

# UNGASS COUNTRY PROGRESS REPORT 2010

## SYRIAN ARAB REPUBLIC (SAR)

### Narrative Report (Draft)

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*Glossary of terms*

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Therapy
CSO	Civil Society Organization
HIV	Human Immunodeficiency Virus
MARPs	Most at risk populations
MENA	Middle East and North Africa
MOH	Ministry of Health
MOHE	Ministry of Higher Education
MSM	Men Having Sex With Men
NAP	National AIDS Program
NGOs	Non governmental Organizations
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RST	Regional Support Team
STI	Sexually Transmitted Infection
UNAIDS	The United Nations Joint Programme on HIV/AIDS.
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
WHO	World Health Organization

I. Status at a glance

(a) the inclusiveness of the stakeholders in the report writing process

The 2010 UNGASS Report enclosed has been prepared with the direct involvement of most stakeholders in the HIV/AIDS response in Syria. This included several governmental partners. Within the Ministry of Health, the NAP played a major role in providing coordination (content and logistics) for the report preparation. This is despite the turnover in the leadership of the NAP during the report preparation phase. Other governmental agencies involved included the Ministry of Higher Education, Ministry of Information, Ministry of Defense (through the National Blood Bank) and the Ministry of Interior. All of these government agencies showed commitment and provided information that were instrumental in completing the report.

International organizations, especially UN agencies, play a pivotal role in the Syrian Arab Republic's response to HIV/AIDS. Such devotion has been mirrored in their commitment to helping Syria in the completion of its first UNGASS report. Members of the UN Theme Group, including UNFPA, UNDP and UNICEF, gladly entertained data requests for the report and made available information that they possessed regarding HIV/AIDS. The main three CSOs involved in HIV/AIDS in Syria, Family Planning Organization, Revolution Youth Organization and the Red Crescent were also involved in the data collection for the report and provided valuable insights into the report elements.

It is worth noting that in addition to the valuable and individual contribution of the organizations/entities mentioned above to the UNGASS report, they were generous with their time devoted to the meetings held to discuss and validate the different processes involved in the UNGASS reporting. Regards are also due to individuals involved in previous technical assistance to the Syrian Arab Republic who helped in further understanding the nature of the disease and response in the country. Lastly, if not for the contribution PLHIVs, MARPs and General Population to previous needs assessments, the report would have missed an important viewpoint.

(b) The status of the epidemic

Similar to a number of countries in the region, the Syrian Arab Republic has a low-level concentrated HIV epidemic.<sup>1</sup> This mentioned, it has to be noted that a trend of increasing rates have been observed in the past few years.<sup>2</sup> For example, the number of registered new cases was under 20 between 1986 and 1993, this rate has increased to under 40 between 1993 and 2004 and more than 40 between 2004 and 2008. A more in-depth description of the nature of the disease and the response is presented in the sections below.

(c) The policy and programmatic response

Although the Syrian Arab Republic has a number of opportunities to further enhance its response to HIV/AIDS, certain milestones achieved in recent years are worth noting. These include:

- HIV /AIDS control has been listed in the Syrian National Five-year Development Plan for 2007-2011. The Plan is currently being revised for the next cycle and based on feedback received from multiple parties, there seem to be a consensus that the next Plan will either equal or enhance the national commitment to HIV
- Various activities conducted over the previous years in the area of HIV prevention , and involving different governmental and non-governmental entities, have shifted the response to the disease from being concentrated at the Ministry of Health to one that is multi-sectorial
- Policy advocacy have been one of the strategies employed by HIV/AIDS stakeholders, especially among parliament members. This resulted in a seemingly more accepting policy environment. The near future would indicate whether the

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<sup>1</sup> Epidemiological Fact Sheet on HIV and AIDS, Core data on epidemiology and response, October 2008, WHO, UNAIDS, UNICEF

<sup>2</sup> HIV/AIDS Situational Analysis and Risk Assessment, 2009

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- HIV/AIDS response community would be able to capitalize on such an investment
- The executive branch of the government (e.g. Ministry of Health) has been supportive of efforts to improve the accessibility of PLHIV to needed care and support services. More than one decree has been passed that addressed the issue of access by PLHIV to services
  - The presence of a specialized AIDS laboratory network across the country consisting of 14 laboratories (one in each governorate). These laboratories constitute a major element in current surveillance effort and can play a key role in the further evolution of HIV/AIDS surveillance.
  - The involvement of the non-governmental sector in the response to HIV/AIDS through multiple venues. The most prominent of which is the establishment of VCT centers and participation in awareness campaigns for certain vulnerable groups, e.g. youth.

