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Congenital Birth Defects in Iraq: Concealing War Crimes against Iraqi Children, Twisting and Distorting the Evidence

The Iraq MOH-WHO Summary Report is Evasive and Misleading

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In-depth Report: IRAQ REPORT

For the last twenty years, people in Iraq have been desperate to see serious action to explain and clear up the circumstances associated with continuous increases of certain diseases such as malignancies and children birth defects (CBD). An increase of these, and other diseases, in many Iraqi cities was associated with several factors, including the contamination of Iraq with Depleted Uranium weaponry in 1991.

The Iraqi Ministry of Health (MOH), recently tried to put an end to two decades of speculation and research on this matter – not through measurements, environmental assessments, or even epidemiological studies as would be the case in other parts of the world, but through conducting a simplistic, basic survey. The summary report of this survey miraculously 'solved' the crisis simply by denying such a problem exists in these areas [1].

The main goal of conducting the study by MOH as stated in the summary report was to "clear out the uncertainty about Children Birth Defects mentioned through [anecdotal reports]". With this statement, the MOH summarized what this study was actually about. The description of articles on CBD in Iraq published in peer reviewed internationaljournals [2], [3], [4], [5] [6] as 'anecdotal' clearly indicates that the major objective of the study is to deny and contradict the findings of all this research and articles.

The World Health Organization (WHO) supervised the study, yet they did not sign the summary with the Iraqi MOH. They emphasized on their website that "this study is not looking at the link between prevalence of CBD and the use of Deleted Uranium" [7]. When concerned critics asked why, the answer would be "there is still further room for more detailed analysis" and WHO is discussing producing a more detailed report with the Iraqi MOH" [8]. Further detailed analysis, in most DU contaminated country in the world, with no budget for these analyses, no expertise, no permissions to conduct such studies. In other words, theyrequired 22 years to ensure that DU related evidence disappears, and another 20 years to ensure that the population who received these higher doses of radiation and toxicants also disappear.

Under the pressure of the American occupation, the related international organizations (UNEP, WHO,etc.) turned a blind eye to these problems in Iraq [9].Unlike Europe, where they rushed to conduct real environmental assessments right after the use of only 12.6tons of

the DU in Kosovo and Serbia in 1999 [10], which represents only 2.5% of the amount of DU expenditure spent in Iraq. That assessment included an intensive exploration program with radiological detection, samples collection, laboratory tests, and facts finding [11]. After all of this, epidemiological studies among armed forces and civilians who were exposed were all done, and follow up studies are still going on.

The significant increase of the CBD rate in Iraq began after the Gulf War in 1991. At this time,the US and UK armed forces used around 320 tons of Depleted Uranium (DU) and hundreds of thousands more tons of other weapons [12]. Around the mid-nineties, a group of medical college professors in Basra published articles about the findings of some of their epidemiological studies. These studies showed significant increases of malignancies amongst thepopulation of Basra, and congenital malformations amongst newborn children [13], [14],and [15].

During the military operations of the invasion of Iraq in 2003, the US and UK troops used about 120 DU munitions, along with other banned weapons like white phosphorous and modified napalm bombs [16]. Other populated areas and cities like Baghdad were contaminated [ ]. In 2004 and 2005, these and other unidentified weapons were also used by occupation forces during massive military assaults on the city of Fallujah [17]. More than half of the city was destroyed by these weapons at the time.

Noreal clean up remedies have been implemented in Iraqto this day, the way the US Corps of Engineers did in Kuwait in 1991. Environmentally isolated and dumped (6,700 Ton) DU wreckage of 1991, dug out from Kuwait and shipped out to Idaho hazardous waste site in USA in 2008[18]. We wonder why since it’s not (Harmful?).

