ in 2001) in Iraq. Based upon these numbers, in **2001**, UNAIDS **estimated** that a maximum of **1150 HIV/AIDS** cases were living **in Iraq** [6]. This qualifies Iraq as a very low prevalence country (under 0.1% HIV infection of the general population).

73% of the reported HIV cases have been found in men of whom most (61%) are aged between 20-49 years, while 37% are aged 5-19 years.

Testing laboratories were available throughout the country with the confirmatory test done by the National AIDS Laboratory in Baghdad (the only such public health facility). Due to the comprehensive economic sanctions, HIV tests were limited, centers were reported to vary from excellent to poor due to limited training and knowledge of case definition among health practitioners as most of the staff had no access to updating knowledge and information on screening of diseases such as STIs, early infection, testing of blood components, and TB and Hepatitis B and C, management and testing of HIV/AIDS.

"HIV screening was performed at border checkpoints for both Iraqis and non-Iraqis entering the country. Gypsies, who are involved in entertainment business, [were] are also considered to be at potential risk and are tested. Other groups who [were] are tested include STD

[4] Data from: (1) UNAIDS, (2) WHO, (3) World Bank draft report on the HIV/AIDS Situation in MENA.

[5] Scarcity of in-depth information about HIV/AIDS in Iraq, at the institutional level, is currently a problem. To fill such information gaps and understand the reality about HIV/AIDS in Iraq, interviews have been carried out in Amman by contacting persons having responsibility for the organisation and implementation of HIV/AIDS programmes in Iraq.

[6] Governments are involved in the formulation of UNAIDS estimates, and according to prevailing perception, each case is shameful for a government, as it denotes immoral behavior (illegal sex, illegal drugs) by its peoples. As a case in point, Saudi Arabia has not reported any cases of HIV/AIDS until very recently, despite estimates of over 1000 cases.

patients, prostitutes caught by the authorities, night club workers, blood recipients, prisoners, patients with TB, Hepatitis B or C, sexual contacts of AIDS patients, blood donors, pregnant women, health workers and couples before marriage. In the year 2000, more than half a million HIV tests were performed and 18 out of the 20 detected HIV positive cases were among travellers, and two were sexual contacts of known HIV cases. No evidence of infection was found among pregnant women tested in 1999 and 2000. One positive HIV was detected among 1,272 prostitutes who were tested in 1996." [7] Given that HIV tests were conducted upon unrepresentative and limited populations, the results are epidemiologically biased.

Hence, Iraq's medical authorities and society at large, had very limited information on the real magnitude, distribution and trends of HIV infection in the Iraqi population remain incomplete and are epidemiologically biased. To these we add other factors associated with under-reporting of HIV, such as a centrally planned socio-economic structure which did not wish to portray a high level of HIV, associated with immoral behaviour, or medical malpractice.

Characteristics of the surveillance system:

(1) **Testing of foreigners** coming to Iraq, at border checkpoints, therefore not contributing information to the HIV status in Iraqis. The testing was more at times an income generating scheme, as travellers had the option of paying for the test, while not getting tested.

(2) **Testing of Iraqis going abroad**: at border checkpoints. Mainly educated, middle class individuals, whose engagement in high risk behavior in Iraq is assumed to be limited. Consequently, they are unrepresentative of those likely at this stage of the epidemic to be HIV positive.

(3) **Extremely limited testing of high risk groups** (sex workers, men having sex with men, injecting drug users) where the virus initially concentrates before spreading to the general population through bridge populations (in low prevalence settings). High risk groups are illegal and stigmatized in Iraq, and hence conduct their illegal activities "underground." They do not have access to information and services. While national HIV surveillance foresees the testing of these high risk groups, medical authorities can only test those who are caught by the police, but their illegal status encourages them to avoid being caught.