(d) UNGASS indicator data in an overview table

Serial	Indicator	Remarks
<b>Reported Indicators</b>		
1	<u>Indicator 1</u> : Domestic and International AIDS Spending	1.66 million USD in 2007 2.01 million USD in 2008 2.02 million USD in 2009 Spending is mostly from domestic sources (public spending is approximately 70-80% of total spending)
2	<u>Indicator 2</u> : National Composite Policy Index	Completed
3	<u>Indicator 3</u> : Percentage of donated blood units screened for HIV in a quality assured manner	Online reported rate: 0% 100% of the donated blood units in Syria are screened for HIV/AIDS. However, there are some logistical barriers to ensuring a consistent internal quality assurance program across all AIDS laboratories in Syria, as well as the Blood Bank. There are plans by the National Blood Bank to include an external quality assurance standard in the near future. None of the 378,921 blood units donated in 2008 was from HIV positive individuals; 1 case of HIV was detected through blood donations in 2009. Total donated blood donors in 2009 was 409,684

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4	<u>Indicator 4:</u> Percentage of Adults and Children with advanced HIV Infection receiving ART	<p><b>2008 Reporting Year:</b>  <u>Total:73</u>  Males&lt;15:2  Males=&gt;15:49  Females&lt;15=4  Females=&gt;15=18</p> <p><b>2009 Reporting Year:</b>  <u>Total:99</u>  Males&lt;15:3  Males=&gt;15:63  Females&lt;15=5  Females=&gt;15=28</p>
5	<u>Indicator 5:</u> Percentage of HIV-positive pregnant women who receive ARV to reduce the risk of MTCT.	<p><b>2008 Reporting Year:</b> 0  <b>2009 Reporting Year:</b> 2  Treatment Regimen: C (based on core indicator guide classification)</p>
6	<u>Indicator 6:</u> Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	There were 0 confirmed cases in 2008 and 2009.
24	<u>Indicator 24:</u> Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART	<p><b>2008 Reporting Year:</b>  <u>Total:5</u>  Males &lt;15=0  Males =&gt;15=2  Females&lt;15=1  Females=&gt;15=2</p> <p><b>2009 Reporting Year:</b>  <u>Total:16</u>  Males &lt;15=0  Males =&gt;15=12  Females&lt;15=0  Females=&gt;15=4</p>
25	<u>Indicator 25:</u> Percentage of infants who are born to HIV-infected mothers who are infected	Modeling will be conducted once data collection is finalized.
<b>Indicators with no information to report on/ Irrelevant to Syria</b>		
7	<u>Indicator 7:</u> Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	HIV testing in Syria is mainly done at the 14 laboratories spread across the governorates which are part of the National AIDS Laboratory Network and organizationally report to the Central AIDS laboratory in Damascus. The laboratories send the NAP forms on a monthly basis indicating the number of HIV tests and test results. In addition, testing is performed at the National Blood Bank. No private