Since the DU contaminated wreckage still exist in Iraq and is considered as continues source of pollution, related contaminates continued to spread out to other Iraqi territories through sand and dust storms and other environmental elements (water, soil, and the biosphere).Continuous mobilization of thousands of tons of DU contaminated wreckage brought by civilian contractors after 2003 inside heavily populated areas in Basra further complicated the problem [19]. In 2004, Paul Bremer, the governor of Iraq under occupation, Passed a resolution which gives the right of any civilian to possess and sell tanks and military vehicles destroyed by these and other weapons[20].Along with the comprehensive economic sanctions imposed on Iraq, the prevalence of CBD soon became an epidemic not only in Basra but in other cities too.

Summary Report of the MOH Study

The questionnaires of the survey were designed to satisfy the political objectives of MOH and not to achieve any scientific goals that might lead to the real detection of risk factors behind the prevalence of CBD. The results of the survey have been discussed in a nonscientific, evasive, and misleading way to reach the designed goals of the study.

The MOH summary report not only denies the existence of any increase in CBDs, but it goes so far as to show that the areas mostly polluted by the heavy military use of DU and other banned weapons (such as Fallujah and Basra), actually came up with the least cases of CBDs than other cities.The report show that theses radioactive and toxic contaminates worked as a cure for population in these areas. This study is simply an innocence certificate to occupation armed forces.

Away from questions raised as to the reliability of the numbers listed in the summary report due to limitations of the study, missing information about the coordinates and locations of the selected clusters, as well as the integrity of the survey's teams personnel and the experts who were administering the surveys to the families in highly sensitive political and sectarian situations, and finally, the implemented analysis techniques.

The following remarks have been noticed about MOH summary report:

Table 1 in the summary report, numbers shows a general increase in all surveyed parameters (abortion /miscarriages, stillbirths, and CBD in Iraq) with time since 1988.Yet one of the major conclusions in the summary report is written as: "The study provides no clear evidence to suggest an unusually high rate of congenital birth defects in Iraq" [1].

The other misleading statement in the summary report is that the "rates for spontaneous abortion, stillbirths and congenital birth defects found in the study are consistent with or even lower than international estimates".

Thus (WHOestimates) the summary report is comparing the results of the survey with (as listed in the Notes of the study) areonly computer generated numbers extrapolated from regression model built on scarcedata from cluster surveys(WHO: Prenatal and Neonatal Mortality rates,2006)[21]. These surveys wereconducted in Iraq prior to the year 2000, yet the WHO estimates were published in 2006 [21]. They are not, as in some othercountries, from demographic censuses records or hospitals vital registry records. Concerning Iraq, the numbers fed to these regression models were taken fromsurveys conducted duringthe period of economicsanctions imposed on Iraqin thenineties. The time when over half a million Iraqi childdied [22] as a result of depriving them from life sustaining necessities.The Iraqi MOH considers these estimates as a base level to compare the increase or decrease of CBDs and infants stillbirth rates with. May be because in reality the situation of children mortality in Iraq under occupation and currently worse than during the economicsanctions [23].

Congenital Birth Defects Data

The following are published CBD ratevaluesin peered reviewed journals. Data of these articles are taken from epidemiological studies conducted by medical college faculty members and / or specialists in Major State Hospitals in Iraq.

- 12.3/1000 birth in maternity and children's hospital in Baghdad [24];
- 8.6/1000 birth in Ramadi General Hospital, 2008 [25];
- 4.7/1000 birth in Dohuk, Kurdistan Region, Iraq, 2004-2008[26];
- 8.4/1000 birth only (NTD) in Diwania, 2000 [27];
- 3.06/1000 birth in Arbil, Kurdistan Region, Iraq [28];
- 50/1000 birth in Fallujah General Hospital, 2010 [2];
- 23-48/ 1000 birth in Basrah Maternity Hospital, 2003-2011 [2];
- 27/1000 birth in Najaf [29]
- 19.3/1000 birth in Al Qaiem District, Anbar, 2009-2011.

Unpublished report signed by 2 MD's from al Qaiem Hospital Study [30]. These numbers might not reflect the actual situation of CBD in Iraq due to their locality and differentials in assessing and diagnosing ofthe CBD cases. But the same holds true for the MOH study.