(4) **Testing of the general population in blood banks.** 2 positive ELISA and 1 Western Blot tests are necessary for confirmation of HIV by Iraqi law. Most blood banks, for blood safety considerations, discard blood from individuals who test positive on the first ELISA or Rapid test. Although the number of positive tests is reported to the MOH (Ministry of Health), they are not included in national statistics. Donors are unaware of the blood tests being conducted on them (Hepatitis B, Hepatitis C, and HIV). If found to be positive, they were not regularly informed, unless they were quarantined by government officials in the special medical facility established 36 kms. outside of Baghdad.

(5) **HIV testing conducted by private laboratories and blood banks:** Unknown

[7] UNAIDS/WHO/UNICEF Country Epidemiological Fact Sheet. 2002 Update.

(6) **People seeking care for sexually transmitted infections in private facilities.** Monitoring trends in STI can provide valuable information on the sexual transmission of HIV as well as the impact of behavioural interventions, such as promotion of condom use. Those having STIs, especially ulcerative ones, have a risk of contracting HIV that is 10 times greater than people who are not infected with STIs. "More than 30,000 STD cases were reported in 2000, of which 18% were attributed to Gonorrhea, 13% to Pelvic inflammatory diseases, and around 9% each of Bacterial vaginosis, Non-Gonococcal urethritis and Trichomonas. Syphilis serology by VDRL among pregnant women showed a positive rate of 0.1% in year 2000. The health authorities believe that these figures are largely underestimated considering the current embargo situation of the country, the limited development of the health facilities and their ability to cope with STD care and prevention. It is believed that the sexual risk factors are not uncommon since the age at marriage has increased." [8]

(7) **Virtually no integration of TB and STI data, and data from routine testing with HIV data**. Even if individual data (be it TB, or STI, or HIV) is not accurate, by triangulating data from these multiple sources, one can be alerted to trends.

(8) **Paucity of data on behaviour**, especially that of young people and high risk groups. Questions related to behaviour, such as age of first sexual encounter, number of sexual partners in the last month, use of condoms during last sexual encounter, etc. were never asked during the few population based reproductive health surveys. We do not even have information on knowledge and attitudes, much less on behaviour and practices. In low prevalence settings, data on the behaviour, especially of high risk and vulnerable people (including adolescents and young people) represents the alarm bell that something will happen before it happens. If one monitors HIV from testing (so-called serological testing), by the time the HIV prevalence increases in the general population, it is already too late.

2.2. MODES OF HIV TRANSMISSION IN IRAQ

As per available information, **the principal mode of transmission is contaminated blood,** representing 84% of reported HIV infection by 2001, while **blood transmission** accounts for 5% of global HIV transmission. Sexual transmission (heterosexual and bi-sexual) represents 11% of HIV reported cases in Iraq. For a low prevalence country, 4% of HIV through **vertical transmission** (from father to mother to child) is high.

A. GOVERNMENT

Lack of high level political commitment. Given prevailing perceptions about the "immoral" nature of HIV (illegal sex and illegal drugs) the Iraqi government has until recently shunned the subject. Due to recent UNICEF advocacy, the Iraqi government has shown increasing interest in addressing HIV. Contrary to a limited number of MENA countries (Djibouti, Iran, Libya, Sudan), the head of state has still not publicly identified HIV as a national threat, be it as a potential threat or otherwise.

[8] UNAIDS/WHO/UNICEF Country Epidemiological Fact Sheet. 2002 Update.

National Coordination Committee. This multi-sectoral committee is formal, not functional, and several relevant powerful national ministries are not included in its composition, such as those of Finance, Planning, and Trade.

National HIV/AIDS Program (NAP):

Is under the MOH Communicable Disease Control Department. This Department is also charged with Iraq's other communicable diseases.

At the national level, staffing is limited. There are also 15 governorate level focal points (1 for each of Iraq's 15 center/south governorates). However, the actual decision making and work was generally conducted by one person: the NAP Director.

The NAP did not undertake a situation analysis. Although having operational plans of action (work plans), these are not based on data, and contain random activities.