		laboratories test for HIV in the country. Most of the ‘clientele’ of the 14 laboratories constitute (1) individuals who are referred to by the 16 VCT centers for positive specimens; these are not a significant number, (2) individuals (mostly MARPS) who are arrested and (3) individuals required by law to do the testing (e.g. employment and residency requirement). The donors in the National Blood Bank constitute mainly low-risk groups doing the test because it is a requirement for the completion of documentation of certain activities (e.g. driver’s license, university admission, etc.). Table 3 includes the number of HIV tests conducted and the test results.
8	<u>Indicator 8: Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results</u>	<p>From a programmatic standpoint, the data presented in table 3 revealed some information on MARPs who underwent the HIV test and the rate of detection of HIV among those groups. However, it has to be noted that most of these MARPs (except those referred through VCT centers) whose data is presented above have done HIV test because it is mandatory (arrest, paper documentation, etc.).</p> <p>The review of a survey conducted among sailors in 2005 revealed that 92.4% of respondents had undergone testing for HIV; the testing was mandatory for 67% of those and 96.7% were informed about their test results.<sup>3</sup> Another survey conducted among long distance truck drivers in the same year revealed that 51% have undergone an HIV test; the testing was compulsory for 50.5% and 94.2% were informed of their test results.<sup>4</sup> In a third survey conducted among youths/students who are away from their families, only 22.5% took the HIV test voluntarily; no information was presented to reveal whether the results were known.<sup>5</sup> A survey among MSMs indicated that the feeling of stigma and shame is a barrier for seeking testing.<sup>6</sup></p>
9	<u>Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programs</u>	Implementing HIV prevention programs among MARPS in Syria is particularly challenging mainly because of legal and law enforcement barriers (mainly among MSMs, IDUs and FSWs). This is further complicated by the fact that some MARPs

<sup>3</sup> KAP Survey among Sailors in Syria. NAP. 2005

<sup>4</sup> KAP Survey among Truck Drivers. NAP. 2005

<sup>5</sup> KAP Survey among Youths Away from Their Family. NAP. 2005

<sup>6</sup> KAP Survey among Homosexuals. NAP. 2006



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		<p>have shortcomings in their knowledge of HIV transmission.<sup>7</sup> For example, only 56% of youth/students living away from their families identified a condom as a means for HIV prevention.<sup>8</sup> A worth noting finding is of those reporting using condoms, only around 6.3% stated that they received from a health center since condoms are distributed only in family planning clinics. This further validates the assumption that prevention/outreach activities are limited. Furthermore, the information collected by the VCT centers does not easily identify individuals who visit the centers as MARPs which limits the ability to quantify their reach out to such populations. Another potential issue with VCT centers is concerns raised by MARPs in the assessments regarding confidentiality assurances in these centers.</p>
10	<u>Indicator 10:</u> Percentage of orphans and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	The indicator is irrelevant to Syria’s HIV/AIDS context.
11	<u>Indicator 11:</u> Percentage of schools that provided life-skills based HIV education within the last academic year	The Ministry of Education introduced HIV/AIDS prevention concepts in the curricula of grades 7, 9 and 11. Furthermore, there have been initiatives undertaken by the Ministry, such as the FRESH School Initiative, that introduces HIV/AIDS concepts through participatory learning. <sup>9</sup> The initiative also includes developing skills-based material targeted at students and teachers. However, there are no school surveys providing relevant information regarding this indicator.
12	<u>Indicator 12:</u> Current school attendance among orphans and non-orphans aged 10–14	Primary school enrollment in Syria was 100% in 2004 with 49% of students in primary school being females. <sup>10</sup> There is no information on the attendance by orphans vs. non-orphans.
13	<u>Indicator 13:</u> Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who	No population surveys conducted are available to fully report on this indicator. However, in collaboration of UNICEF and the Family and Social Department of Arab League States, the MOH conducted a survey of women aged 15 to 49 years in

