# COUNTRY PROGRESS REPORT

# SYRIAN ARAB REPUBLIC

**Reporting period: January 2010-December 2011**

**Submission Date: 31 March, 2012**

# TABLE OF CONTENTS

# I. STATUS AT A GLANCE

## (a) Inclusiveness of the stakeholders in the report writing process

The development of this Global AIDS Response Progress (GARP) Report 2012 was undertaken under the auspices of His Excellency the Minister of Health. High-level officials of the Ministry of Health and other key ministries have been involved from the beginning and provided support to the entire data collection, validation and review processes.

The process to develop the Syrian GARP Report 2012 was led by the National AIDS Programme (NAP), which is based at the Ministry of Health. The process involved consultations with key stakeholders involved in the national response to HIV/AIDS for the collection of data for the NCPI as well as indicators. UNAIDS MENA provided an international consultant to assist in the overall process of data collection and consolidation of the final report.

Data collection for the indicators and the NCPI took place through review of policy documents, programme reports, statistics, health facility reports, research reports and studies, as well as visits to key facilities and interviews with national stakeholders and key informants from government, civil society and UN agencies.

After incorporation of all inputs that were received through the data-collection process described above, final data entry was done by the NAP and UNAIDS consultant. All data entered was cross-checked and discussed with local stakeholders before final submission.

## (b) Status of the epidemic

Syria has a *low-prevalence* HIV epidemic, with very low levels of HIV among the general population, as well as among key populations at risk, such as female sex workers (FSWs) and their clients, men who have sex with men (MSM) and injecting drug users (IDUs). Between 1987 and December 2011, a total of 762 HIV and AIDS cases were reported. In 2010 and 2011, 66 and 69 new cases of HIV/AIDS were found respectively. The *male-to-female sex ratio* among reported *Syrian* HIV cases is 3:1. HIV trends show a slow but steady increase of new reported HIV cases over time. While the annual number of reported cases stayed below 25 till the year 2000, since 2006, the number of new cases increased to between 50-70 per year. Large-scale HIV screening took place in 2010 and 2011, with more than 675,000 tests conducted in 2011. Two main HIV-testing mechanisms – among blood donors and premarital couples – accounted for 81% of all tests in 2011, while VCT coverage was very low, with 1,541 clients in 2011.

Officially reported modes of HIV transmission of the cumulative number of 371 Syrian HIV patients show that most HIV transmission is heterosexual (63%), representing 71 percent of HIV cases among women, and 60 percent among men. Overall, blood transfusions contribute to 8 percent of HIV transmission, while injecting drug use and mother-to-child transmission are minor HIV-transmission channels (5% each). Homo- or bisexual transmission reportedly represents 14 percent of cases among men (10.5% of all HIV cases).

While current HIV rates remain low, various factors could drive a potential HIV epidemic in the future, if not attended. Poverty, massive labour migration and mobility, human trafficking, increased exposure to external cultural and economic systems, as well as changing sexual behaviours among young people may drive future HIV transmission. Population groups such as male and female sex workers, injecting drug users and men who have sex with men are

all at particularly high risk. In addition, young people in disadvantaged economic situations may be more vulnerable to HIV. In this context the national response to HIV/AIDS needs to focus on these key populations and drivers of the epidemic. This requires supportive legal, policy and social environments, which enable the effective implementation of targeted HIV prevention, treatment, care and support programmes and services.

## (c) Policy and programmatic response

The national response can be distinguished at two levels: 1) national *commitment and political support;* and 2) actual programme *implementation*.

1) High-level ***commitment and political support*** for the national HIV response continues to be crucial, as there are still a number of challenges in this area: overall, the profile of HIV/AIDS on the national agenda needs to be strengthened. Specific achievements and challenges in this field are reflected at: 1) the *institutional and organisational* level; 2) in *policy and programme development*; and 3) in terms of *allocation of human and financial resources*.

- At the *institutional level*, main challenges remain with regard to effective multisectoral coordination through a revitalised National AIDS Committee which can mobilise all government sectors beyond health. Similarly, the National AIDS Programme needs more sustained technical, financial and infrastructural support to effectively implement the new NSP 2011-2015; while civil society needs to be strengthened and empowered to assume the key role it has to play in HIV prevention, especially among MARPs.
- At the *policy and programmatic level*, top priority should be given to the implementation of the NSP and the operational plan for 2011-2015. This requires the rapid take-off of the Global Fund grant which aims to strengthen capacity and the evidence base for a better focused national response.
- Inadequate *allocation of human and financial resources* has been the main stumbling block for the scattered implementation of the national response to date. Efforts have largely remained restricted to screening and treatment, while very limited funds were allocated to prevention. However, without the resources needed, preventable HIV infections will continue to occur.

2) In terms of actual ***implementation of programmes and services***, 2010-2011 has not seen major progress. Despite promising developments in terms of a new, comprehensive NSP and costed operational plan, as well as a successful Global Fund application in 2010, the new policy framework and earmarked financial resources have not yet been reflected on the ground: in 2010-2011 the response to HIV has continued its skewed focus on large-scale, mandatory HIV-screening programmes, as well as health-sector driven interventions for HIV patients. Few concrete steps were made towards conducting priority research; implementing targeted and innovative HIV prevention for MARPs and vulnerable youth; and strengthening partnerships between government and civil society organisations in implementing programmes and services.

## (d) Indicator data in an overview table

| NO. | INDICATOR | REPORTED DATA AND COMMENTS |
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| | | **SEXUAL TRANSMISSION** |
| 1.1 | Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual | No accurate data is available for this indicator, as no recent study has been conducted in this field. The latest studies date back to 2005 and 2006 and both reveal many misconceptions on HIV/AIDS. 1) The first study was done in 2005 among 1,000 young women and men (18-25 years) on university campuses in Damascus and Aleppo. While general HIV awareness was high and a majority |

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| | transmission of HIV and who reject major misconceptions about HIV transmission | had some knowledge of HIV transmission and protection, there were many misconceptions regarding HIV risks, modes of transmission and negative attitudes about PLHIV. More than 85% of young people had knowledge about HIV/AIDS and basic modes of HIV transmission (MTCT, blood transfusion, unprotected sex), but 30% also had misconceptions about HIV transmission. Furthermore, perceived personal risk of contracting HIV was low: almost two-thirds (64%) said they had no risk of HIV infection at all, while only one-fifth (18%) said there was some risk. 2) The second study included 600 adolescents (15-24 years) in disadvantaged communities in Damascus and Rural Damascus, including school dropouts, working, as well as unemployed youth. While general awareness on HIV/AIDS was high (97%), specific knowledge about HIV transmission was limited, with misconceptions about HIV being transmitted through public swimming pools, sharing food, shaking hands or public toilets. Since the data is 6-7 years old, new studies are urgently required to update data on HIV knowledge among young people. |
| 1.2 | Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 | No accurate data is available for this indicator, as no recent study has been conducted in this field. The only 2 studies that discuss sexual activity and the age of sexual debut are mentioned under (1.1) and date back to 2005 and 2006. 1) In the 2005 study among 1,000 University students (18-25 years), 9.1% admitted having had sexual relationships outside marriage. Almost half (45.5%) of these sexually active students had had their first sexual contact between 15 and 18 years of age. The majority of them had had sex with multiple partners. Only 38% of these had used a condom at last sex, while the majority (58%) had not used a condom. 2) The second study was held among 600 adolescents (15-24 years) in disadvantaged communities in Damascus and Rural Damascus. Sex without marriage among these adolescents was much higher than among university students: almost 29% of males and 12% of females admitted having had sex without marriage. These rates were even higher among young people who did not live with their parents; and those who worked and did not study. 56% of the sexually active group said they had not used a condom at last sex. Furthermore, 2% admitted MSM contacts. Since the data is 6-7 years old, new studies are urgently required to update data on HIV knowledge among young people. |
| 1.3 | Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months | * No accurate data is available for this indicator, as no recent study has been conducted in this field. In the context of prevailing socio-cultural and religious norms and values in Syria, sexual intercourse with more than one partner is expected to be very low for women.<br>* Findings from studies among young people in 2005 and 2006 mentioned under (1.1) and (1.2) indicate that 29% of young men (15-24) and 12% of young women (15-24) from disadvantaged communities reported sex outside marriage, but there is no information on the number of partners. Among university students only 9% reported sex without marriage, most of them with multiple partners. Hence, there are considerable differences among young people according to social position.<br>* The only other data on sexual behaviour comes from studies among mobile adult men, who are unlikely to be representative for the general population. A 2005 KAP study among 200 sailors in Tartous found considerable rates of unprotected sex with non-regular partners. 32% admitted having ever had extramarital sex, half of whom (48%) in the past year. Some 29% of men had had sex with non-regular partners; 25% with non-Syrian women. Three-quarters of those who had had extramarital relations said they had used a condom during their last sexual contact (MOH/NAP, 2005-3).<br>* In another KAP study in 2005 among truck drivers, 22% admitted having ever had extramarital sex, of whom almost one-third in the last year. Almost 70% indicated some of their colleagues had engaged in extramarital sex. It should be emphasised, however, that NONE of these studies is representative for the general male or female population, but result merely indicate that sex with |

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| | | more than partner is considerable among certain groups. |
| 1.4 | Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse | * No accurate data is available for this indicator, as no recent study has been conducted in this field among the general 15-49 year old male and female population.<br>* The only data on condom use by men who had more than one partner is from the studies in 2005 mentioned among sailors and truck drivers. Of those sailors who reported having had extramarital sexual contacts, three-quarters reported condom use the last time they had sex.<br>* Among truck drivers, of the 22% who admitted having had extramarital sex, 40% said they used a condom at last sex. |
| 1.5 | Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results | * No accurate data is available for this indicator, as no studies have been conducted in this field. However, most HIV testing in Syria is done as part of blood safety (62% of all tests) or mandatory screening programmes for premarital couples (19%), labour migrants (15%) and other categories. Negative test results are not shared with clients; hence most people are not aware of their HIV status. Those with positive test results are counselled and informed about the test result, but they are a minority of the whole population tested. In 2011, more than 675,000 people were tested: only 1,600 people were informed about their test result (those positive and those who were tested at VCT centres).<br>* Furthermore, VCT services are available in Syria, but utilisation is low, with a mere 1,541 clients in 2011. In this context, very few people aged 15-49 received an HIV test AND knew their results. |
| 1.6 | Percentage of young people aged 15–24 who are living with HIV". | * No accurate data is available on HIV prevalence in young people (15-24), nor on the general population. In the absence of ANC screening, no prevalence data is available on this group. Nevertheless, some key statistics can put this indicator into perspective: Syria has a low-prevalence epidemic, with HIV rates among the general population estimated to be extremely low. By the end of December 2011, a cumulative total of 762 HIV cases had been reported, of whom 441 Syrians (58%) and 321 foreigners (42%) (mostly tested in the context of applications for work permits).<br>* A 2008 modelling exercise using SPECTRUM estimated the number of Syrian HIV cases at more than 1,150 (at the time), which is 2.6 times more than the actual number of reported Syrian cases to date (2011).<br>* Blood donors may be used as a proxy of the general young population, since most donors are required to donate blood as part of military service, enrolment in universities etc., hence they are not a very selective group. In 2011, 18 out of 416,350 blood donors were HIV-positive, a prevalence rate of 0.0043%. On a population of 20.4 million (2010) this would roughly translate into 882 HIV cases – double the cumulative total of 441 Syrian cases reported by the end of 2011.<br>* Of all 762 cases (Syrian and non-Syrian) reported by the end of 2011 (1987-2011), 145 were aged 15-24, which represents 19% of the total. In 2010-2011 the proportion of young people 15-24 had decreased to 12% of the total (16 out of 135 total new HIV/AIDS cases in 2010-2011). |
| 1.7 | Percentage of sex workers reached with HIV prevention programmes (condom distribution; HIV testing) | No accurate data is available on this indicator, since no surveys or other studies have ever been conducted among sex workers in Syria. To date, however, no HIV-prevention programmes for sex workers have been implemented, therefore the percentage of sex workers reached will be close to zero. Services for sex workers are included in the NSP 2011-2015 Operational Plan, but in the absence of funds allocated for MARP groups, these services were not implemented in 2010-2011. |
| 1.8 | Percentage of sex workers reporting the use of a condom with their most recent client | To date, no systematic biological and behavioural surveillance studies have been conducted among sex workers in Syria. However, findings from a study in 2005 among 400 female sex workers showed that overall HIV awareness and knowledge were relatively high, but most sex workers were unable to effectively use this knowledge and protect themselves against HIV. Although |