As we notice from the above published data, the highest CBD values are in Basrah, Fallujah, and Najaf. Again Comparing the above data with the mean values of CBD of the summary report, we notice that most of the numbers of CBDs in the MOH summary report are 2-3 fold higherthan the above values exceptin Basrah and Fallujah! To show that the increase of CBD values in surveyed areas are insignificant, MOH compared them with CBD values of20-40/1000 birth on inclusion criteria and ascertainment methods reported from high income countries (European Countries)[[31]. This statement contradictsthe following statement in the same MOH summary report:

“Because of the limitations mentioned above, prevalence estimated in this study cannotbe compared directly with data from congenital anomaly registries in high incomesettings, where diagnosis is made by specialists using strict criteria and advanceddiagnostic techniques [1].”??

Stillbirth Rate Related data

In Table 1 of the summary report, mean values of stillbirths per1000 births also show a general increase from the first survey interval of 1988-1992 all the way to last one.

Again the report skips this increase and interprets the numbers as “the reported stillbirth rate for 2008-2012 is considerably lower than the WHO estimate of 32/1,000”.

As explained previously how the(WHO international stillbirth estimates)generated. In this same context, the summary does not discuss or compare the results of the survey with otherestimates of the neighboring countries in the same literature [21]. Where stillbirth rate in Kuwait is (6/1000 births), Syria (9/1000), Jordan (13/1000), SaudiArabia (11/1000). Because of the economic sanctions and the occupation, Iraq has become one of the worst 30 countries with highest rates of stillbirths among 192 countries of the world according to WHO list of stillbirth rate around the world, 2006 [21].

In more recent surveys, like the Iraq Family Health Survey 2006/2007 [31], the stillbirth rates in the center/south regions and Iraq Kurdistan region were found to be 8 and 9 per 1000 births respectively.

Also, WHOpublished the rate of stillbirths in Iraq in 2009 to be (8.6/1000 birth) (source: World Health Organization and Save the children) [32]. Why doesn’t the summary report compare therate of the stillbirthswiththese values? Does the difference between these two estimates (24,508 dead infant) in 2006 means anything to MOH??

Spontaneous abortion/Miscarriage Data

Mean values of spontaneous abortion/1000 pregnancies has increased by twofold from the first survey interval of (1988-1992) to last interval (2008-2012). Discussion of these values in the summary is written in a vague way to avoid admitting this increase and its correlation to expected environmental risk factors. They wrote “The apparent increase over time is commonly observed in surveys and likely due to under reporting for earlier periods: women are less accurate in their reports of early pregnancy endings that occurred longer ago”. Even though Abortion/Miscarriage rate in (IFHS 2006/2007) survey conducted by Iraqi MOH, MOP, and WHO/Iraq showed this rate as (78/1000 pregnancy) in south and center regions of Iraq and (99/1000) in Kurdistan Iraq region[33].

General Remarks about the MOH Survey

In conducting any survey, oneobvious step is to look at the published reports, registry records, and available data. Also, it is important to communicate with MOH general hospitals doctors and specialists all over the country to check the consistency in diagnosing such incidences, or other useful notes that help design the questionnaire to cover all related aspects.

As we understood, none of the questionnaire teams communicated with hospitals or doctors who published or pointed out the prevalence of CBDs. As Head of the Maternity Department in Fallujah General Hospital,Dr.Samira Al-Ani, emphasized in personal communication, that nobody contacted them or even indicated where these questionnaires were distributed. It might have been distributed in one of the villages many miles away from Fallujah city, yet, it would still be called Fallujah.