<sup>7</sup> HIV/AIDS Situational Analysis and Risk Assessment, 2009

<sup>8</sup> KAP Survey among Youths Away from Their Family. NAP. 2005

<sup>9</sup> HIV/AIDS Situational Analysis and Risk Assessment, 2009

<sup>10</sup> National information Center & Central Bureau of statistics, 2006

	reject major misconceptions about HIV transmission	2006. The survey included items on HIV knowledge and revealed that only 78.5% have heard about HIV/AIDS. Results revealed that the only 7.9% had good knowledge of about modes of transmission. Two other surveys inform this indicator. The first was among students/youth living far from their families. The survey included 100 students aged 18 to 25 years and spread across two governorates (Damascus and Aleppo). The knowledge level was noteworthy and reached 85% when modes of transmission were assessed. <sup>11</sup> The second survey was conducted among six hundred youth aged 15 to 24 who were out of school and lived mostly in the Damascus and Rural Damascus governorates. <sup>12</sup> The knowledge of respondents who only had a primary education was lower than that of secondary school attendees.
14	<u>Indicator 14:</u> Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	A number of surveys among MARPs assessed the knowledge of these groups of modes of transmission and prevention. A survey among FSW was conducted in 2006 by the NAP, in which 400 FSWs from Damascus were interviewed. Interviewees had acceptable knowledge of HIV prevention methods (75% identified three methods). Another small survey (28 participants) was conducted among MSMs in 2006. The findings revealed very poor knowledge of HIV transmission and prevention methods. <sup>13</sup> A survey of 200 sailors in the Tartous seaport revealed a high level of awareness and knowledge of HIV/AIDS, especially modes of transmission. Ninety percent of respondents were able to name three methods of prevention. Similar findings were observed among truck drivers <sup>14</sup> with 75% able to name three HIV/AIDS prevention methods.
15	<u>Indicator 15:</u> Percentage of young women and men who have had sexual intercourse before the age of 15	Information is not available on that indicator.
16	<u>Indicator 16:</u> Percentage of women and men aged 15–49 who have had sexual intercourse with	An HIV/AIDS KAP survey was conducted among the general population in 2006 that included 2,000 households in Damascus and Aleppo. The survey
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<sup>11</sup> KAP Survey among Youths Away from Their Family. NAP. 2005

<sup>12</sup> KAP Survey among Youths out of School. NAP. 2005

<sup>13</sup> KAP Survey among Homosexuals. NAP. 2005

<sup>14</sup> KAP Survey among Sailors. NAP. 2005

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	<p>more than one partner in the last 12 months</p> <p><u>Indicator 17:</u> Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse</p>	<p>revealed that 10% of men reported having sex with a non-regular partner in the last 12 months; Of those, 32% were married men.<sup>15</sup> Condom use was reported only among 41.7% of men who reported having extramarital sexual intercourse. The rates were not reported among females.</p>
18	<p><u>Indicator 18:</u> Percentage of female and male sex workers reporting the use of a condom with their most recent client</p>	<p>The illegality of sex work and absence of mapping for this group limits the ability to collect data on this group. No specific data is available on the indicator. However, a survey of four hundred FSWs in Damascus showed that only 54.8% use a condom. It was found that only 13.2% of always used condoms with clients; with 51% and 15.2% sometimes using condoms and 15.2% never using condoms.<sup>16</sup></p>
19	<p><u>Indicator 19:</u> Percentage of men reporting the use of a condom the last time they had anal sex with a male partner</p>	<p>In focus groups of 28 MSMs conducted by NAP with the collaboration of UNAIDS, the use of condom was found to be very low.<sup>17</sup></p>
20	<p><u>Indicator 20:</u> Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse</p>	<p>HIV prevalence in IDU have been estimated to be 0.31%.<sup>18</sup> No further information is available on the use of condom among IDUs.</p>
21	<p><u>Indicator 21:</u> Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected</p>	<p>The use of high-risk behavior among injecting drug users in the Middle East and North Africa (MENA) Region is well-documented, especially needle sharing.<sup>19</sup> In Syria, it is estimated that injecting equipment sharing occurs in 47% of IDUs.<sup>20</sup></p>

<sup>15</sup> KAP Survey among the General Population. NAP. 2006

<sup>16</sup> A Survey of FSWs in Syria. NAP. 2005

<sup>17</sup> KAP Survey among Homosexuals. NAP. 2006

<sup>18</sup> Aceijas C, Stimson GV, Hickman M, Rhodes T (2004). Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users. AIDS 18: 2295-2303.

<sup>19</sup> Altaf A, Shah SA, Zaida NF, Memom A, Nadeem R et al (2007). High Risk Behaviors of Injection Drug Users Registered with Harm Reduction Programs in Karachi, Pakistan. Harm Reduct J 4: 7; Parviz S, Fatmi Z, Altaf A, McCormick JB, Fischer-Hoch S et al (2006). Background Demographics and Risk Behaviors of Injecting Drug Users in Karachi, Pakistan. Int J Infect Dis 10: 364-371; Razzaghi EM, Movaghar AR, Green TC, Khoshnood K (2006). Profiles at Risk: A Qualitative Study of Injecting Drug Users in Tehran, Iran. Harm Reduct J 3: 12; SAR AIDS, The World Bank (2008). Mapping and Situation Assessment of Key Populations at High Risk of HIV in Three Cities of Afghanistan. Human Development Sector, South Asia Region, The World Bank.