Education: Although HIV as a subject has been introduced in the mid 1990s in the elementary / intermediate level school curricula (for 13-14 year olds), under biology, the teaching of these pages is optional, and is frequently skipped by teachers uncomfortable with addressing the subject. Also, there is no documentation or references available on the curricula. Hence the intermediate school curricula do not equip Iraqi youth with the information and skills to protect themselves from the ever increasing risks to contract HIV.

Youth Friendly Health Services: most adolescents and young people do not have access to:

a. **Accurate information** concerning reproductive health, sexually transmitted infections (STIs), including HIV
b. **Youth friendly services:** there is a medical service gap between childhood and marriage
c. **Voluntary and Confidential Counselling and Testing**: no services available. With the pre-1991 policy of quarantining those found to be positive, there were significant incentives not to get tested.

Protection of people infected with HIV: Until 1991, people detected with HIV were quarantined. In 1991, shortly prior to the onset of the 1991 Gulf War, people living with HIV were released. According to some reports, a special government committee chaired by the Ministry of Health provided them with:

special monthly stipend (10,000 Iraqi dinars = US$ 2-3/mo) (avereage monthly salary for government civil servants = $2-3 / mo)

special monthly food ration, in addition to the one provided through the oil for food program, consisiting of wheat, rice, sugar, milt, tea, cooking oil)

special medical services (in a facility 20 kms.=12 miles outside of Baghdad) providing:

regular check ups (monthly) for dental services, other medical services through 5 medical specialists contracted by the Ministry of Health (including psycho-social, pediatric services, obstetrics, gynecollogy, etc.), hair dresser, irregular ARV therapy as of 1995

However, the isolation of PLWHAs was in practice an abuse of human rights rather than a more effective preventive measure.

B. MEDIA
The little media attention awarded to HIV, used scare tactics, and were not part of a multi-year, multi-media, multi-target group communication strategy.

C. CIVIL SOCIETY
Greater involvement of civil society.

D. GIPA (greater involvement of people living with and affected by HIV/AIDS).
GIPA is highly recommended for its positive impact on:

1. Prevention and consciousness-raising: The few examples of PLWHA (people living with and affected by HIV/AIDS) involvement in prevention activities have a powerful effect on public perceptions and attitudes - putting a human face on the epidemic and countering some of the terrifying public images of illness and death.
2. Service delivery: PLWHA are better able to identify PLWHA needs, and implicitly those who are negative, but at risk for contracting HIV.
3. Non-infected people: people who associate with PLWHA gain a broader understanding of PLWHA needs.

However GIPA is extremely difficult to implement in Iraq. There is widespread discrimination against risk groups and those infected with HIV/AIDS, due to the stigma associated with HIV (commercial sex, drug use, men having sex with men), widespread ignorance concerning the modes of HIV transmission (especially that it cannot be transmitted through direct or indirect physical contact). Consequently, people who suspect they might be infected with HIV are afraid to be tested for HIV, due to the **realistic fear of experiencing social death many years before sickness and actual biological death**. Those who are aware of their positive HIV status dare not disclose this status due to fear of social death.

E. PRIVATE SECTOR
As most Iraqi society, the private sector does not address HIV.

F. INTERNATIONAL RESPONSE
Among UN System partners, only WHO supported the Government of Iraq in a limited manner since the mid 1990s. In the early 2000s, the Government of Iraq had begun to encourage a few international agencies (International Federation of the Red Cross and Red Crescent Societies) in supporting training, development of resource material, counselling and IEC material production.

