Strengthening HIV prevention among most-at-risk populations (MARPs) in the Syrian Arab Republic

The Integrated Bio-Behavioral Survey (IBBS) in Syria: 2013-2014

Final Report

Prepared by:
Dr. Loulou Kobeissi, MPH, DrPH
Epidemiologist
Los Angeles Country-Department of Public Health
Division of HIV/STIs Program
Assistant Professor
School of Middle Eastern and North African Studies
University of Arizona

Oct. 13, 2014

Published by:
UNDP, Country Office Syria
Ghazawi Street, 8
West Villas, Mazzeh
Damascus-Syria
Website: www.undp.org.sy

This work was supported by a grant from the Global Fund to support the National AIDS Programme in Syria

Forward

Syria is a low prevalence HIV/AIDS country and the number of PLWHIV is very low when compared with other countries in the region. However, the studies and research conducted in relation to HIV were very limited and lack of conclusive evidence.

The Global Fund to Fight AIDS, Tuberculosis and Malaria, GFATM has approved a grant for Syria in 2011; United Nations Developing Programme, UNDP was selected to be the Principle Recipient of this grant. The grant has two main objectives, a study of the Bio-Behavior of Most-at-Risk Groups, MARPs and the Legal Environment for PLWHIV and MARPs. A comprehensive field study of the Bio-Behavior of MARPs was c in 2011 in collaboration with the Ministry of Health, Country Coordinating Mechanism, the Syrian Family Planning Association and the Syrian Arab Red Crescent.

Despite the unfortunate disruption which started during the second half of 2011; UNDP, GFATM and partners continued their work under a hostile and unpleasant environment to finalise this important and conclusive study which will help the country in the development of its National Strategy to control the spread of HIV among MARPs and the general population. In addition after four years of uncertainty in the country the results of this study will be of great importance for the evaluation of HIV among MARPs and the general population. The study has, for the first time established base line information for the Bio-Behavior of MARPs.

The current crisis has significant impact on the health system. The lack of resources and the collapse of the health system in some parts of the country will have negative impact on the control of communicable disease including HIV. We believe the country needs help and assistance; not only through financing the health system, but also by conducting evidence based surveillances and studies on the status of communicable & non-Communicable disease. Solid and evidence based research will assist the Government in adopting viable, applicable and productive National Strategic Plans.

Finally, I would like to extend my sincere thanks and gratitude for all those who participated in this work, including Global Fund Team of UNDP Country Office, Syria CCM, Ministry of Health, the Syrian Family Planning Association and the Syrian Arab Red Crescent.

Janthomas Hiemstra
UNDP Country Director

Acknowledgements

This report is dedicated to all the people who participated in this Integrated Bio-Behavioral Surveillance Survey (IBBSS) in Syria. Without their contribution, this survey would not have been possible. Access to comprehensive harm reduction strategies that could empower the different most at risk populations is a basic human right - It is neither leisure nor luxury. It is hoped that the current report to clearly reflect this and to entice moving forward at the national Syrian level.

In Syria, this study was supported by the United Nations Development Program- Country Office Syria (UNDP-Syria), in close coordination with the National AIDS Control Program, the National AIDs Committee, and the involvement of three main key relevant NGOs: the Syrian Red Crescent, the Syrian Family Planning Association, and Sham for Health. The survey was conducted between November 2013- September 2014. It was funded by the Global Fund.

Thanks also to the following people who contributed to this work at all levels: Dr. Ghassan Shannan (UNDP); Dr. Hala Al Khair (UNDP), Mr. Ayad AL Adal (Data Entry). the Syrian Arab Red Crescent, the Syrian Family Planning Association, and Sham for Health, National AIDs Program, National AIDs Committee; (list of names, table 12) Dr. Loulou Kobeissi (the Researcher and Consultant on this Project); The Global Fund; Last but Not least to ALL the Research Participants without whom this Survey would not have been POSSIBLE

This work was supported by a grant from the Global Fund to support the National AIDS Programme of the Syrian Arab Republic to control the spread of AIDS among MARPs Groups and the General population.

The United Nations Development Programme as a Principle Recipient of the grant has played a vital role in coordinating, supervising and facilitating the activities of the grant including this unique and important study.