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| | | 46% considered themselves at risk of HIV, consistent condom use was very low at 13%; while 15% and 50% respectively said they never or occasionally used condoms. The main reasons for not using condoms during commercial sex were the client's refusal (45%), and the sex worker's own lack of interest (28%). More than 80% of sex workers reported more than one client per day, while half of the respondents had suffered from STI-related symptoms in the last 12 months. |
| 1.9 | Percentage of sex workers who received an HIV test in the past 12 months and know their results | * No accurate data can be reported on this indicator, as no research has been done on VCT among sex workers. Overall, however, uptake of the existing VCT services is low, with only 1,541 clients in 2011, a mere 0.23% of all tests conducted that year. Few of these VCT clients will have been sex workers, as services are not adequately targeting sex workers. However, some female VCT clients may be sex workers who wanted to check their HIV status in a confidential setting.<br>* In 2011, 108 sex workers were tested after being arrested by the police; none tested positive; therefore none was informed about the test results. However, this represents a very small proportion of the estimated 15-25,000 sex workers in Syria. In addition, 6,550 bar girls and club workers were mandatorily tested for HIV in 2011, as some percentage is presumed to engage in sex with clients; however, none tested positive. |
| 1.10 | Percentage of sex workers who are living with HIV | Although sex work is present in Syria, with an estimated 15-25,000 sex workers, it is hidden and no biological surveys on HIV have been done to date. Hence, no accurate data is available on HIV rates among sex workers. No HIV cases were found among the very few (108) known sex workers that were tested in 2011; nor among the 6,550 bar girls and club workers tested in 2011, some of whom are presumed to be active in sex work. |
| 1.11 | Percentage of men who have sex with men reached with HIV prevention programmes | No accurate data is available on this indicator; although 2 studies (one yet to be published) have been conducted among MSM in Syria, coverage of HIV-prevention services was not addressed. To date, HIV-prevention programmes for MSM are not available; therefore the percentage of MSM reached will be (close to) zero. Services for sex workers are included in the NSP 2011-2015 Operational Plan, but in the absence of funds allocated for MARP groups, these services were not implemented in 2010-2011. |
| 1.12 | Percentage of men reporting the use of a condom the last time they had anal sex with a male partner | * No accurate data is available for this indicator, as very little research has been done to date on MSM in Syria. A study in 2005 among 28 MSM, aged 25-45 years revealed that many MSM lead "double" lives – being married, while also having unprotected sex with multiple male sexual partners. Anal and oral sex were common, but a large majority does not use condoms or other protection methods, despite the fact that most MSM are aware of HIV/STI risks. The main reason given for not using condoms is reduced sexual pleasure. A very small number reports condom use, but only if their sex partner agrees. Safer sex is practised depending on the perceived "safety" of the sex partner. Many MSM believed that the HIV risk was the same for "active" or "passive" (receptive) anal sex.<br>* High-risk unprotected sex was also reported by a regional internet-based study in 2009. The results show that unprotected MSM sex is common in all countries; with 64% of Syrian respondents indicating they "always" used a condom, while 17% said that condom use "needs discussion", 1% said they "never" used a condom, while 18% refused to provide an answer. |
| 1.13 | Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results | No accurate data can be reported on this indicator, as no research has been done on VCT among MSM. Overall, however, uptake of the existing VCT services is low, with only 1,541 clients in 2011, a mere 0.23% of all tests conducted that year. Few of these VCT clients will have been MSM, as services are not adequately targeting MSM, although some VCT clients may have been MSM who wanted to check their HIV status in a confidential setting. MSM-friendly VCT services are part of the NSP 2011-2015, but have not been implemented yet in 2010-2011. It is expected that improved VCT would attract |

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| | | more MSM. |
| 1.14 | Percentage of men who have sex with men who are living with HIV | In the absence of biological surveys among MSM, accurate data on HIV rates among MSM are not available. Official data indicate that 14% (39 cases) of the officially registered HIV infections (1987-2010) among Syrian men are reported to be the result of same-sex relations. However, this is likely to be an underestimation, since most MSM – especially married men – will not admit they were infected through sex with other men, given the severe social stigma and discrimination. |
| | | **INJECTING DRUG USERS** |
| 2.1 | Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes | To date, needle-and-syringe-exchange programmes (NSEP) services are unavailable in Syria. Hence, no questions on NSEP were included in a 2006 study among IDUs by NAP. However, the study did enquire about utilisation of drug-treatment services: only 26% had ever been treated for drug dependence, the vast majority of them (84%) for heroin use. The low utilisation of rehabilitation services reflects the limited accessibility, as well as the absence of outreach services for drug users in Syria. Criminalisation and marginalisation of IDUs hamper effective peer-education and outreach programmes for IDUs. Harm-reduction programmes, including an NSEP pilot programme, are part of the NSP 2011-2015 Operational Plan, but due to inadequate prioritisation and funding, these programmes have yet to start in 2012. |
| 2.2 | Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse | No accurate data is available on condom use by IDUs in the last month. However, results from a study by NAP in 2006 among IDUs show that unprotected sex with multiple partners was common among drug users: 90% was sexually active, with two thirds having had sex in the last month with an average of 7 sex partners. Although many respondents (61%) recognised the importance of condoms for HIV prevention, consistent condom use was the exception rather than the rule, mainly because of the perceived reduction of sexual pleasure (63%) or partner rejection of condoms (25%).<br>* Of 254 respondents who had had sex in the last 12 months, 39% had used a condom less than half the time; 21% had used a condom more than half the time, 21% had not used a condom, and 19% had used a condom every time.<br>* A worrying fact is that 47% of the respondents had ever had sex in exchange for some kind of remuneration (money, drugs, food or shelter), with 40% in the last month. Of these IDUs, 17% had always used a condom; 5% had used it more than half the time; 27% had used it less than half the time, and 51% had never used a condom (n=135). This indicates that transactional sex or even sex work may be an income-generating activity for a considerable proportion of IDUs. Furthermore, a small number (n=12) had had same-sex contacts with a male partner. |
| 2.3 | Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected | A study among 336 Syrian IDUs in 2006 revealed detailed information on HIV-risk behaviour. However, accurate data on the use of sterile injecting equipment the last time of injection is not available. The results reveal a high prevalence of high-risk injection practices, including sharing of injection equipment without proper cleaning. 51% of respondents had ever injected drugs, with 47% in the last 30 days. Awareness of the HIV risks of sharing equipment was limited, while sharing of needles, syringes and other injection equipment was common: 46% of those who had ever injected reported that they had ever used a needle or syringe after someone else had used it. 28% of those who had injected drugs in the last 30 days reported they had shared syringes with others – mostly friends (68%) or sex partners (20%). 40% of those who reported sharing syringes did not always clean used syringes; among the 60% who said they always cleaned it, effective cleaning of used syringes with bleach was practically absent.<br>* Study findings also show that half of the respondents have been imprisoned in the past, and that almost half of them continued to use drugs in prison. The majority of these drug users injecting in prison also report sharing of injection |

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| | | equipment, and a considerable number also report experience or knowledge of unprotected sex and rape inside the prison. |
| 2.4 | Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results | No accurate data can be reported on this indicator, as no research has been done on VCT among IDUs. Overall, however, uptake of the existing VCT services is low, with only 1,541 clients in 2011, a mere 0.23% of all tests conducted that year. Few of these VCT clients will have been IDUs, as services are not adequately targeting IDUs. MSM-friendly VCT services are part of the NSP 2011-2015, but have not been implemented yet in 2010-2011. It is expected that improved VCT would attract more MSM. |
| 2.5 | Percentage of people who inject drugs who are living with HIV | In a bio-behavioural surveillance study by NAP/UNODC-UNAIDS in 2006 among 336 IDUs, 204 people agreed to undergo rapid HIV testing at the end of the interview. A single individual (<1%) tested positive.<br>* In the same study, 120 people REPORTED they had ever been tested for HIV BEFORE: of 97% who knew the results, only 1% (n=1) reported that they knew their test to be positive, 96% reported that they knew their test to be negative; the remainder were not aware of the test results.<br>* In 2011, 478 IDUs were screened for HIV (most likely in the context of arrest by police or imprisonment): no HIV cases were found.<br>* Although 1 out of 204 IDUs who volunteered to be tested in the NAP-UNODC study in 2006, the data is not reliable, as there was considerable selection bias (only 61% agreed to be tested); in addition, the sample size may have been too small to derive accurate prevalence rates. Nevertheless, this result, as well as the results of reported test results (1 positive out of 120) and the zero cases found through screening of 478 IDUs indicates that HIV is not yet widespread among IDUs in Syria. However, more research with a larger sample size will be needed to get more conclusive statistics.<br>* Sero-surveillance studies among IDUs and other MARPs are part of the NSP 2011-2015 Operational Plan, but have not yet been implemented. |
| | | **PMTCT** |
| 3.1 | Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission | In the absence of estimations for the number of HIV-positive pregnant women within the past 12 months, accurate data on the *INDICATOR* is not available. No sentinel surveillance studies have been conducted among ANC attendees in Syria, nor are they routinely screened for HIV (unlike the many other population groups that are screened, e.g. premarital, foreign residents). Hence, there is no information on the total number of HIV-infected pregnant women.<br>* No information is available either on the NUMBER of HIV-positive pregnant women who received ARVs to reduce MTCT. However in the absence of PITC in ANC settings, the HIV status of not all HIV-infected pregnant women will be known; hence PMTCT services are not offered to all women in need. |
| 3.2 | Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth | Data was not provided on EID. In the 2010-2011 period, only 2 new HIV cases were found as a result of mother-to-child transmission. It is not known, however, how many children were born to HIV-positive mothers in this period. The recently updated PMTCT guidelines include EID. |
| 3.3 | Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months | In the absence of an estimation of the number of HIV-infected women who delivered in the previous 12 months, no accurate data is available on the estimated percentage of MTCT. In 2010, 2 MTCT cases were found; in 2011 zero cases. However, due to weaknesses in the ANC system, it cannot be assumed that most pregnant women attended ANC; nor is it clear to what extent those who did were properly assessed for possible HIV infection: as mentioned, pregnant women attending ANC services are NOT routinely tested for HIV. |
| | | **ANTIRETROVIRAL TREATMENT** |
| 4.1 | Percentage of eligible adults and children currently receiving | 130 HIV patients were receiving ART by 31 Dec. 2011. There is no accurate estimation for the Denominator (estimated No. of adults and children with advanced HIV infection), hence no accurate data can be provided on the |