<sup>20</sup> UNODC ROMENA and UNAIDS MENA RST. Assessment of HIV Risk and Sero-prevalence among Drug Users in Greater Damascus .

22	<u>Indicator 22: Percentage of young people aged 15-24 who are HIV-infected</u>	Data from NAP reveals that there are a total of 117 cases of HIV/AIDS cases in that age group. This is lower than Spectrum estimates which were 429, <sup>21</sup> which is to be expected since Spectrum using an estimation model beyond what is reported (Table 2).
23	<u>Indicator 23: Percentage of most at risk populations who are HIV-infected</u>	There is limited information on the prevalence of HIV/AIDS among MARPs in Syria because of the lack of accurate information on the total number of MARPs. However, there have been some estimates based on models. For example, the estimated percentage of HIV in IDUs is 0.3%. <sup>22</sup>

Table 1. Number of HIV tests done and number of positive tests among different groups in Syria in the year 2009, NAP

Group tested	Total number of HIV tests	Number of HIV positive tests
STI patients	505	0
FSW	878	0
Bar girls	8479	0
MSM	47	0
IDU	386	0
Blood recipients	127	0
Sexual contact of AIDS patients	10	6
Suspected AIDS patients	2846	23
Prisoners	1172	0
TB patients	56	0
Long distance truck drivers	699	0
Voluntary counseling and testing	2678	7
Non-injection drug users	1002	0
Dialysis patients	4358	0
Taxi drivers	10	0
Blood donors	409684	0
In-migrants	58064	29
Out-migrants	66815	3
Premarital tests	3388	1
Club workers	2911	0
Health survey	751	0
Unsexual contact of AIDS	15	1
<b>Total</b>	<b>564,871</b>	<b>70</b>

<sup>21</sup> WHO. 2008

<sup>22</sup> Aceijas C, Stimson GV, Hickman M, Rhodes T (2004). Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users. AIDS 18: 2295-2303.

Table 2. HIV/AIDS cases by age and sex, 15-24 age group

	Cumulative total (1987-2008) $\parallel$			Cumulative total (1987-2008) $\mp$		
	HIV/AIDS			HIV/AIDS		
(Year)	Male	Female	Total	Male	Female	Total
No.	45	72	117	301	128	429
%	0.0021	0.0036	0.0028	0.014	0.006	0.010

$\parallel$  NAP numbers;  $\mp$  Spectrum estimates

## II. Overview of the AIDS epidemic

A total of 627 HIV/AIDS cases have been reported from 1987 through 2009. AIDS cases comprised 41.0% (257); HIV cases were 370.<sup>23</sup> The majority of HIV/AIDS cases (54.8%) were reported among Syrians with the rest being among non-Syrians. Most cases occurred in the 20-39 age group with a slightly higher percentage of HIV cases occurring in females (205, 55.4%) and more males classified as AIDS cases (196, 76.3%). The main mode of transmission remains through heterosexual intercourse (86.5% of HIV cases and 69.3% of AIDS cases).

Table 3. HIV/AIDS cases by age and sex

Age	Cumulative total (1987-2009)				Cumulative total (1987-2008)			
	HIV			AIDS				
(Year)	Male	Female	Unkno wn	Total	Male	Female	Unkno wn	Total
<b>0-4</b>	1	4	0	5	2	4	0	6
<b>05- 09</b>	1	2	0	3	5	0	0	5
<b>10-14</b>	1	2	0	3	1	1	0	2
<b>15-19</b>	10	11	0	21	4	2	0	6
<b>20-24</b>	22	63	0	85	12	3	0	15
<b>25-29</b>	39	59	0	98	22	10	0	32

<sup>23</sup> NAP-Syria data, 2009

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<b>30-34</b>	30	38	0	68	33	9	0	42
<b>35-39</b>	25	16	0	41	44	9	0	53
<b>40-44</b>	7	3	0	10	26	6	0	32
<b>44-49</b>	9	0	0	9	16	11	0	27
<b>50+</b>	8	4	0	12	30	6	0	36
<b>Unknown</b>	12	3	0	15	1	0	0	1
<b>Total</b>	165	205	0	370	196	61	0	257