The Iraqi Red Crescent, with support from the International Federation of Red Cross and Red Crescent Societies, and the Lebanese Red Cross, staged the country's first-ever training workshop on HIV prevention on 27-31 October, 2002 in Baghdad. Thirty-six Red Crescent volunteers, comprising male and female participants, mostly from government-run centres, health care centres and teachers received the first in-service training on HIV prevention since the NAP started in Iraq. The main objective was to facilitate the training of master trainers on detailed knowledge about reproductive health, communication methods, leadership and training skills. The trainees were also trained in the use of

condoms which is still a highly sensitive issue in Iraq. The other objective of this training session was to train youth in self-esteem and help young people in particular to resist peer pressure regarding risk behaviour. Since 2000, the Red Crescent has also been offering training to non-specialized people on reproductive health and healthy life styles. This two hour training session has modules about the HIV virus, ways of infection and means of prevention along with a first aid module. These master trainers further provide six days training sessions to their colleagues in their respective branches.

Having all the necessary risk factors for an explosive epidemic, Iraq may be sitting on a fast ticking time bomb.

1. **Predominantly young population**: Over 50 % of Iraq's population is under 24 years old, and through the opening up brought upon by the 2003 Gulf War, social norms are changing. Even before the recent war, the average age of marriage has increased, and young people are reported to start sexual activity at a younger age, with some anecdotal information of as early as 15 years old. However, most young people do not have access to information and services.

2. **Sexually transmitted infections (STI)**: numbers were previously unknown, but ever increasing recent reports of rape, would be associated with an increase in STIs. High risk groups are expected to have considerably higher levels of STIs than in the general population, however due to the stigma associated with sex before and outside of marriage, and between men, and injecting drug use, they would naturally remain "underground."

3. **Increasing sex work (CSW):** sex work (or prostitution) in Iraq was illegal, with considerable penalties foreseen. Despite penalties, due to economic pressures of poverty and scarcity of men (from the Iran-Iraq war between 1980-1988, and the first Gulf War in 1991), a surge in female sex was reported under the sanctions period.

4. **Men having sex with men (MSM)**: accurate data does not exist, as the practice is frowned upon socially and treated as an illegal activity, but unofficial reports indicate that it was not uncommon. Being highly stigmatized, MSM remain isolated, underground, with limited access to services or information.

5. **Drug Use**: illicit drug use was penalized severely. Hence, there is limited information concerning how widespread its use was.

6. **Unsafe medical practices:** while global averages attribute 5% of HIV transmission to **unsafe blood**, in Iraq it is 84%.

3.2 VULNERABILITY FOR HIV

1. **Gender inequity**: Iraq signed the CEDAW (Convention on the Elimination of all forms of Discrimination Against Women) in 1981, and made considerable progress on

gender issues in recent years. Despite the signing of this international covenant, Iraq is a strongly male-oriented society especially in rural areas. Women who might have suffered from STIs or reproductive health infections (RTIs) were either unable to seek a cure due to traditional constraints regarding travelling, or unaware that such an infection exists. Besides, the lack of health and social service facilities that were available or accessible, declined due to the deterioration of the social sector during the last thirteen years.

2. **Poverty**: over 50% of Iraq's population is estimated to live in absolute poverty, completely dependent upon government subsidies for food and other services. The levels living on less than $2 per day are considered to be much higher. Poverty is associated with illiteracy, poor health, limited knowledge and skills, limited economic opportunities, and high levels of vulnerability leading to risk behaviour.

3. **Illiteracy**: over 40% of Iraqi adults are illiterate [9], despite considerable progress made in the 1980s in education. Girl's enrolment in formal education has increased significantly, however statistics show a higher dropout rate for girls, especially at higher levels of schooling. The markedly lower literacy rate among women compared to males (83% for male and 63% for women according to the MICS 2, 2000), and gender inequalities at the socio-cultural level, affected a woman's ability to exert control over her own health, especially reproductive health.

4. **Population Mobility**: Iraq's large contingent of Egyptian and Sudanese foreign workers left the country during the time of the first Gulf War. With comprehensive international sanctions, followed by an exodus of Iraqi professionals in the aftermath of the Gulf war, the government imposed strict measures on the foreign travel of its citizens. The food ration system, requiring stability of address for registration, limited migration. Migration results in the disruption of social bonds and norms, with people engaging in high risk behaviour. Hence from this perspective, Iraq was at less risk for HIV than neighbouring countries.