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| | antiretroviral therapy | percentage of eligible PLHIV on ART. |
| 4.2 | Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | No accurate data is available on 12-month retention rates. There are still issues regarding the enrolment of eligible patients, as well as the quality of HIV patient follow up, which may affect enrolment and retention in ART for those eligible. To date, a mere 130 HIV patients have been enrolled in ART. |
| | | **TB-HIV CO-INFECTION** |
| 5.1 | Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV | No accurate data is available. Among 822 TB patients tested for HIV in 2011, no HIV cases were found. The 2010 WHO estimate for the number of TB patients that are HIV-positive is 5; The percentage of tested TB patients that are HIV-positive is 6 (WHO, 2010). If TB patients are found HIV-positive, they will be treated for both TB and HIV in accordance with national guidelines. |
| | | **AIDS SPENDING** |
| 6.1 | Domestic and international AIDS spending by categories and financing sources | * Very limited financial data is available. The only data reported is for 2011; however, large expenditure categories could not be included, in particular costs of mandatory screening of 675,000 persons per year (2011) (test kits, lab costs, staff); as well as programme management costs for the NAP.<br>* Expected Global Fund funds (approx. 3.5 million) not yet available in 2011.<br>* Total reported amount 2011 USD 809,850:<br>(1) Government: USD 620,000 (ART, lab costs, dental & psychol. Care)<br>(2) UN: USD 189,850 (BCC, VCT, workplace, STI, PMTCT, male circumcision) |
| | | **CRITICAL ENABLERS & SYNERGIES** |
| 7.1 | National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and M&E) | Overall ratings (1-10)<br>1. Civil Society involvement: 5<br>2. Strategic Planning: 6<br>3. Political Support & Leadership: 8<br>4. Human Rights: 8<br>5. Prevention: 6<br>6. Treatment, care & support: 7<br>7. M&E: 3 |
| 7.2 | Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months | No accurate data is available on intimate partner violence. However, there is ample anecdotal evidence of domestic violence. A small number of faith-based organisations (FBOs), in close collaboration with the Ministry of Labour and Social Affairs, have established shelters for victims of sexual violence since 2009. These FBO-run services have proven to be in a better position to reach marginalised communities, including MARP groups. Furthermore, the Syrian Family Planning Association (SFPA) is currently already providing sexual and reproductive health services to victims of violence against women in 18 clinics and two mobile clinics in marginalised neighbourhoods of large cities. Programmes and services for victims of gender-based violence and women trafficking, including (former) sex workers have been explicitly included in the NSP 2011-2015 Operational Plan. Proposed activities include expansion of existing and new shelters |
| 7.3 | Current school attendance among orphans and non-orphans aged 10–14 | Topic is not relevant for the Syrian epidemic. |
| 7.4 | Proportion of the poorest households who received external economic support in the past 3 months | No data is available on the number of poorest households that received external economic support. The topic may be relevant, as PLHIV often lose their employment, despite laws protecting their employment rights. A better understanding of the needs of poor households that are affected by HIV is needed. The NSP 2011-2015 aims to support the establishment of a PLHIV association, which will ensure more attention for effective advocacy and lobbying of economic, legal, social and psychological support for PLHIV and their families. |

# II. OVERVIEW OF THE AIDS EPIDEMIC IN SYRIA

To date, Syria is characterised by a *low-prevalence* HIV epidemic, with very low levels of HIV among the general population, as well as key populations at risk, such as female sex workers (FSWs) and their clients, men who have sex with men (MSM) and injecting drug users (IDUs).

In the period between 1987, when the first HIV tests were conducted, and December 2011, a total of 762 HIV and AIDS cases were reported, of which 441 (58%) were Syrian citizens, while 321 (42%) were foreigners *(MOH/NAP, 2012)*. Out of the total of 762 cases to date, 433 have died. In 2010 and 2011, 66 and 69 new cases of HIV/AIDS were found respectively. Out of the total number of 135 new HIV cases found in 2010-2011, 96 (71%) were Syrian citizens and 39 (29%) non-Syrian. Most of these foreigners were tested when they applied for a residency permit for marriage, studies or work in Syria.

The *male-to-female sex ratio* among reported *Syrian* HIV cases is 3:1; while among *non-Syrians* it is 1:2; this shows that most Syrian HIV cases are men, while most foreign HIV cases are women seeking work in the entertainment industry.

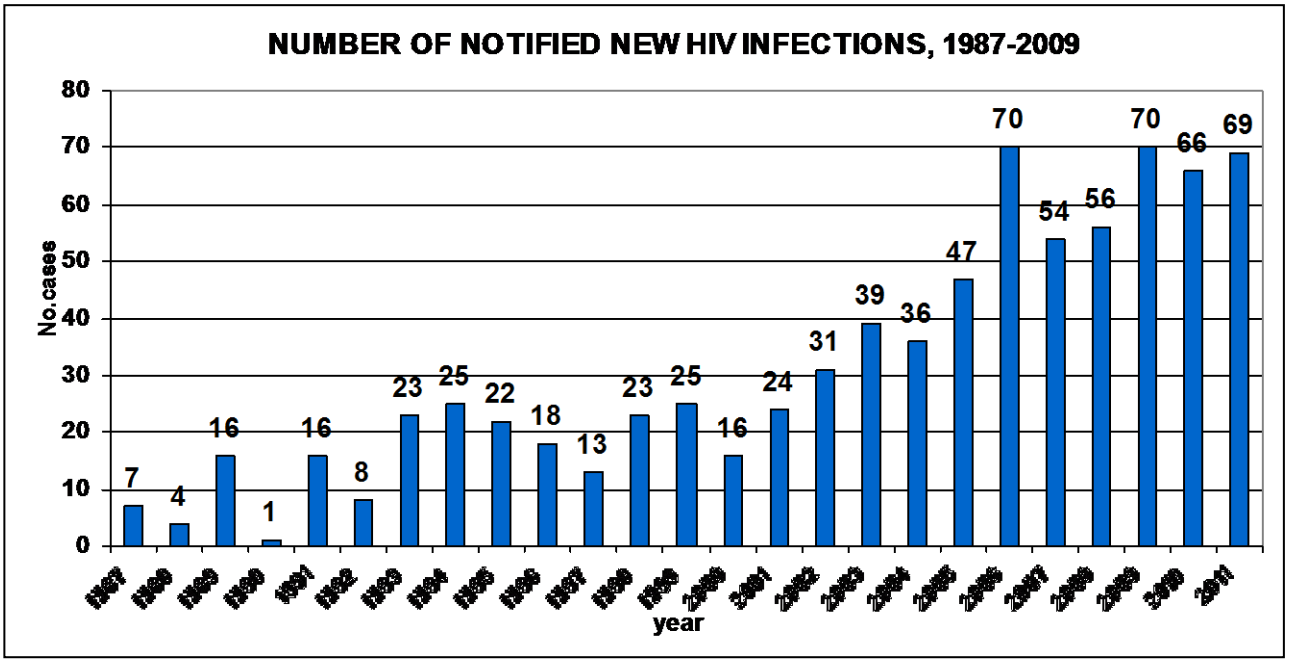


**Figure 1: Officially reported new cases of HIV and AIDS, 1987 to 2011** *(NAP, 2012).*

*Figure 1* shows the slow but steady increase of new reported HIV cases over time. While the annual number of reported cases stayed below 25 till the year 2000, since 2006, the number of new cases increased to between 50-70 per year. Although the absolute number of officially reported cases remains low, the steadily increasing trend highlights the importance of strengthening the national response to HIV/AIDS, especially since the officially reported cases are likely to be the tip of a much larger iceberg.

The geographic distribution of HIV cases shows that most people living with HIV are found in the big cities, with almost two-thirds of PLHIV in Damascus (41%) and Aleppo (23%). Approximately 10 percent of PLHIV were found in Homs, while 5 percent was found in Al

Sweida, which has the highest number of cases compared to its number of inhabitants (2.7 per 100,000).

### *Understanding the epidemiological data on HIV/AIDS in Syria*

At present, Syria does not have a reliable HIV-surveillance system: apart from a few small-scale studies among vulnerable and most-at-risk groups (see below) to assess HIV-related knowledge, attitudes and practices, no reliable HIV-surveillance studies have been conducted among the general population or specific most-at-risk populations. Most of the existing epidemiological data on HIV/AIDS is based on *officially reported cases* from a number of sources: 1) Routine screening of blood donors (approx. 62% of all HIV tests); 2) Premarital HIV testing (19%) – which was introduced in 2010 – and testing of Syrian out-migrants (8.5%) and foreign in-migrants (6.3%). However, voluntary counselling and testing at VCT centres accounts for a mere 0.2 percent of all HIV tests.

**Table 1: Number of HIV tests conducted in 2011 through main HIV-testing mechanisms** (MOH/NAP, 2012**)**

| Results of HIV tests in 2011 | | | | | |
|---|---|---|---|---|---|
| **Group tested** | **No. tested** | **% of total No. of tests** | **No. positive** | **% of total HIV (n=69)** | **% HIV positive** |
| Sex workers | 108 | 0.02 | 0 | 0 | 0.0 |
| Men who have sex with men | 5 | <0.001 | 0 | 0 | 0.0 |
| Injecting drug users | 478 | 0.07 | 0 | 0 | 0.0 |
| Non-injecting drug users | 171 | 0.03 | 0 | 0 | 0,0 |
| Prisoners | 457 | 0.07 | 1 | 1.45 | 0.219 |
| VCT clients | 1,541 | 0.23 | 10 | 14.49 | 0.649 |
| Suspected AIDS patients | 1,315 | 0.19 | 14 | 20.29 | 1.065 |
| Sexual contact of AIDS patients | 17 | 0.003 | 6 | 8.70 | 35.294 |
| Non-sexual contacts of AIDS patients | 12 | 0.002 | 0 | 0 | 0.0 |
| STI patients | 8,989 | 1.33 | 0 | 0 | 0.0 |
| TB patients | 822 | 0.12 | 0 | 0 | 0.0 |
| Blood donors | 416,350 | 61.61 | 18 | 26.09 | 0.004 |
| Blood recipients | 2,573 | 0.38 | 0 | 0 | 0.0 |
| Premarital tests | 1751 | 0.26 | 1 | 1.45 | 0.057 |
| Premarital clinics "Syrian" | 128,824 | 19.06 | 5 | 7.25 | 0.004 |
| Pregnant women | 177 | 0.03 | 0 | 0 | 0.0 |
| Child of HIV+ mother | 0 | 0 | 0 | 0 | n/a |
| Dialysis patients | 5,423 | 0.80 | 0 | 0 | 0.0 |
| Health survey health staff | 753 | 0.11 | 0 | 0 | 0.0 |
| In-migrants | 42,076 | 6.23 | 10 | 14.49 | 0.024 |
| Out-migrants | 57,241 | 8.47 | 4 | 5.80 | 0.007 |
| Long-distance truck & taxi drivers | 102 | 0.02 | 0 | 0 | 0.0 |
| Bar girls and club workers | 6,550 | 0.97 | 0 | 0 | 0.0 |
| **Total** | **675,735** | | **69** | | **0.010** |

*Table (1)* shows the number of HIV cases that were identified through all the different mechanisms for HIV testing in 2011. It reveals that the two main HIV testing mechanisms – among blood donors and premarital couples – which accounted for 81% of all tests in 2011, only detected one third (33%) of all HIV cases. This reflects the overall very low HIV prevalence among the general population. It also shows that despite the very low utilisation of VCT services (1541 clients, a mere 0.2% of all tests) almost 15 percent of HIV cases in 2011 (n=10) was found through VCT, which indicates that VCT clients represent a self-identified higher-risk population. The table also shows that more than one-third (35%) of sexual contacts of HIV patients were infected as well.