Table 4. HIV/AIDS Mode of transmission

Mode of transmission	Cumulative total (1987-2008)			Cumulative Total (1987-2008)		
	HIV			AIDS		
	Male	Female	Total	Male	Female	Total
<b>Heterosexual</b>	127	193	320	<b>129</b>	49	178
<b>Homosexual/bisexual</b>	5		5	<b>29</b>		29
<b>Blood &amp; Blood product</b>	4	3	7	<b>17</b>	5	22
<b>Injecting drug use</b>	5	0	5	<b>13</b>	0	13
<b>Mother to child</b>	3	5	8	<b>4</b>	5	9
<b>Unknown</b>	21	4	25	<b>4</b>	2	6
<b>Total</b>	165	205	370	<b>196</b>	<b>61</b>	257

### III. National response to the AIDS epidemic

Countries should specifically address the linkages between the existing policy environment, implementation of HIV programs, verifiable behavior change and HIV prevalence as supported by the UNGASS indicator data.

The national response to HIV/AIDS in Syria has shown some progress in recent years. However, many areas remain in need for further development. The sections below

highlight specific areas within the policy environment, prevention and treatment where developments were made and their potential effect.

*(a) Political leadership & supportive policy environment*

Historically, the political support for the HIV/AIDS response and commitment to affected individuals has been noteworthy. The scale and policy exposure of the issue of HIV/AIDS have gained interest in recent years, especially with media campaigns that address the issue of stigma. The role of the Ministry of Information, with support from several HIV/AIDS stakeholders, has been a key on that front. This has been supplemented with activities targeted at policy makers to increase their awareness of the issues/obstacles facing the HIV/AIDS response. An example is the participation of members of the Syrian Parliament in a one day workshop in 2006 to discuss the status of AIDS in Syria and related policies; the workshop also discussed strategies to address the HIV/AIDS stigma in the society. In addition, a Syrian Parliament Member has recently joined the National AIDS Committee.

It has to be noted, however, that support has been historically tilted towards endorsing activities targeting education and prevention of the general public, rather than addressing the impact of the disease in the most vulnerable groups, e.g. MARPs, or affected population (PLHIV). The latter has been addressed by a Ministry of Health regulation (Regulation No 38, Ministry of Health) that was passed in 1997 specifically mentioning that civil rights of all Syrian Citizens infected with HIV are protected including their rights of access to medical care, social care, education and employment. However, studies done recently with PLHIVs indicated a continuing concern over the rights mentioned in the decree, especially as it relates to obtaining medical treatment and job opportunities.

Another policy/legal theme relates to MARPs is since the Syrian Arab Republic is classified as a concentrated low-epidemic country as it relates to HIV/AIDS, special attention should be directed to that group. Historically, there have been limited activities targeting MARPs such as needs assessment studies. However, the recent leadership of the Ministry and the Directorship of Communicable and Chronic Disease are supportive of

the NAP's planned events to focus on vulnerable groups in the work plan for the following few years. It would facilitate translating such commitment into action is the presence of an enabling policy environment for the involvement of CSOs with activities focusing on MARPs.

*(b) Prevention programs*

Most prevention efforts in the Syrian Arab Republic are geared towards the general population, with a focus on youth in recent years.<sup>24</sup> At the core of these efforts are communication and awareness campaigns conducted by various ministries, CSOs and the NAP. For example, the Ministry of Information spearheaded a national media campaign (national television stations, radio and press) to promote better knowledge of HIV/AIDS. The Ministry of Higher Education organized seminars in University Cities and the Ministry of Education introduced HIV/AIDS prevention concepts in the curricula of certain middle and high school grades. CSOs also conducted different awareness campaigns, among which is a peer education program developed by the Syrian Family Planning Association targeting youth and some MARP groups (prison inmates and FSWs). It is the hope that prevention efforts would evolve to include targeted action-oriented activities, e.g. condom distribution and clean needle exchange programs.