List of Abbreviation

IBBSS = Integrated bio-behavioral Surveillance Survey

MARPS = Most At Risk Populations

RDS = Respondent-driven sampling

AIDS = Acquired Immune Deficiency Syndrome

ANC = Antenatal care clinics

ART = Anti-retroviral therapy

HIV = Human immunodeficiency virus

HBV = Hepatitis B virus

HCV = Hepatitis C virus

FSW = Female sex work

IDU = Injecting drug use

MSM = men having sex with men

NGO = Non-governmental organization

PLHIV = Person living with HIV

STI = Sexually transmitted infection

UNAIDS = United Nations Joint Programme on HIV/AIDS

UNFPA = United Nations Population Fund

WHO = World Health Organization

UNGASS = United Nations General Assembly Special Session

VCT = Voluntary counseling and testing

HRS/HRSs = Harm Reduction Strategy (ies)

Table of Content

List of Tables

EXECUTIVE SUMMARY

Introduction

This report presents data on the first Bio-behavioral HIV Surveillance Survey (IBBSS) among most at risk population in Syria, using respondent-driven sampling (RDS) methodology between 2013-2014. The MARP included: prisoners (n=400), Female Sex Workers (FSW) (n=400), men having sex with men (MSM) (n=400) and intravenous drug users (n=394). The data was collected in four main areas in Syria known to be the most heavily populated, urbanized and to which the majority of the population from other governorates fled to because of the current conflict, these are: Damascus, Suburbs of Damascus, Tartous, Lattakia.

The survey was conducted between Nov., 2013- Sept., 2014. The survey aimed at assessing the prevalence of HIV, Hepatitis B & C by collecting biological specimens, as well as to analyzing relevant risk-taking behaviors in this most- at-risk population.

It is hoped that the survey's findings will provide baseline to monitor bio-behavioral data in Syria over time; as well as to measure the effectiveness of intervention programs aimed at reducing the "at risk" behavior of the most-at-risk populations. With repeated surveys, changes as well as trends over time can be observed and evaluated.

In particular, the survey assessed the prevalence of HIV and viral Hepatitis B&C among FSWs, MSMs, IDUs and Prisoners. It also analyzed relevant risk-taking behaviors in these most- at-risk populations.

This survey will also be used as a tool to provide the UNGASS related indicators for Syria.

The specific objectives for this IBBS survey in Syria revolved around collecting data on:

a) Prevalence of HIV, hepatitis B and C among MARPs
b) Patterns of sexual risk taking among MARPs,
c) Injecting drug use,
d) HIV testing among MARPs,
e) Self-reported symptoms associated with STIs among MARPs,
f) HIV knowledge among MARPs, and
g) Stigma toward PLHIV among MARPs.

Methods

a. Formative Stage

The formative stage of this research was carried out using methods of operational research; mainly qualitative methods. It assisted in the identification and setting the ground for participation of the main field stakeholders, which included: Syrian Red Crescent, Syrian Family Planning Association and Sham for Health. It also assisted, in conjunction with the HIV/AIDs epidemiology in Syria, to identify the MARPs for this survey, which included: FSWs, MSM, IDUs and Prisoners. This stage also assisted in the determination of the geographical coverage of this survey, based on vivid discussions with the field stakeholders (indicated above) and evidence-based data that assisted in the identification of the major cities the MARPs are most likely to cluster in.

b. Study Design

This IBBSS is a cross-sectional survey that used a respondent-driven sampling method, extending over four main cities in Syria: Damascus, Suburbs of Damascus (Rif Damascus), Lattakia and Tartous.

c. Sampling

A total sample of 400 FSWs, 400 MSM, 400 Prisoners and 394 prisoners were selected. The sample was selected using respondent-driven sampling (RDS). The RDS involved a long chain-referral process (similar to snowball sampling), where by the members of the most-at-risk population recruited peers from their own social networks. The number of referrals was maintained

to be limited in order to ensure that recruitment chains are fairly effective in penetrating the diverse social circles.

d. Data collection

The survey tools were based on the FHI-published manual Behavioral Surveillance Surveys: Guidelines for Repeated Behavioral Surveys in Populations at Risk for HIV. The questionnaires were translated into Arabic, using both forward and backward translation. During translation, it was ensured that the questions and issues raised are culturally relevant, adequate and acceptable. Four different questionnaire versions were used for each of the MARPs subgroups.

Multiple field teams were simultaneously recruited in order to collect the data among the four different MARPs in each of the four different cities. The teams consisted of: a supervisor, community liaison staff, a laboratory technician, and interviewers. Data was collected using face-to-face interviews, in a private location specifically set up for the interview. The location of the interviews varied depending on the MARP subgroup. The face-to-face interviews were followed by blood drawing to analyze for HIV, HBV and HCV. All laboratory specimens were analyzed at the Ministry of Public Health- Central Laboratory.