No HIV cases were found among MARP groups in 2011. Very few MSM (n=5) were tested for HIV in 2011: these were most likely MSM that were arrested and tested as such; however, data on routes of transmission for 2011 (Table 3) indicate that in 2011 6 HIV cases identified through other testing mechanisms (e.g. VCT) were attributed to MSM contacts. Similarly, no sex workers were found positive among 108 tested; however, with an estimated 15 to 25,000 sex workers in Syria, the sample of 108 tested represents less than one percent of all sex workers, which may be too low to find any HIV. A promising result is that no cases were found among 478 IDUs either, which seems to indicate that HIV is still extremely low in this group, although those tested may represent a very specific sub-sample of the whole UDU population, while no accurate data is available about the total size of this population.

### *Reported modes of HIV transmission*

Table 2 shows the reported mode of transmission of the 371 Syrian cases (281 males; 90 females) that had been reported by June 2010. The official data show that most HIV transmission is reported to be heterosexual (63%), representing 71 percent of HIV cases among women, and 60 percent among men. Overall, blood transfusions contribute to 8 percent of HIV transmission, while injecting drug use and mother-to-child transmission are minor HIV-transmission channels (5% each). Homo- or bisexual transmission reportedly represents 14 percent of cases among men (10.5% of all HIV cases).

**Table 2: Reported modes of HIV transmission among *Syrian* men and women, 1987-June 2010** (MOH/NAP, 2010-1)

| Reported mode of HIV transmission | Men | % of HIV transmission among men | Women | % of HIV transmission among women | All | % |
|---|---|---|---|---|---|---|
| Heterosexual | 169 | 60.1% | 64 | 71.1% | 233 | 62.8% |
| Homo and/or Bisexual | 39 | 13.9% | --- | 0% | 39 | 10.5% |
| Blood transfusion | 22 | 7.8% | 9 | 10.0% | 31 | 8.4% |
| Injecting drug use | 18 | 6.4% | 0 | 0% | 18 | 4.85% |
| Mother to child | 7 | 2.5% | 11 | 12.2% | 18 | 4.85% |
| Unknown | 26 | 9.3% | 6 | 6.7% | 32 | 8.6% |
| **TOTAL** | **281** | **100%** | **90** | **100%** | **371** | **100%** |

A first glance at these data seems to reveal a predominantly *heterosexual* epidemic, with a limited role for homosexual contacts and injection drug use. However, the data on the

reported modes of HIV transmission presented in Table 2 need to be interpreted with great caution. Firstly, as discussed, the data only reflect *officially reported* cases, leaving out the many non-reported HIV cases, many of whom may be among most-at-risk populations who will shun HIV testing. Thus, the data is likely to considerably *under-represent* HIV cases among most-at-risk populations such as MSM, IDUs and female sex workers.

Furthermore, Table 2 shows *reported* modes of transmission, making it highly susceptible to (self) reporting bias: few members of MARP groups will voluntarily admit having contracted HIV through homosexual contacts or injecting drug use, due to strong stigma, discrimination and criminalisation of homosexuality and drug use. Thus, the proportion of homo/bisexual and IDU transmission is likely to be underestimated. Finally, the data masks the role of sex work and other forms of extramarital sex, as the majority of men reporting HIV infection through heterosexual contacts will have contracted HIV *outside* marriage – from sex workers, girlfriends or other casual sex contacts. In addition, the "heterosexual" category is a safe haven for men who have sex with men who are also married, as it will be extremely difficult for these men to admit having engaged in homosexual contacts. Thus, the proportion of MSM transmission is likely to be considerably higher than the officially reported 14 percent.

**Table 3: Reported modes of HIV transmission (Syrian and non-Syrian) 2010-2011** (MOH/NAP, 2012)

| Reported mode of HIV transmission | Men | % of HIV transmission among men | Women | % of HIV transmission among women | All | % |
|---|---|---|---|---|---|---|
| Heterosexual | 55 | 59.1% | 38 | 90.5% | 93 | 68.9% |
| Homo and/or Bisexual | 13 | 14.0% | --- | 0% | 13 | 9.6% |
| Blood transfusion | 6 | 6.5% | 1 | 2.4% | 7 | 5.2% |
| Injecting drug use | 0 | 0% | 0 | 0% | 0 | 0% |
| Mother to child | 1 | 1.1% | 1 | 2.4% | 2 | 1.5% |
| Unknown | 18 | 19.4% | 2 | 4.8% | 20 | 14.8% |
| **TOTAL** | **93** | **100%** | **42** | **100%** | **135** | **100%** |

Table (3) shows the same results as Table (2), but just for the reporting period 2010-2011, and for all cases, both Syrian (96) and *non*-Syrian (39). While most percentages are similar to the 1987-2010 period, the percentage of "unknown" is particularly high among men, almost one-fifth. This may be due to people reluctant to disclose MSM or IDU practices, or contacts with sex workers; or they may reflect the non-Syrian (cases, who may be more reluctant to provide details on transmission routes. Furthermore, the proportion of MSM is the same at 14 percent of HIV among male cases. It is worrying to see that 7 new HIV cases in 2010-2011 were reported as due to unsafe blood or blood products; this highlights the need to further strengthen blood safety measures.

# POTENTIAL DRIVERS OF THE HIV EPIDEMIC IN SYRIA

Potential drivers of the HIV epidemic include structural socioeconomic and cultural factors that are not easily measured, and which increase people's vulnerability to HIV infection (UNAIDS, 2008). Examples include poverty and unemployment, gender inequality, sexual and gender-based violence, and HIV-related stigma and discrimination. *Socioeconomic problems*, including *unemployment and poverty,* are important drivers of HIV-related risk behaviours. Poverty affects 11.4 percent of all people in Syria; it is more common in rural areas, where 62 percent of the country's poor people live. Research among *female sex workers* in Syria *(MOH/NAP, 2005-4)* has revealed that most of them are driven by economic reasons. *Unemployment and poverty* are also the main drivers for *work-related mobility and labour migration*. Overall, about 25 percent of young men (20-24 years) are unemployed, with the result that many, mainly young, Syrians seek employment abroad, where they are vulnerable to unprotected sexual contacts *(IFAD, 2010). Socio-cultural norms* also contribute to increased HIV risks among specific groups. Taboos on issues related to sexuality hamper effective HIV/STI education for young people, and make it difficult to implement HIV-prevention programmes specifically targeting MARPs.

# Key Populations at Risk and Affected by HIV

Most-at-risk populations are characterised by specific behaviours that put them at higher risk for HIV infection, including unprotected heterosexual or homosexual contacts with multiple, non-regular partners, and unsafe injecting drug use. MARP groups include female sex workers and their clients; men who have sex with men – including male sex workers – and their sexual partners, including non-regular male partners and the wives of these MSM; as well as injecting drug users (IDUs). Other population groups that are more vulnerable to HIV include young women and men, mobile populations, including migrant labourers and other mobile men; and infants born to HIV-infected mothers.

## HIV risks among female sex workers

Sex work in Syria is largely hidden, as it is *illegal* and surrounded by large *societal taboo* on sexuality in general and extramarital sex in particular. Sex work is present and well organised throughout the country, with an estimated number of sex workers between 15,000 to 25,000 *(Bozicevic, 2008).* A survey among female sex workers in 2005 *(MOH/NAP, 2005-4)* revealed that the majority are vulnerable young women and girls, who became involved in sex work at a young to very young age – more than 50 percent under the age of 18 – and that most are primarily driven by *economic reasons.* Furthermore, much sex work in Syria and the wider region is *dominated by organised crime networks*, involved in human trafficking of foreign women to Syria *(UNHCR, 2008; ECPAT, 2009).* Sex work takes place in different settings: the most hidden and hard-to-reach group are female sex workers operating from private houses or apartments. Taxi drivers often play a key role as intermediates between the pimp, sex worker and her clients *(Phillips, 2005).* Mobile phones play an ever increasing role for pimps and sex workers to contact their clients. In addition to these private houses, sex workers also operate from certain bars, nightclubs and hotels. Yet others operate as *'call girls'* for the richer clientele. The HIV risks of female sex workers depend largely on the conditions in which they operate, and the level of control they have over their own situation. Most at risk are the sex workers who have been lured or forced into sex work, and who often operate on the low side of the market.

*HIV knowledge and risk behaviours among female sex workers*

To date, no systematic biological and behavioural surveillance studies have been conducted among sex workers in Syria. Findings from a study that was conducted in 2005 among 400 female sex workers showed that overall HIV awareness and knowledge were relatively high, but most sex workers were unable to effectively use this knowledge and protect themselves against HIV *(MOH/NAP, 2005-4).* Although almost half (46%) thought they were at a considerable risk of contracting HIV, consistent condom use was very low at 13 percent, while 15 and 50 percent respectively said they never or occasionally used condoms. The main reasons for not using condoms during commercial sex were the client's refusal (45%), and the sex worker's own lack of interest (28%) *(MOH/NAP, 2005-4).* More than 80 percent of sex workers reported more than one client per day, while half of the respondents had suffered from STI-related symptoms in the last 12 months.