5. **Street Children**: In the period before the first Gulf War, government allocation for social services were second only to defence. The sanctions deprived the government of legal revenue, and hence social services were severely disrupted. Children had to drop out of school and help parents with household chores. In the sanctions period, a limited number of children, boys and girls, were living on the streets, especially in Baghdad. Following the latest war, international agencies are reporting an increasing number of street children.

[9] UNESCO 1997.

A. STAFFING & RESOURCES

1. Need for professionals in NAP with **full time HIV responsibility.**

2. **GIPA** (**greater involvement of people living with and affected by HIV/AIDS**). Recruit by the NAP of persons infected with HIV to work on the national HIV program.

3. Support the introduction of HIV programs at the governorate/district level, through:
    a. **Dedicated UNVs** (United Nations Volunteers) and / or
    b. **Students** and/or
    c. **NGOs**

4. Greater government allocation for HIV.

B. INCREASE IN THE KNOWLEDGE BASE

5. **Review of legislation:**
    a. legislation serving as the basis for the prevention of HIV.
    b. to assist in the creation of a supportive policy, legislative and regulatory environment, formulation of an advocacy plan (reform of legislation, regulations, policies, jurisprudence).

6. **Behavior:**
    a. S*upport*, a group of consultants and researchers to be contracted to formulate country specific recommendations for policy and programs. The same gathered behavioural data could be used to formulate a comprehensive multi-year, multi-media, multi-target group communication strategy.

7. **Evaluation of Previous NAP Programs and Projects**: To guide future programs, an evaluation of previous work should be undertaken, and documented, especially in light of recommended priority NAP interventions (advocacy, communication, GIPA, peer education, etc.).

8. **Best practices / Lessons Learnt:**
    d. Irrespective of its deficiencies, previous HIV programs should be documented.

9. Review of School curricula:
Review existing curricula, and mainstream HIV issues across all school curricula

C. HIGH IMPACT AND STRATEGIC INTERVENTIONS

10. **Advocacy**
    a. To garner high level political commitment for HIV at the presidential / prime minister / first lady / cabinet of ministers level, rather than resting HIV at the MOH level, once they become established.

b. To have powerful ministries actively participate in the National Coordination Committee, such as those of Trade, Planning, Finance, etc.
c. To operationalize the National Coordination Committee
d. To promote greater openness in discussing the risk of HIV to Iraqi society, and the need to provide adolescents and young people with the information, skills, and services to protect their health.
e. To encourage the implementation of the HIV curricula in primary/intermediate schools, so that it is not optional for teachers to teach.
f. Advocate for the introduction of information on prevention, and the provision of life skills in the school curricula.
g. To encourage the government of Iraq to initiate negotiations with pharmaceutical companies to have preferential prices for ARVs [10].

11. Development of a **comprehensive** multi-year, multi-media, multi-target group **communication strategy.**

12. **Operational Action Plan via Strategic Planning**: It is vital that Iraq begins the process of national strategic planning which would 1) involve sectors in addition to the health sector; 2) ensure that all actors base their programmes on data and national strategies; 3) ensure a budget for HIV/AIDS, etc.

13. **HIV prevention in children/adolescents/young people, through:**
    d. **GIPA**: Capacity building of those willing to disclose their status in: communication, lobbying, organization, networking, etc.
    e. **Peer education activities** related to young people's sexual and reproductive health and rights. Linkages with the Iraqi Red Crescent and Scouts movements, and other NGOs has the potential to broaden the reach and depth of their current efforts.
    f. **Voluntary Confidential Counselling and Testing (VCCT)**. The Ministry of Health with the HIV Theme Group have created a Task Force for the formulation of a VCCT policy and piloting of such programs,

14. **Prevention of HIV transmission from fathers to mothers to children** (vertical transmission) [11].