Prior to the start of the survey, a one-week pilot test was held. The pilot-testing involved assessing the various parts of the survey process, including the study protocol, the methodology, training and data collection.

e. Laboratory Procedures:

Sero-prevalence of HIV infection was determined by using the standard diagnostic algorithms in place by the National AIDS Programme. Tests for Hepatitis B and C, were as well carried out according to the national standards.

f. Data Management, Analysis & Indicators

Data was entered, managed, and analyzed using the Statistical Packages for Social Sciences (SPSS) version 22. The software was used to generate

population proportion estimates and confidence intervals. These estimated population proportions and their corresponding confidence intervals provide a method for characterizing the larger MARPs.

g. IRB & Informed Consent

The research protocol was submitted and approved by the Institutional Review Board (IRB) of the University of Damascus. All participants were asked to sign an Informed consent to fill out the face-to-face interviews as well as to do the laboratory tests. The informed consent highlighted for the participants the purpose and procedures of the study. It ensured that participation is completely voluntary, private and confidential, with the option to withdraw from the study at any time. It also explained the harms, benefits and compensation (6$) of participation.

Results

a. FSWs

A total of 400 female sex workers (FSW) were recruited, 49.8% were recruited from Damascus, 25% from Tartous and 25.2% from Lattakia. Mean age was 29.04 (7.9) with the bulk of the sample clustered between 20-25 years old.

No HIV positive cases were found among the FSWs. The HBV prevalence was 5.3%. The HCV prevalence was 0.8%.

96% of FSWs indicated that they have heard of HIV/AIDs. 4.8% indicated that they have a friend with HIV and 3% indicated that they have a relative with HIV. The average HIV/AIDs knowledge score of risk factors (answering correctly to all 10 standard questions assessing HIV knowledge) was 5.6 (+2.2) compared to a perfect score of 10. Only 35.3% indicated that they have ever tested for HIV/AIDs, among which only 22.8% were voluntarily tested. Knowledge of STI related symptoms for women were better among the FSWs compared to their knowledge of men related symptoms. Less than 30% indicated consistent condom use with clients during the past six months, with an average number of sexual partners during the past week

of 5.2 (+5.8). 64.8% indicated that they drink alcohol; among which, 13% indicated that they drink on daily basis. 11% indicated drug use.

In regard to their attitudes towards people living with HIV (PLHIV), 74% indicated that they will not share food with some who has HIV, 75.8% indicated that they will not buy food from someone who has HIV and 62% indicated that they will feel shameful to disclose the status of a relative suffering from HIV. Hence, the FSWs' attitude towards PLHIV can be considered rather stigmatizing. 35.8% indicated that they have been forced to have sex.

b. MSM

A total of 400 men having sex with men (MSM) were recruited, 53.8% were recruited from Damascus, 31.2% from Tartous and 15% from Lattakia. Mean age was 25.2 (+10.9) with the bulk of the sample clustered between 20-34 years old.

Two cases of HIV positive (0.5%) were found among the MSMs. The HBV prevalence was 2.3% (9cases). The HCV prevalence was 0%.

95.5% of MSMs indicated that they have heard of HIV/AIDs. 8% indicated that they have a friend with HIV and 1.5% indicated that they have a relative with HIV. The average HIV/AIDs knowledge score of risk factors (answering correctly to all 10 standard questions assessing HIV knowledge) was 6.2 (+1.8) compared to a perfect score of 10. Only 31.8% indicated that they have ever tested for HIV/AIDs, among which only 20.5% were voluntarily tested. Knowledge of STI related symptoms for women were better among the MSMs compared to their knowledge of men related symptoms. 13% indicated condom use during oral sex; 32% indicated using condoms during their last anal sex; Less than 37% indicated consistent condom use partners during the past six months, with an average number of sexual partners whom practiced with oral sex during the past six months was 45.7(+189.2); and whom practiced with anal sex was 26.4 (+127.8). 67.5% indicated drinking alcohol, among which 11% indicated that they drink on daily basis. 12.3% indicated drug use.