In the absence of biological surveys among sex workers, there are no statistics on HIV rates among female sex workers in Syria. Very few sex workers re known to be tested: in 2011, no HIV cases were found among 108 arrested sex workers. To date, most studies in other countries of the Middle East and North Africa have failed to detect high levels of HIV infection among female sex workers, with rates between 0.85 in Egypt (2006; *Shawky et al., 2009)* to 3.9% in Algeria *(WHO/UNICEF/UNAIDS, 2009).*

## HIV risks among potential clients of sex workers – including mobile men

Clients of sex workers constitute a *key bridge population* for transmission of HIV to the general population. Clients of sex workers include *local* Syrian men; *mobile* Syrian men who are away from their families for longer or shorter periods – such as migrant labourers, international truck drivers, sailors; as well as businessmen and tourists from the Middle East *(DPA, 2009).* While no reliable data on the importance of sex work for HIV transmission is available, interviews with HIV-infected women in Syria have revealed that most have been infected by their husbands. Twenty percent of all HIV infections occurs through heterosexual transmission from husband to wife, while 58 percent occurs through heterosexual transmission outside of marriage *(MOH/NAP, 2010-1).*

To date, only two studies have been conducted among mobile men in Syria. In 2005, a KAP study among 200 *sailors* in Tartous found considerable rates of unprotected sex with non-regular partners. More than 70 percent of respondents indicated they became sexually active *before the age of 23*: 41 percent between 14-18 years, and 30 percent between 19-22 years. A third (32%) of respondents admitted having ever had *extramarital* sex, almost half of whom (48%) in the past year. Almost 90 percent of these men had had sex with *non-regular* partners, with almost 80 percent with non-Syrian women. Three-quarters of those who had had extramarital relations said they had used a condom during their last sexual contact *(MOH/NAP, 2005-3).*

Another category of mobile men are *truck drivers*, whose number is estimated to be around 6,000 *(Bozicevic, 2008).* In a KAP study in 2005 among long-distance truck drivers, 22 percent admitted having ever had extramarital sex, of whom almost one-third in the last year. Almost *70 percent* indicated some of their colleagues had engaged in extramarital sex.. Forty percent of respondents said they used a condom at last sex, although it is not clear whether this reflected sex with non-regular sex partners only *(MOH/NAP, 2005-2).*

***Syrian migrant labourers*** form a particularly large group at risk of HIV: a regional study in 2005 on migration estimated that 1.9 million Syrians were working outside the country. Large numbers of Syrian men work in Lebanon, where many are employed. Currently, an estimated

15 percent of Syria's workforce is in Lebanon, with 300,000 of them working in in the construction sector or in unskilled labour without work permits *(Baldwin-Edwards, 2005).* Other main countries of destination for labour migrants include Jordan, the Gulf states and Saudi Arabia. A regional study estimated there were 170,000 Syrian labourers in Saudi Arabia and another 95,000 in Kuwait in 2002 *(Kapiszewski, 2004).* While no specific research has been done on the HIV risks and vulnerabilities of Syrian labour migrants in these countries, anecdotal evidence from press articles and other reports shows the presence of high-risk sex behaviours in labour camps in the Gulf states, as well as a vibrant sex work business in Lebanon, especially in the capital Beirut *(IRIN, 2009; DPA, 2009).*

## HIV risks among men who have sex with men (MSM)

In the absence of biological surveys among MSM, reliable data on HIV rates are not available. Official data indicate that 14 percent (39 cases) of the officially registered HIV infections among *Syrian* men are *reported* to be the result of same-sex relations. In 2010-2011, 9.6 percent (13/135) of all HIV cases was reported as due to MSM contacts; this represented 14 percent of *male* HIV cases. The real proportion, however, is likely to be higher, since many MSM will not admit they were infected through sex with other men *(MOH/NAP, 2010-1)*

Very little research has been done to date on MSM in Syria. The results of a new study in 2011 are still pending. The only other study among MSM in Syria was a qualitative study in 2005 among 28 MSM, aged 25-45 years *(MOH/NAP, 2005-1)*. This study revealed the severe social rejection and marginalisation of MSM in Syria, which led most MSM to lead "double" lives – with many of them eventually marrying in order to live up to social expectations of their family. Many of these married MSM have unprotected sex with multiple male sexual partners, while at the same time having sexual contact with their wives. Results show that MSM meet in specific public places, such as public bathhouses, public parks, squares and cinemas in major cities, including Damascus, Aleppo, Homs and Lattakia. In addition, the internet has rapidly become an important medium for MSM to meet socially. Respondents report anal and oral sex as common practice, but a large majority does not use condoms or other protection methods, despite the fact that most MSM are aware of the risk of HIV and other STIs, and know that condoms offer effective protection. The main reason given for not using condoms is reduced sexual pleasure. A very small number reports condom use, but only if their sex partner agrees *(MOH/NAP, 2005-1).*

Similar results of high-risk unprotected sex were found in a *regional study* that was conducted in 2009 through the Internet by a regional MSM organisation among several thousand MSM in eight countries in the Middle East, including Syria *(GME, 2009)*. The results show that unprotected MSM sex is common in all countries; 64 percent of Syrian respondents indicated they *"always"* used a condom, while 17 percent said that condom use "needs discussion", one percent said they "never" used a condom, while 18 percent refused to provide an answer. The researchers indicated that *"condom use needs discussion"* reflect those who tend to practise unsafe sex most of the time.

***Male sex work*** – An important finding of the Syrian study was that some men – especially those identified as "effeminate" MSM, who may be transsexual men – provided paid sexual services to other MSM. Research in other countries has shown the existence of mostly young MSM sex workers, who provide sexual services to – often older – married men, who prefer to pay for sexual services without engaging in personal relationships to avoid discovery of being homosexual. These male *sex workers are at a particularly high risk of HIV infection* given the high frequency of unprotected anal sex with male clients.

Findings of the Syrian MSM study reveal that *overall awareness on HIV and STIs is high*, but few had correct knowledge about HIV transmission, and misconceptions regarding the routes of HIV transmission and HIV infection were common. E.g., general "clean and elegant" appearance was considered to be the best way to judge whether a partner could be HIV-infected or not. *Safer sex* is practised depending on the *perceived* "safety" of the sex partner. Many MSM believed that the HIV risk was the same for "active" or "passive" (receptive) anal sex. Many also believed that injecting water in the intestine (*"sharnagha"*) cleans a person completely and prevents HIV/STI infection. These widespread misconceptions reflect the lack of HIV-prevention programmes among MSM.

***MSM sex among male prison inmates*** – A study by the Syrian MOH in 2008 revealed that sex among male inmates, including rape, is not uncommon. Five percent (n=10) of respondents reported having had sex inside the prison, with an average of *three different* sexual partners. None of them had used a condom, while they were mainly active injecting drug users *(MOH/NAP, 2008).* Furthermore, almost half of respondents (n=184) reported they knew of at least one case of rape inside the prison, while 86 respondents knew an *average of eight* inmates who had been raped during their prison sentence. While estimates on HIV prevalence in prisons are not reliable, one study estimated the HIV rate in Syrian prisons at 0-0.2 percent *(Dolan et al, 2007).*

## HIV risks among injecting drug users (IDUs)

A regional study in 2008 revealed a considerable increase in *injecting* drug use in recent years in the region, including in Syria. While heroin is the most common drug injected, other drugs that are injected in Syria include diazepam *(Cook et al, 2008).* A Syrian study in 2006, which included HIV tests among 204 drug users found only one HIV case. However, this cannot be considered a reliable estimate of the true HIV rate among IDUs, as the sample was not representative of the total IDU population *(MOH/NAP, 2008)*. Official Syrian HIV/AIDS data over the period 1987-June 2010 reveal that 18 HIV infections were attributed to injecting drug use, all among men, which represent 4.9 percent of all HIV infections in that 20-year period (and 6.4% of all male cases) *(MOH/NAP, 2010-2).* In the 2010-2011 reporting period, no new HIV infections were reported as a result of injecting drug use. These low numbers are more likely to reflect weaknesses in the reporting system than the actual number of IDU-related HIV infections. The real extent to which injecting drug use contributes to HIV infections in Syria may be much higher, as accurate data on the size of the drug-using population and on HIV rates among this group is not available.

A study conducted in 2006 by the Syrian NAP and supported by UNODC and UNAIDS provides an insight into the HIV risk behaviours and HIV prevalence among IDUs in Syria. The community-based study was conducted among 336 predominantly male active drug users in the Greater Damascus area, while biological samples for rapid HIV antibody testing were collected from 204 drug users *(MOH/NAP, 2008)*. Only one HIV case was found in the study (0.5%). While this indicates that HIV infection is currently not a major health problem among IDUs, the high rates of reported HCV and the high-risk injection and sexual behaviours identified among the study population show that HIV has a *high potential* to spread very quickly among this population, unless adequate HIV-prevention programmes are put in place. Drug treatment centre screening tests among IDUs in Syria have shown HCV rates of over 50 percent *(MOH/NAP, 2008)*.

While general HIV *awareness* was high, *accurate knowledge was poor*, especially with regard to the risk of *HIV transmission* through injecting drug use: most respondents knew that HIV can be transmitted through unprotected sex (94%), and fewer through blood transfusion (65%), but less than half identified the sharing of injecting equipment as a route

of transmission (47%). Similarly, active knowledge of HIV-prevention methods was poor: only 38 percent identified avoiding needle sharing as a way to protect themselves from HIV infection; the same percentage mentioned condom use, and 36 percent cited avoiding extramarital sex.

***Drug-use patterns*** among the respondents showed that most were poly-drug users of heroin, pharmaceutical drugs and hashish. Almost a quarter of all respondents were active cocaine users, but heroin was the only drug that was commonly *injected*. Most injecting takes place inside IDUs' homes and most sharing involves friends, as opposed to sex partners. Although most respondents reported easy access to new syringes, not all respondents consistently used clean injecting equipment, since the need for sterile equipment was not fully recognised *(MOH/NAP, 2008).* Behavioural data from the Syrian IDU study reveal: a) the use and sharing of non-sterile injecting equipment; as well as b) unprotected sex with multiple concurrent partners, or in the context of sex work or sex between men.

***a) Unsafe injection practices*** – The results reveal a high prevalence of high-risk injection practices, including sharing of injection equipment without proper cleaning. More than half of the respondents (51%) had ever injected drugs, with 47 percent having injected in the last 30 days. Even among these active injectors, awareness of the HIV risks of sharing equipment was weak, while *sharing* of needles, syringes, and other injection equipment was *common*: almost half of those who had ever injected (46% or 23% of all respondents) reported that they had ever used a needle or syringe after someone else had used it. Almost a third of those who had injected drugs in the last 30 days (28%, or 13% of all respondents), reported they had shared syringes with others – mostly friends (68%) or sex partners (20%) – in the last month. Forty percent of those who reported sharing syringes did not always clean used syringes; among the 60 percent who said they always cleaned it, effective cleaning of *used* syringes with bleach was practically absent *(MOH/NAP, 2008).*

***b) Risky sexual behaviour*** – Study results show that unprotected sex with multiple partners was common among drug users: a large majority was sexually active (90%), with two thirds having had sex in the last month with an average of *seven* sex partners. Although many respondents (61%) recognised the importance of condoms for HIV prevention, consistent condom use was the exception rather than the rule, mainly because of the perceived reduction of sexual pleasure. A worrying fact is that almost half of the respondents (47%) had ever had sex in exchange for some kind of remuneration (mostly money, but also drugs, food or shelter), with 40 percent in the last month. Less than one-fifth (17%) of those who had had sex in exchange for money or an in-kind remuneration had used a condom. This indicates that *transactional sex or even sex work* may be an income-generating activity for a considerable proportion of IDUs. Furthermore, a small number (n=12) had had same-sex contacts with a male partner.

The study specifically enquired about their ***utilisation of drug-treatment services***: only one quarter (26%) said they had ever been treated for drug dependence, most (84%) for heroin use. The main reasons for not seeking drug treatment included the lack of perceived need (31%), shame (26%), not being aware of any treatment centre (22%), and lack of faith in the effectiveness of treatment (14%). The low utilisation of drug-treatment services reflects the limited accessibility – the main drug-treatment centre is located in Damascus, with smaller ones in Homs and two private psychiatric hospitals in Damascus treating addiction – as well as the complete absence of outreach services for drug users in Syria *(MOH/NAP, 2008).* The strong criminalisation and marginalisation of drug users in Syria makes it very challenging, however, to establish effective peer-education and outreach programmes among IDUs. MOH study findings from Syria show that half of the respondents have been imprisoned in the past, and that almost half of them continue to use drugs in prison. The majority of these drug users injecting in prison also report sharing of injection equipment, and a considerable number also report experience or knowledge of unprotected sex and rape inside the prison:

this highlights the importance of effective prison-based HIV-prevention programmes among IDUs using a harm reduction approach *(MOH/NAP, 2008)*.