Currently, the Syrian Arab Republic has 16 VCT centers; 8 centers are run by the NAP, 7 by the Family Planning Association and 1 by the Red Crescent. Findings from testing conducted at these VCT centers do not reveal a high case detection rate.<sup>25</sup> Furthermore, there is little evidence on what roles exactly these centers play in providing support for PLHIV or their attempts to target/attract MARPs.

*(c) Care, treatment and/or support programs*

In terms of treatment provision, Syria has a system where the patient prospectively chooses in which governorate AIDS office s/he would like to receive

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<sup>24</sup> HIV/AIDS Situational Analysis and Risk Assessment, 2009

<sup>25</sup> Ibid



treatment. this procedure is installed to preserve anonymity, an issue of concern among PLHIV as revealed in previous assessments. ARV treatment in Syria is provided free of charge and available to all patients in need of medications. However, the available medication is limited to a combination of two nucleotide-reverse transcriptase inhibitor (NRTI) and one non nucleotide-reverse transcriptase inhibitor (NNRTI) and there are no alternatives in case of intolerance or resistance. The country is also in need of treatment prophylaxis and palliative therapy guidelines, as well as post-exposure prophylaxis guidelines. Furthermore, the number of physicians in HIV care and management is small, partly due to the small number of PLHIV/AIDS in Syria.

In 2009, there were 99 individuals who were receiving ARV treatment. Of those, 3 were males younger than 15 and 63 were males 15 years of age and older. On the other hand, there were 33 females receiving ARV treatment, 5 younger than 15 and 28 who were 15 years and older.

#### IV. Best practices

A number of achievements/milestones that happened in Syria in the past few years are worth noting.

- (1) A number of needs assessments have been conducted in the past few years that helped in better understanding the gaps that exist in the HIV/AIDS response. These include, but are not limited to, HIV/AIDS Situational Analysis and Risk Assessment, Needs Assessment of People Living with HIV in Syria, and Assessment of Surveillance Activities.
- (2) The nature of the HIV/AIDS response have witnessed a paradigm shift from single involvement of Ministry of Health to involving multiple governmental agencies including the Ministry of Information, Ministry of Education, Ministry of Higher Education and other agencies. This multi-sectorial involvement will undoubtedly have an effect on the impact of the response.
- (3) There is a revived commitment from the leadership of the Ministry of Health and the Directorship of the Communicable and Chronic Disease on the issue of

- HIV/AIDS. This is indicated by their commitment to facilitate and assist in preparation of UNGASS report for the first time, as well as a number of intra-organizational arrangements to enhance the response level.
- (4) The great supporting role of the HIV theme group among UN agencies has been a key factor in maintaining the level of HIV/AIDS response throughout recent years. This has been achieved through the provision of financial, programmatic and technical means.
  - (5) Although the number of CSOs involved in the HIV/AIDS response remains limited, but those that are involved made considerable contributions to prevention, treatment and support services, e.g. VCTs, campaigns, etc.

#### V. Major challenges and remedial actions

The abovementioned milestones in Syria's HIV/AIDS response is matched with a number of major challenges that have to be addressed. Some of these can be addressed through short- and medium-term remedies, while others would need considerable investments with longer-term impacts.

- (1) The Syrian Arab Republic does not have a National Strategic Plan (NSP) and an Operational Plan. This is considered a major challenge to the HIV/AIDS response in that country. In the absence of an NSP and OP, the targeted and cohesive response will not exist and the response will continue to be shortcoming and potentially inefficient and ineffective. The remedial action for such a shortcoming can be addressed relatively in a short-time frame, if there is a national commitment to participate in such a needed activity. The timing also would be optimal since the National Development Plan will be for years 2011-2016. As such, if a NSP and OP to be developed in 2010, a syncing of both plans is possible (*short-term*).
- (2) The surveillance system in the Syrian Arab Republic can be significantly improved. This has been noted in recent WHO mission and report that assessed the current situation and suggested remedial actions (*medium-term*).