D. **IRAQ EXPANDED THEME GROUP (ITG) on HIV**

15. Increased **coordination among international and national players.**

16. **HIV in the Workplace**:

    a. Development and implementation of policies on HIV in the Workplace. Strengthen the provision of HIV in the Workplace services, including information, and free condoms in the men and women's washrooms (adopted

[10] This has been accomplished in MENA (e.g. Lebanon, Morocco, etc.) and WHO/EMRO has hosted a workshop on the issue.

[11] These programs are erroneously called Prevention of Mother to Child transmission, however, the vast majority of women are monogamous, and are infected by their husbands, who either have extramarital relations, usually with sex workers or other men, are drug users, or all of the above.

in a culturally sensitive manner), supported through the new personnel/consultants.

E. ACTIVE PARTICIPATION OF ADOLESCENTS AND YOUNG PEOPLE

17. HIV prevention should be carried out through active participation of high risk behaviour groups. Life skills education interventions should likewise ensure that priorities have been given to the targeted groups - gypsies, sex workers, MSM, truck drivers, PLWHAs, drug users, including out of school adolescents and street youth, vulnerable girls and women at the community level. Life skills should be employed as strategies in designing training and resource materials to put knowledge into practice through trained peer educators. Skills are to be developed on how to use condoms properly and other preventive measures. The instruction for their use should be carried out in a culturally sensitive manner and will employ non-formal education strategies.

F. GENDER MAINSTREAMING

18. As over 71% of all new HIV infections in young people in MENA is in young females, issues related to gender mainstreaming have to be promoted.

Healy. Iraqi Doctors Worried About 'Surge' in HIV, other Infectious Diseases Following Collapse of Nation's Health System. *Boston Globe*, 5/29. May 30, 2003.

Red Cross Red Crescent. *Red Cross Red Crescent News*. http://www.ifrc.org/docs/news/02/02/11901

UNAIDS/WHO/UNICEF: Epidemiological Fact Sheet Iraq, 2002.

UNAIDS. *HIV/AIDS in Pakistan: A Situation And Response Analysis.* Islamabad: UNAIDS, 2000.

UNAIDS; UNESCO. UNESCO Regional Seminar on Institutionalising HIV/AIDS within the School System in the Arab States, Brumana, Lebanon October 1-5, 2001. Final Report. UNESCO: nd

UNAIDS; WHO. *AIDS Epidemic Update: December 2002*. Geneva: UNAIDS, 2002

UNDP. http:// www.hivanddevelopment.org/regionalupdate, 2001.

UNESCO. *World Education Forum: Final Report*. Paris, 2000.

UNICEF. Gender & AIDS fact sheet: HIV/AIDS and Young People. UNICEF Draft. Jordan: UNICEF HOUSE, no date.

UNICEF. Iraq. UNICEF Draft April 2003. Baghdad: UNICEF Iraq, 2003.

UNICEF. Programme Working Note, HIV Prevention Among Young People. UNICEF Draft October 2002.

UNICEF. The Situation of Children in Iraq 2002. An Assessment Based on the United Nations Convention on the Right of the Child. Baghdad: UNICEF Iraq, February 2002.

WHO. WHO Communicable Disease Profile for Iraq. Baghdad: EMRO WHO Office, March 2003.

WHO; UNAIDS; The World Bank. Overview of The HIV/AIDS Situation in the Middle East and North Africa and Eastern Mediterranean Region. A Conference Draft. nd

Age group(year)	No. of cases	Percentage
0-4	4	2%
5-14	42	18%
15-19	44	19%
20-49	141	61%

Mode of transmission	No. of cases	Percentage
Blood component recipient	195	84%
Sexually transmitted	26	11%
Mother to child transmission	10	4%

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
152	4	7	7	14	6	15	6	3	5	3	9

Source: Ministry of Health reported in UNICEF, 2003

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