## Behavioural risks among young people

While traditional religious and social norms and values with regard to sexual relationships protect many young men and women against HIV and related sexual health risks, studies among university students (2005) and young people in disadvantaged communities (2006) reveal that a *considerable* proportion of Syrian adolescents and young people is sexually active and engage in unprotected sex without marriage, often with multiple partners.

1) The first study was done in 2005 among 1,000 mainly Syrian young women and men (18-25 years) on university campuses in Damascus and Aleppo. While general HIV awareness was high and a majority had some knowledge of HIV transmission and protection, there were many misconceptions regarding HIV risks, modes of transmission and negative attitudes about PLHIV. More than 85 percent of young people had knowledge about HIV/AIDS and basic modes of HIV transmission (MTCT, blood transfusion, unprotected sex), but almost one-third (30%) also had *incorrect* knowledge and misconceptions about HIV transmission. Furthermore, perceived personal risk of contracting HIV was low: almost two-thirds (64%) said they had *no risk* of HIV infection at all, while only one-fifth (18%) said there was *some* risk. Almost one-tenth of university students (9.1%) *admitted* having had sexual relationships outside marriage. Almost half (45.5%) of the sexually active adolescents had had their first sexual contact between 15 and 18 years of age. Furthermore, the majority of the sexually active youths indicated they had had sex with multiple partners. Only two-fifths (38.4%) of these had used a condom at last sex, while the majority (58.1%) had not used a condom. The main reasons for not using a condom included that they did not like using condoms (27%); it was not necessary (19%); their partner refused (17%); or they were not available (17%) *(MOH/NAP, 2005-5)*.

2) The second study among 600 adolescents (15-24 years) in *disadvantaged communities* in Damascus and Rural Damascus showed even higher HIV risks. This group included school dropouts, working, as well as unemployed youth. While *general* awareness on HIV/AIDS was high (97%), *specific* knowledge about HIV transmission was limited, with misconceptions about HIV being transmitted through public swimming pools, sharing food, shaking hands or public toilets. *Sex without marriage* among these adolescents was much higher than among university students: almost one-third of males (29%) admitted having had sex without marriage, while 12 percent of females had had sex without marriage. Sex outside marriage was higher among young people who did not live with their parents; and those who worked and did not study. Forty percent of the sexually active group said they had used a condom at last sex, while 56 percent had not used a condom. Furthermore, 2 percent admitted to having had homosexual contacts *(MOH/NAP, 2006).*

## Infants Born to HIV-Infected Mothers

Although *sexual* transmission of HIV is the dominant route, and only 19 children (5% of all Syrian HIV infections) have so far been infected through their mothers, Although a PMTCT policy was developed before 2010, and an increasing number of health facilities were upgraded and health-care staff trained to offer PMTCT services, HIV transmission from mothers to their unborn or newborn children remains a concern. In 2010-2011 only one MTCT case was reported, but in the absence of antenatal screening, it is likely that not all HIV-infected pregnant women are provided with PMTCT services. Furthermore, inadequate

antenatal care, and low rates of women consistently using ANC services, further increase the likelihood of HIV-infected pregnant women not being enrolled in PMTCT.

## People Living With HIV (PLHIV)

As of December 2012, a total of 762 persons had been officially reported with HIV in Syria, 441 (57.9%) of whom were *Syrian* citizens, while the remaining 321 (42.1%) were *non*-Syrians, most of them *non*-residents, who subsequently left Syria after they tested positive for HIV. According to *official statistics*, by December 2011, a total of 130 people with HIV had been enrolled in antiretroviral treatment (ART). In 2010-2011, 35 new patients were enrolled in ART.

***Access to HIV services*** – However, the majority of Syrian PLHIV does not have access to HIV treatment and care, including ART: the main obstacle is that most HIV-infected people are *unaware* of their HIV status, since they have never been tested for HIV, either with or without adequate counselling. Each year, many people are tested for HIV: by the end of 2011 a (cumulative) total of approximately 7 million HIV tests had been conducted, with more than 675,000 HIV tests in 2011 alone. Despite the large number of people tested each year, the vast majority of the approximately 20.5 million Syrians – especially among MARP groups – has never been tested. Hence, the official number of HIV cases is likely to be a serious underestimation of their real number. A 2008 estimation using SPECTRUM put the number of people living with HIV at 1,152, 5-6 times higher than the officially registered cases *(CCM, 2009).*

# III. SYRIA'S NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The previous section showed that Syria remains a low-prevalence country, with a relatively stable number of new cases each year. It also revealed, however, that there are many potential drivers in Syria that could lead to a more rapid increase of the number of HIV cases in the near future, unless effective measures are taken.

## 1. National Commitment

The first condition for an adequate national response to HIV is ***political support and leadership***. The 2010 UNGASS report mentioned "some progress in the national response to HIV/AIDS", but also highlighted that "many areas still require further development". The main weaknesses mentioned in 2010 included the fact that the national response was biased towards education and prevention among the general public, which is at low risk, while there was very limited political support for HIV prevention among MARP groups, as well as concerns with regard to the actual protection of PLHIV's rights with regard to access to treatment and job opportunities.

In the 2010-2011 period there have been some achievements, but many challenges still remain with regard to political support and leadership. These challenges are reflected at: 1) the *institutional and organisational* level; 2) in *policy and programme development*; and 3) in terms of *allocation of human and financial resources*.

1) At the ***institutional and organisational*** level, the main government institutions tasked with HIV/AIDS include: a) the *National AIDS Programme* (NAP), which was established at the Ministry of Health (MOH) in 1987, and b) a multisectoral *National AIDS Committee*, which was established to ensure the involvement and overall coordination of different government sectors. c) In addition, institutional challenges remain in the *civil society sector*, which has an important role to play.

a) With regard to the *NAP*, little progress was made in 2010-2011 regarding a number of challenges that continue to hamper the functioning of the NAP: while the NAP is well-staffed, it continued to face inadequate work facilities (inadequate office space, insufficient computers, no Internet access), as well as a lack of clearly established roles and responsibilities of staff, which leads to inefficiencies in the implementation of key programme components. Furthermore, NAP staff requires further capacity strengthening in areas such as M&E, policy advocacy, and HIV prevention among MARPs, including the role of civil society.

b) While the *National AIDS Committee* (NAC) has managed to involve many sectors to some degree in the national response, their actual involvement on a practical level in HIV programmes and services has been suboptimal. Few non-health sectors have been able to effectively use their comparative advantages in specific areas, such as workplace programmes, mass media campaigns, prison programmes, or programmes for out-of-school youth. No significant improvements were made in 2010-2011 in this area.

c) A major challenge is the *weak development of civil society* in Syria. Few NGOs exist, and even fewer have an interest or the capacity to work in the HIV field, especially when it comes to prevention among MARPs. Prior to 2010, NGOs such as the Syrian Family Planning Association and the Red Crescent had been involved in isolated HIV-related activities. This situation has not improved in 2010-2011: CSOs continue to be involved on a low level, and any programmes they may be involved in are scattered, ad-hoc activities, which lack a systematic approach and longer-term follow-up.

2) Major progress was made in 2010-2011 with regard to ***policy and programme development***. In 2010, the NAP and partners developed a comprehensive National Strategic

Plan and costed Operational Plan for the period 2011-2015. Implementation of the planned activities in 2011, however, has remained poor due to the limited implementation capacity of government and especially civil society organisations in the field of MARPs. Furthermore, inadequate resources for key HIV-prevention activities in the NSP did not allow their implementation as planned (see next).

3) In terms of ***allocation of human and financial resources***, 2010 was marked by the successful application for Global Fund support in the field of HIV/AIDS. This was the first time Syria managed to secure GF funding for HIV. However, the grant is limited to strengthening of surveillance, research and M&E, as well as capacity building for government and CSOs in HIV/AIDS, while no resources were committed for actual implementation of HIV prevention among MARPs. Hence, adequate funding for this key priority area remains very limited, as the Syrian government has not made any funds available for this area. The continued lack of national and external funding for one of the most important areas – HIV prevention among MARPs – highlights the lack of concrete commitment.

National AIDS spending in 2011 remained tilted towards mass screening and ARV treatment. A breakdown of government funding in 2011 shows that most funding went to various HIV screening programmes, while the rest went to ARV treatment and a small proportion for associated care and support. No government funding was available for HIV prevention; the UN has been funding VCT services and some prevention activities. The main challenge, therefore, remains the very low allocation of financial resources for HIV, especially for prevention; while no funds are available for interventions among MARPs.

## 2. Programme Implementation

While the previous section showed existing national commitment in terms of established institutions, such as the NAP and NAC, as well as progress with regard to the National Strategic Plan 2011-2015, the continued *inadequate allocation of funds* by the Government in 2010-2011 shows the *actual* national commitment to HIV, which remains low, and has yet to materialise into adequate funding. Although an amount of approximately USD 3.5 million was secured from the Global Fund, few of these monies have been spent in 2011, due to delays in grant negotiation, as well as national events that prevented the implementation of planned activities. In this context, programme implementation in 2010-2011 remained confined to the same standard programmes and services that were also implemented in previous periods, and which are mainly financed through existing budgets in the health sector, while very limited earmarked funding has been available for specific HIV/AIDS activities elsewhere.

### HIV prevention

In the HIV prevention field, *massive HIV-screening programmes* constituted the bulk of HIV-related activities. As presented in Table (1) above, the large majority of all HIV tests took place in the context of blood safety (62%) and mandatory screening of groups such as premarital couples (19%) and migrant workers (15%) (both Syrian out-migrants, and foreigners applying for work permits and residency in Syria), while a mere 0.23 percent of all HIV testing was done in the context of VCT.

*Premarital HIV testing* was introduced in January 2010. In 2011, six HIV cases were found among a total of 130,575 premarital tests conducted. Premarital testing accounted for a large proportion of the increase in HIV tests since 2009. In 2009, a total of 485,857 tests were conducted. In 2011, this had increased by almost 190,000 to 675,735 tests: a two-fifths (39%) increase since 2009.

Since 2006, *VCT centres* have been established countrywide, with 14 Government-run VCT centres (one in each Governorate) and 10 VCT centres that are run by the Syrian Red Crescent Society. However, due to the lack of proactive promotion of VCT services and the inadequate training of staff, the utilisation of VCT services is low. The continued low uptake of VCT services (1,541 clients in 2011) shows that no progress was made in scaling this up since 2009, when 2,089 clients used VCT services, hence a *decline* of 26 percent in these 2 years.

It is important to observe that the dramatic increase of HIV testing of almost 40 percent since 2009, has resulted in *very few additional HIV cases detected*: only 6 HIV cases were found as a result of large expenses made for conducting more than 130,000 premarital HIV tests. At the same time, no further investments were made in the quality and coverage of VCT services: the number of VCT clients decreased by more than a quarter since 2009. Nevertheless, the few HIV tests in the context of VCT (1,541 visits) accounted for 10 HIV cases found. Hence, investing in the promotion, quality and utilisation of the existing VCT services would likely be more cost-effective than massive screening.