- (3) There is no monitoring and evaluation system for HIV/AIDS in the country. Most M&E activities are being conducted on a per-needed basis with much time and energy invested to obtain indicators with questionable reliability (*short- to medium-term*).
- (4) There is a scarcity of CSOs that are directly involved in the HIV/AIDS response. The current CSOs, supporting AIDS/HIV program, are mainly human resources agencies who cater for a wide range of social services. Their involvement in HIV/AIDS has been primarily to address a gap in the response and, to a lesser degree, to capitalize on resources that may be available for HIV/AIDS. Although the efforts of these CSOs have been instrumental in the sustenance of response to date, there is a great need for CSOs to develop whose primary role is to address gaps in the social commitment to the disease. However, for this to happen, a welcoming political environment should exist, as well as resource support (*medium to long-term*).
- (5) The NAP office in the Syrian Arab Republic has played the most important role in the HIV/AIDS response to date. However, frequent turnover in leadership and staffing/productivity issues may have prevented it from delivering its full potential given the level of experience accumulated since its inception in 1987 (*short- to medium-term*).
- (6) The nature of the epidemic in the country should make the MARPs constitute the focus of surveillance and response, which has not been the case so far. Syria can take some significant steps in addressing that shortcoming through the following actions:
  - a. Mapping activities (*short- to medium-term*)
  - b. Tailored prevention campaigns (*medium to long-term*)
  - c. Social support services (*short- to medium-term*)
  - d. Harm reduction strategies (*short- to medium-term*)This approach is may be necessary to achieve an effective prevention strategy. However, to initiate such activities, there should be political, legal and social/religious support.

- (7) The involvement of PLHIV in decision making/advisory capacities is currently sub-optimal and can easily be improved (*short-term*).
- (8) The support for laboratory and testing services at the Syrian Arab Republic has been acceptable. However, given the critical role the testing facilities play in the surveillance efforts of any country, there is room for improvement at two levels, the AIDS laboratory Service and the National Blood Bank. The leadership of both services showed a commitment to enhanced quality and that commitment should be supported to be translated into action (*medium to long-term*).
- (9) The number of VCT clinics in the Syrian Arab Republic remains small and the effectiveness of such clinics is unclear. As such, there is a need to expand the number of VCT clinics and the scope of its activities. This requires financial and logistical support, as well as human capacity building (*medium to long-term*).
- (10) The number of clinics specialized in treatment and management of HIV and STI is small and Syria may benefit from establishing such specialized clinic and provide training to health care professionals.

#### VI. Support from the country's development partners

For the above mentioned challenges to be addressed and remedial actions to be realized, a considerable investment by the country's development partners should be committed. Although it has to be noted that these have been very supportive in Syria's to-date HIV/AIDS response approach, the nature and scale of support have to be enhanced. Such an upscale of involvement has been observed in 2009 with the support of several needs assessment missions. Given that the main gaps have been identified, remedial actions preliminary chartered and there is a renewed political support, it is expected there would be a shift towards a more focused and action-oriented support. Such a shift would require a three-angled support strategy: financial, logistical and technical.

## VII. Monitoring and evaluation environment

The Syrian Arab Republic still lacks a formal monitoring and evaluation plan and structure. There are information on the response in terms of coverage, prevention and services. However, these remain very scattered and require a solid synthesis to transform into a monitoring and evaluation system. No clear channeling of information occurs among the different parties involved in the HIV/AIDS response including the AIDS laboratories, governorates offices, VCTs and NAP. In the absence of such system, reliance is on on-the-spot as-needed information gathering. Even data that is present in NAP is not filed automatically for easy retrieval.

An assessment of the surveillance system was conducted that highlighted the need for a stronger surveillance system and structured monitoring and evaluation plan. The existence of such a system can inform the planning and evaluation efforts of the HIV/AIDS response in the country

The following action can serve as a preliminary roadmap for addressing the gaps in the M&E system:

- 1- Conducting an analysis of the current M&E system
- 2- The establishment of a national M&E committee or working group with a clear mandate and terms of reference to coordinate M&E activities
- 3- The approval of a designated budget for the implementation of M&E plans and activities
- 4- Building M&E capacity at the NAP level
- 5- Formalizing the design of an M&E system with associated data collection tools, points, indicators, communication routes, responsibility centers and dissemination approaches, as well as clear timeframes