Points which increase the rate of uncertainty in the findings of this survey are:

- This survey, not like other previously conducted similar surveys in Iraq by MOH and other UN organizations like (ICMMS 1999, ILCS 2004, and IFHS 2006/2007)[34][35][33]. The current survey covered only 8 governorates and not all 18 Iraqi governorates. The MOH justification is that "it included areas that had and had not been subjected to heavy fighting" [1]. So, the only logical explanation is that the control areas are the ones with no heavy fighting. If the MOH and WHO made it clear that "this study is not looking at the link between prevalence of CBD and the use of Deleted Uranium". The questionnaire also excluded any questions related to war or living under occupation conditions, what is the point of selecting areas of heavy military fighting and non-military fighting?
- Another question that arises would be: is there any area in Iraq since 1991, that has not been subjected to heavy bombing with laser guided missiles, Depleted Uranium, White Phosphorous, Cluster Bomb, Napalm, GBU laser-guided bombs, GBU – 28/27 Bunker Buster, Thermo boric weapons, Tomahawk / AGM, cruise missiles, MK 84/ 2000 lb bomb, and more[12]?
- This justification is built on the assumption that other war and weapons related contaminants are stagnant and immobile and stick to areas of heavy military engagements only. This is a totally incorrect assumption. Persistent contaminants such as heavy metal oxides and fumes,radioactive isotopes, and complex synthetic organic gels, fluids, and vapors all have the ability to spread out and mobilize to other areas hundreds of miles away through different environmental elements (air jets, winds, water, sand and dust storms, and biosphere).
- Keeping sources of pollution with no clean up or confinement remedies spread them out to most Iraqi cities. Likewise, contaminants from Fallujah were carried away not only by wind but also with surface runoff to nearby Euphrates River downstream to Musaib, Hila, Karbala, Najaf, Nasiriya, and Basra cities. Part of these contaminates are in the bodies of the people who drank polluted water.
- The women's questionnaire is the most important one. The questionnaire was designed for women living under normal living conditions and not in cities surrounded by concrete walls (like Berlin's wall), under war and continuous armed engagement, and raids in residential areas.
- In previous surveys of MOH and WHO, like IFHS 2006/2007, the women's questionnaire investigated domestic violence and its impact on the health and wellbeing of women and children. This survey avoided asking about war and

occupation related violence.Hardship and traumas women were going through duringthe questionnaire period(economic sanctions and American occupation to date). Impacts of socio economic conditions are well defined onthe rate of miscarriages and malformations [36]. Conditions such as repeated forced displacement due to raids, military, sectarianmilitias, and terrorist's attacks on civilian residences that include thousands of pregnant women were all excluded. How would the questionnaire indicate that majority of highly contaminated Zubair District population in Basra left their houses gradually since 2005 as a result of continues killing andsectariantargeting?As well as other 6 million Iraqi forcefully migrated. Would the detailed report (honestly) mention the impact of these important remarks events on the outcome of this survey?

- The Children Questionnaire mainly concentrated on mothers and families of the children with birth defects. Trying to correlate birth defects to limited risk factors like smoking. But definitely not the fumes and toxic smokes of weapons or the miserable conditions the invasion and occupation of Iraq have created for pregnant women during the period of the questionnaire.
- Again, the questions were all designed as if the family live in happy normal living conditions. Socioeconomic and political factors were all excluded.
- The questions were related to mother's health care system of first trimester, her career and related exposure if any, exposure to diagnostic and therapeutic radiations (only). No questions about other exposures or intakes like heavy metals, synthetic organics, etc.).

As was mentioned earlier, the surveys were designed to not identify any real prevalence in CBD or establish causal correlation with specific environmental risk factors.They were designed to deny and contradict reports and articles written and published by specialists work in hospitals and institutes of the Iraqi Ministry of Health.

Finally, as we have seen from the report, rates of CBD, stillbirths and Abortion/miscarriages in Iraq are higher than neighboring countries and most countries of the world. Each governorate in Iraq after three major wars and occupation definitely need to conduct Comprehensive Environmental Assessments with related epidemiological studies to define real causes behind these records.

To reduce the cost of these assessments, Universities research centers and graduate studies programs in each governorate should focus in their research topics on different aspects of the planned environmental assessments. Involvement of related NGO's and International expertise is very necessary in such a campaign. Definition of the causal relationship between incidences and risk factors through well planned joined efforts between Medical, Environments Science and Engineering, Demographic departments and colleges, can definitely be accomplished.

Notes

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