*PMTCT* – Despite the presence of large-scale mandatory screening of many different groups, HIV screening as part of antenatal care currently is not available. In 2011, only 177 pregnant women were tested, and no HIV-infected cases were found. While no HIV cases were identified among new-born infants, in the absence of ANC screening, it is likely that a small number of HIV-infected pregnant women delivered, while no PMTCT services could be offered. The risk of mother-to-child transmission may be reduced to some extent through the introduction of premarital screening, which identifies a few HIV cases who would otherwise not be able to take precautionary measures to avoid transmission from mother to child.

Apart from existing *infection control measures in the health-care sector, and blood safety*, very few other activities have taken place in the field of HIV prevention.

### *HIV prevention and research among MARP groups*

Despite the prioritisation of MARPs and vulnerable youth in the recently developed NSP 2011-2015 – which contained detailed activities and clear targets – *no targeted HIV-prevention programmes for MARPs* were implemented in 2010-2011. This was mainly due to lack of financial support; low capacity in government and civil society; as well as an overall lack of government commitment to this key intervention area. Government is unlikely to support interventions in this area, due to criminalisation of MARPs and many competing priorities in the health field.

Nevertheless, some important steps were taken in 2010-2011 towards future interventions for MARPs. First of all, while actual implementation of many programmes is still pending, the NSP 2011-2015 provides a clear policy basis for initiating targeted HIV-prevention programmes among MARPs, including peer outreach and education; STI services; MARP-friendly VCT; and a harm-reduction pilot programme. Furthermore, with Global Fund support, a first study was conducted among MSM in 2011, whose results yet to become available. Additional studies are planned for sex workers and IDUs in 2012. The results of these studies are expected to inform the development of targeted interventions for these groups, and may facilitate resource mobilisation from government of external donors.

In addition to these planned studies among MARPs, the Global Fund grant will also support *capacity building* for HIV prevention among MARPs, with special attention for strengthening technical and institutional capacity of civil society in this field.

Despite the absence of specific HIV interventions for MARPs, some services exist for *injecting drug users*, such as drug-treatment services in Damascus. However, these services have low coverage rates, and limited results: relapse among drug addicts is very high, and specific HIV-prevention programmes are not available. A promising development in 2010 was the GFATM grant awarded to MENAHRA, the Middle East and North Africa Harm Reduction Association. MENAHRA will use this grant to build capacity in the field of harm reduction throughout the region, including in Syria.

### *The role of non-health sectors, civil society and UN agencies*

To date, the national response has mainly been driven by the health sector, with limited involvement of *other government sectors*. As mentioned earlier, several UN agencies and other international institutions have been providing support to the national response to HIV. The World Bank and UNAIDS supported the development the NSP in 2010; WHO supported the development of the successful GFATM grant; furthermore the ILO Regional Office for the Middle East has been providing technical support to the Ministry of Labour, Chambers of Commerce and Unions for the development of a joint policy on HIV/AIDS in the world of work. UNDP will be managing the Global Fund grant on HIV. Furthermore, UNFPA has been providing support in the field of mapping studies.

## HIV treatment and care

*ARV treatment* (ART) has been available since 2003. From January 2010 till December 2011, 35 new HIV patients were enrolled in antiretroviral treatment (ART). The total number of people on ART by the end of December 2011 was 130. However, a 2008 estimation using SPECTRUM modelling put the estimated number of PLHIV in Syria at more than 1,150 (which will be even higher in 2012), which implies that a considerable number of PLHIV in need of ARV treatment does not have access to ART. Similarly, the quality, comprehensiveness and utilisation of HIV-related *treatment, care and support* services have been inadequate. To date, there are no official ARV-treatment protocols and guidelines, and the available ARV drugs are limited to a small range of generic first-line drugs only. Furthermore, the monitoring of ART patients is not in accordance with international standards, while the monitoring of ARV-drug resistance is inexistent. Also, Syria lacks specialised clinics for HIV treatment, and has very few physicians with experience in treatment of HIV patients, particularly outside the capital Damascus. As a result, the quality and access to the available ARV treatment are limited. Furthermore, most PLHIV lack social and psychological counselling and support to deal with the impact of HIV on their mental health. In addition, PLHIV need a supportive legal and policy environment to protect them against discrimination with regard to access to health care, employment and education.

# IV. BEST PRACTICES

As described in the previous section, the Syrian national response to HIV faces many challenges still. These will be addressed in the next section in more detail. Nevertheless, it is important to acknowledge the important achievements and best practices that Syria has been able to make.

***National AIDS Programme*** – A first achievement has been the establishment of the National AIDS Programme since the early stages of the epidemic. Compared to some other countries in the wider region with very few, sometimes just part-time staff, Syria's NAP is relatively well-staffed, although certain challenges still remain. The NAP has established several key elements of the national response, such as a system to monitor new HIV cases; blood safety; ARV treatment for eligible HIV patients; and VCT (see below).

***Multisectoral involvement*** – Furthermore, the NAP has been able to mobilise a large number of sectors in the HIV response, including the national Planning and International Cooperation Commission, the Ministries of Health, Education and Higher Education, Labour and Social Development, Interior, Defence, Religious Affairs, Justice, Information. Furthermore, a variety of national institutions, such as the Women's Union, Youth Union, Transport Union, as well as Muslim and Christian religious leaders, and civil society organisations, such as the Syrian Family Planning Association and the red Crescent are actively involved in national policy and programme planning.

***Voluntary counselling and testing (VCT)*** – the establishment of a VCT system is an important achievement in a region where many countries only have mandatory screening without VCT services. While Syria also has mandatory screening, the VCT system provides people with an opportunity to get anonymous and confidential counselling and testing. Although uptake is still relatively low – with merely 1,541 clients in 2011 – the VCT services manage to identify new HIV cases who were not found through the screening systems, and enrol them in life-saving treatment and care. In 2011, 10 new cases were found among a mere 1,541 VCT clients (one in 154 clients), while the remaining 59 cases in 2011 were found through 679,194 mandatory tests (less than one in 11,500 tests).

In 2010, the NAP developed a ***comprehensive national strategic plan and costed operational plan*** with active participation of all sectors, civil society and PLHIV. The NSP was the basis for the first successful application (see below) for Global Fund support for HIV in Syria the same year. The NSP has a clear focus on prevention, with special attention for sex workers, men who have sex with men and injecting drug users, MARP groups which had not been included in previous NSPs. Planned interventions for these MARP groups include innovative services, such as a harm reduction pilot project for IDUs, and peer outreach programmes for sex workers and MSM. Other key components include education for most-at-risk adolescents. These are important achievements given the sensitivities surrounding MARP groups and sex education for young people.

***Resource mobilisation*** – The successful GFATM application in 2010 will allow Syria to build capacity of the NAP and civil society organisations to deliver HIV-prevention services among MARP groups. In addition, the Global Fund support will support the establishment of a unified national surveillance and M&E system on HIV/AIDS, which includes strengthening surveillance and M&E through mapping and size estimations of MARP groups; the establishment of second-generation surveillance; and a comprehensive national database.

# V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

The previous chapters revealed that there are still many challenges facing the national response to HIV in Syria. Some were addressed in the 2010-2011 period, such as the development of a costed NSP and financial support through a Global Fund grant, but many remain. HIV-prevention efforts have been particularly weak, especially among MARPs and other vulnerable groups, including youth, for whom no special programmes have been implemented in 2010-2011.

## *Specific challenges, specific remedies*

A more systematic, evidence-informed response to HIV in the next two years, 2012-2013, requires addressing the main challenges in a number of areas:

***1. Strengthening and operationalising political support*** – In the 2010, high-level decision-makers in the MOH and other ministries expressed their full support for the development and implementation of the NSP 2011-2015. However, this 'non-material' political support remained general, without translating into concrete financial and operational support on the ground for the actual implementation of the policies that are formally supported and endorsed. A challenge in this regard is the weak connection between official policies and plans on the one hand, and allocation of specific budgets on the other hand. In addition, policy makers and technical staff at lower levels in the MOH and in NAP lack the means to successfully lobby for the financial and human resources needed to implement programmes on paper.

***Remedial action***: A combination of strong evidence *(see next)* and effective advocacy and lobbying is needed to further convince high-level decision-makers of the need to strengthen HIV prevention, and to provide proactive support, especially for HIV prevention among MARPs. In addition, leadership from the highest levels is needed to garner support at lower administrative levels. International experience and technical assistance may help highlight the priority issues.

***2. Lack of evidence*** regarding: a) the potential drivers of a future HIV epidemic; b) the existence and scale of high-risk behaviours and MARP groups; and c) effective interventions makes it difficult to convince political leaders and policy makers to provide political support and allocate the necessary financial and human resources for effective HIV-prevention, care and treatment programmes. The absence of adequate surveillance systems, research and M&E systems hampers an *evidence*-informed approach. One of the top priorities of the NSP 2011-2015 was to gather more evidence through special surveillance studies among MARPs. To date, only one study – among MSM – has been conducted, but results are not available yet. Furthermore, the slow implementation ofnthe NSP with regard to HIV prevention among MARPs has not allowed collecting M&E data that would provide evidence of the most cost-effective approaches.

***Remedial action*:** 1) Implementation of the *already planned* social and behavioural research among MARP groups, youth and other vulnerable groups, in accordance with the priorities identified in the NSP 2011-2015 and operational plan. 2) Strengthening of *existing* HIV-surveillance systems, especially bio-behavioural surveillance studies among young people and MARPs; as well as an improved *national M&E system*, that support effective information flows from data collection down to the use of data for evidence-informed decision-making. This requires clear protocols regarding data collection, reporting/sharing, and most of all analysis and utilisation of data for planning purposes. *Financial* support for all planned HIV-surveillance and research activities is already guaranteed through a Global Fund grant; in addition, external *technical* assistance will be needed.

***3. Inadequate institutional support systems and budgets*** – a) One of the main problems hampering an effective HIV response is the lack of real prioritisation of HIV prevention at the highest political levels. The absence of a functional *National AIDS Council* (NAC) or equivalent structure, comprising high-level leadership from different sectors, hampers a strong, multisectoral response to HIV. This high-level support is essential for implementing sensitive interventions that may be opposed unless they are endorsed by the highest political level. To date HIV services remain largely restricted to screening and ART, but strong political support is needed for HIV prevention among MARPs, such as outreach to sex workers, MSM and IDUs, as well as harm-reduction programmes: these are part of the NSP, but their actual implementation has not been prioritised.

b) In addition to concrete support from the highest policy level, management structures and technical capacity and expertise of the MOH-based *National AIDS Programme* (NAP) need to be further strengthened. To date, the NAP has not been able to ensure implementation of key HIV interventions, especially in the field of HIV prevention for MARPs. While technical expertise needs to be strengthened, another important issue are effective management structures, and clear TORs and job descriptions for all staff; as well as adequate office conditions. A well-resourced NAP with adequate institutional and operational budgets and infrastructure is instrumental to oversee and support the implementation of the national response and to support the NAC.

c) Adequate allocation of financial resources to NAP and partners for implementation of the NSP is not available. Current health-sector-based HIV programmes are largely financed through regular budgets, but innovative approaches to HIV prevention require additional, earmarked funding. A recently approved Global Fund grant included only capacity building and research, but did not include funds for implementation of HIV prevention among.

***Remedial action:*** a) Establishment of a functional NAC, with effective membership from key sectors – including but not limited to health, police and interior, education, social affairs, labour – as well as clear mandates and TORs, and adequate administrative support. To avoid another "paper committee", the NAC needs affective secretarial support and technical assistance from the NAP, with a clear mandate and agenda. b) Strengthening of NAP in accordance with planned interventions of the NSP 2011-2015: budgets for capacity strengthening are available through a Global Fund Round-10 grant. This grant needs to be effectively implemented. c) NAP needs to conduct more proactive and targeted advocacy and lobbying with the State Planning Commission to ensure adequate resources are available for key HIV services. These efforts can be supported with support from local development partners, such as UN agencies or regional organisations, such as MENAHRA which can fund some IDU-related activities. To this effect, evidence from surveillance and research data needs to be used more systematically to influence policy decisions and budget allocations.

***4. Non-implementation of planned interventions – especially in the field of HIV prevention for MARPs and vulnerable groups –*** As mentioned above, Syria has an updated NSP and detailed Operational Plan for 2011-2015 with clear priorities and targets in the field of prevention. However, implementation of these planned activities is hampered by a number of factors, including: a) Lack of political support and financial resources; b) Weak support structures (NAC) and technical expertise at NAP; as well as c) Lack of output-oriented partnerships by development partners through *"adoption"* of certain NSP components.

***Remedial action:*** Remedial actions with regard to political support (a) and support structures (NAC and NAP) (b) have already been described above: advocacy and lobbying for political support to materialise into on-the-ground financial support; as well as sustained investments in building capacity both within the NAP and among implementing partners (see next point). (c) In addition, targeted support by external partners for the implementation of

specific components of the NSP can make a difference. The NAP and local partners may not have the capacity (technical, human resources) to fully implement all components of the NSP, but NAP should engage in *partnerships* with local partners to "adopt" specific components of the NSP. This has already happened in the past to some extent, with UNAIDS and The World Bank supporting the development of the NSP, or UNFPA financing some studies, but these partnerships should be part of a broader overall partnership framework, whereby partner organisations coordinate their for specific components of the NSP.

***5. Lack of experience and capacity in HIV prevention and weak civil society*** – To date, there has been very limited experience with targeted HIV programmes, especially with regard to prevention. These programmes require specific experience and skills to work with often hard-to-reach groups in sensitive areas, which can often not be offered through government institutions. The lack of experience in Syria is further compounded by an overall weak civil society, with few CSOs experienced or interested in working in HIV prevention with MARP groups. The main CSOs with some experience in HIV/AIDS are the Syrian Family Planning Association (SFPA) and Red Crescent. However, few other organisations have the expertise or willingness to work with PLHIV, sex workers, MSM or IDUs. In addition, existing laws and policies with regard to MARP groups may not always facilitate HIV programmes for these MARPs. Hence, working in HIV prevention, especially with MARPs, is perceived to have many down sides and few benefits.

***Remedial action:*** Strengthening capacity involves specific training and capacity building in the field of a) Technical expertise and skills; and b) Institutional and organisational capacity, especially for the weak civil society. C) In addition to capacity building, partnerships with international NGOs – especially in neighbouring countries and the wider region – can help local CSOs with on-site support and exchange of experiences. Regional meetings and conferences can further help strengthening regional networking. Specific areas to be addressed include working with sex workers, MSM, IDUs and PLHIV. Neighbouring countries already have some experience in this field.

***6. Lack of supportive legal, social and policy environments, including stigma and discrimination*** – In addition challenges already mentioned above, existing legal and policy frameworks, and social norms and values often hamper specific HIV/AIDS programmes and services. Criminalisation of MARPs hampers effective outreach or may not allow certain interventions, such as opioid substitution therapy, safe-injection programmes, condom promotion or explicit HIV education for young people. In the absence of more supportive environments, none of the above challenges can be effectively addressed.

***Remedial action:*** the creation of supportive environments is complex and may typically meet resistance from different groups. Therefore, HIV programmes need to be culturally and religiously sensitive, and actively involve political, community and religious leaders. This requires involving them in research, programme development, implementation and evaluation. Furthermore, lobbying and advocacy strategies need to focus on gaining support from political leaders at national, Governorate and community levels. Overall, emphasis needs to be placed on mobilising support for effective HIV prevention, care and treatment programmes.

# VI. SUPPORT FROM SYRIA'S DEVELOPMENT PARTNERS

The 2010-2011 period has seen some important support for the Syrian national response to HIV/AIDS by international development partners. In 2010, The ASAP programme, which is supported by The World Bank and UNAIDS, provided technical and financial support for the development of Syria's National Strategic Plan 2011-2015, and the associated costed Operational Plan. Furthermore, WHO-EMRO supported the development of a successful Round-10 proposal for the Global Fund in AIDS, Tuberculosis and malaria (GFATM), which focused on financial support for selected parts of the NSP. In addition support was given for the development of PMTCT guidelines and infection-control guidelines and associated training of trainers (TOT). Other UN agencies have been actively involved in both processes, and also provided technical and/or financial support in specific areas: e.g. UNFPA supported a number of studies on most-at-risk populations; the ILO Regional Office for the Middle East has been supporting the development of a policy on HIV/AIDS in the world of work with the Ministry of Labour, the Syrian Chamber of Commerce and the Labour Union. Furthermore, UNDP will be acting as principal recipient (PR) of the Round-10 GFATM grant, and will thus be heavily involved in implementing key components of the NSP that are supported by this GF grant.

Other donors have not been supporting HIV/AIDS-related programmes and services, as Syria is a middle-income country with low HIV prevalence; therefore HIV/AIDS is not among the priorities of most donors in the region.

### *Future support from development partners*

As mentioned earlier, in addition to the technical and financial support that the UN system has been providing in 2010-2011, UN agencies can play an important role in facilitating the implementation of specific components of the NSP, which have so far not been implemented for a variety of reasons.

UN agencies can play a particularly important role by actively engaging the NAP and other national partners (line Ministries, NGOs, national associations, unions, religious and community leaders) in specific components of the NSP. UN agencies have a unique added value in specific technical areas, and can help mobilise the political, financial and technical support needed to implement NSP components on these areas, especially with regard to HIV-prevention activities for MARP groups, young people and most-at-risk adolescents, in the workplace, and other areas. These *partnerships* between NAP, UN agencies and other partners will be essential for a break-through in those areas of the NSP that will fail to be implemented unless focused support from partners is provided.

# VII. MONITORING AND EVALUATION ENVIRONMENT

## (a) Overview of the current monitoring and evaluation (M&E) system

To date, Syria has not had a proper *system* for monitoring and evaluation of HIV/AIDS, nor has it developed a joint national M&E *plan* to systematise the collection, reporting, storage and utilisation of all HIV-related data for planning and programming purposes.

The available HIV-related data is mainly based on large-scale HIV screening of selected population groups (blood donors, premarital testing, migrant labourers) and specific settings (prison, STI, TB patients); as well as data from clinical monitoring of HIV patients. However, there is no HIV-surveillance system that accurately assesses HIV prevalence among the general population, nor among most-at-risk groups, such as sex workers, MSM and IDUs, although IDUs are tested to some extent through police, prisons and drug-treatment facilities (but this does not represent systematic data).

A number of behavioural surveillance studies have been conducted among young people, sailors, truck drivers, IDUs and MSM, but most of these studies were conducted more than six years ago, and need follow-up research. In addition, many of the studies lacked scientific rigour, and future research will need to be conducted in a more systematic manner. In this regard, the absence of a national research agenda to identify research priorities in the HIV field is an important gap.

Furthermore, given the limited experience with HIV-prevention programmes among the general population or MARP groups, programmatic M&E data is mainly restricted to clinical monitoring of HIV patients. There is hardly any M&E data on coverage of other programmes.

Adequate financial monitoring of HIV interventions is difficult, as there is no central overview of HIV expenditures; most HIV-related expenditures are not earmarked as such. Therefore it is difficult to get an accurate overview of expenses made in the context of HIV/AIDS. E.g. the financial matrix in the context of this GARP report has many gaps that could not be filled for lack of data. Most of these costs are for HIV screening, ARV treatment and ART monitoring (laboratory), while much smaller amounts are spent on other interventions, especially in the field of HIV prevention.

## (b) Challenges faced in the implementation of a comprehensive M&E system and remedial actions to be taken

*Specific challenges* with regard to current M&E systems include the following issues:

1. Absence of national M&E plan and framework on HIV/AIDS;
2. Inaccuracies and gaps in data collection;
3. Availability, accessibility and utilisation of HIV-related data; and
4. Adequate human resources and infrastructure for HIV-related data management.

1) In the absence of a comprehensive national surveillance and M&E Plan and Framework for HIV/AIDS, it will difficult to develop and roll out a systematic approach to HIV data management. Therefore, a priority *remedial action* is the development of a national M&E plan and system as already stipulated in National Strategic Plan 2011-2015 and its costed Operational Plan. Funds for the development of this plan and for rolling out key components of the system will be available through the Round-10 Global Fund grant that Syria secured last year. The grant will have a very strong focus on strengthening all aspects of surveillance,

research and M&E systems. The implementation of this grant should be started as soon as possible.

*2) Inaccuracies and gaps in data collection:* Official HIV data rely mainly on reporting of HIV cases found through health services and screening activities. However, this system does not give an accurate picture of HIV among vulnerable groups of the general population – such as most-at-risk adolescents – and especially with regard to HIV rates among MARP groups. People with high-HIV-risk behaviours typically tend to screen themselves out for standard screening programmes, such as for blood donors, premarital testing and pre-employment testing. In addition to inaccuracies with regard to HIV surveillance among the general population, there are *significant gaps* with regard to special studies on MARP groups and other vulnerable populations. Positive in this regard is the fact that there is already some experience with studies among MARP groups that can be built on. In addition, and as a result of the lack of interventions in the prevention field, there is no specific experience or systems for monitoring of interventions in this field.

Hence, *remedial actions* in this area involve the establishment of a system of integrated biological and behavioural surveillance (IBBS) studies, specifically focusing on MARP groups. Syria already has experience with a bio-behavioural study among IDUs in 2006, which can serve as the basis for additional studies on other groups. In addition to systematic "second-generation surveillance" among key populations, a research agenda is needed to ensure that priority research topics are identified and systematically addressed. Here too, detailed plans for these activities and earmarked funding is already available through the NSP 2011-2015 and the Global Fund grant. Hence, implementation depends on initiatives by NAP and key stakeholders, such as UNDP (principal recipient of GF grant) to start taking the necessary steps in early 2012.

3) Apart from the gaps in data *collection*, there are also problems regarding the *availability and accessibility of data*. While most HIV data is collated and available at the NAP, there is no true central database that contains all HIV-related data. E.g., financial data collection is hampered due to a lack of clear financial monitoring systems. A priority *remedial action* in this field is the establishment of a central database on HIV at the MOH-NAP, using exiting health information systems and staff. This will require improved infrastructure and equipment, as well as staff training. The database needs to be the basis for evidence-informed decision-making regarding HIV policies, programmes and resource allocation.

4) The lack of a unified national M&E system is further compounded by the *absence of dedicated, trained data-management staff in the NAP* at MOH. Hence, *remedial action* involves capacity building in this field to ensure adequate operation of M&E systems. This also applies to civil society organisations, which will be expected to play an increasingly important role in the national response, and who will (therefore) need to establish effective programme M&E systems, as well as conduct operational research.

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# ANNEXES

ANNEX 1: National Commitments and Policy Instrument (NCPI)

*(see separate file)*