In regard to their attitudes towards people living with HIV (PLHIV), 56.3% indicated that they will not share food with some who has HIV, 72.5% indicated that they will not buy food from someone who has HIV and 59.5% indicated that they will feel shameful to disclose the status of a relative suffering from HIV. Hence, the MSMs' attitude towards PLHIV can be considered rather stigmatizing. 35.8% indicated that they have been forced to have sex.

c. IDUs

A total of 394 Intra-venous drug users (IDUs) were recruited, 11.9% were recruited from Damascus, 61.9% from Tartous and 26% from Lattakia. Mean age was 32.1 (+9.9) with the bulk of the sample clustered between 20-24 years old.

No HIV positive cases were found among the IDUs. The HBV prevalence was 0.5% (2 cases). The HCV prevalence was 3.3% (13 cases).

98% of IDUs indicated that they have heard of HIV/AIDs. 7.4% indicated that they have a friend with HIV and 0.8% indicated that they have a relative with HIV. The average HIV/AIDs knowledge score of risk factors (answering correctly to all 10 standard questions assessing HIV knowledge) was 6.7 (+2.1) compared to a perfect score of 10. Only 43.4% indicated that they have ever tested for HIV/AIDs, among which only 26.9% were voluntarily tested. Knowledge of STI related symptoms for women were better among the IDUs compared to their knowledge of men related symptoms. Less than 30% indicated consistent condom use with clients during the past six months, with an average number of sexual partners during the past week of 5.2 (+ 5.8). 93.9% indicated that they drink alcohol, among which 29% indicated that they drink on daily basis and 56.8% indicated that they drink more than once per week. 31.1% indicated using drugs more than once a day. The average age of drug abuse initiation was 24.1 (+7.1). The most common types of drugs used included: Heroin (86%); Heroin and Cocaine (8.4%), and Cocaine (3%). 19.5% indicated that they have used a syringe used by

someone else the last time they injected, and 11.2% reported using a syringe used by someone else during the last month. 38% cleaned the used syringes with either alcohol or water. Only 20.3% indicated receiving management/ rehabilitation for their addiction (current or past).

In regard to their attitudes towards people living with HIV (PLHIV), 72% of IDUs indicated that they will not share food with someone who has HIV, 82% indicated that they will not buy food from someone who has HIV and 76.6% indicated that they will feel shameful to disclose the status of a relative suffering from HIV. 72.8% think that a PLHIV should be quarantined. Hence, the IDUs' attitude towards PLHIV can be considered rather stigmatizing. 22.3% indicated that they have been forced to have sex.

d. Prisoners

A total of 400 prisoners were recruited. All were recruited from Damascus, the Syrian Central Prison. Mean age was 32.8 (+10.9), with the bulk of the sample clustered either between 20-34 years old or older than 40 years of age.

No HIV positive cases were found among the prisoners. The HBV prevalence was 2.5% (10 cases). The HCV prevalence was 1.5% (6 cases).

96.3% of prisoners indicated that they have heard of HIV/AIDs. 2.5% indicated that they have a friend with HIV and 1.3% indicated that they have a relative with HIV. The average HIV/AIDs knowledge score of risk factors (answering correctly to all 10 standard questions assessing HIV knowledge) was 5.5 (+1.6) compared to a perfect score of 10. Only 40% indicated that they have ever tested for HIV/AIDs, among which only 41.8% were voluntarily tested. Knowledge of STI related symptoms for women were slightly better among the prisoners compared to their knowledge of men related symptoms. The mean age of sexual activity was 14.46(9.293). The average number of sexual partners during the past year was 16.67(122.0). 25.8% indicated using condoms during their last sexual act; 4.3% indicated consistent condom use with casual partners during the past six months. 21% indicated that they get

paid to have sex with a casual partner. 46.3% indicated drinking alcohol, among which 17.3% indicated that they more than once per week. 22% indicated drug use.

In regard to their attitudes towards people living with HIV (PLHIV), 67.5% of the prisoners indicated that they will not share food with some who has HIV, 74.3% indicated that they will not buy food from someone who has HIV and 50.7% indicated that they will feel shameful to disclose the status of a relative suffering from HIV. Hence, the prisoners' attitude towards PLHIV can be considered rather stigmatizing. 10.3% indicated that they have been forced to have sex.

Conclusion

For the four MARPs, the average age ranged between 20-24 years old, except for prisoners who were slightly older. Although, the majority of the subgroups have heard about HIV/AIDs; yet, their overall knowledge of risk factors was not sufficient and their overall exposure to health awareness campaigns to HIV/AIDs was limited. This necessitates intensifying HIV/AIDs awareness efforts among these groups, whose risk is 5-6 times greater than that of the general population. The same holds true for knowledge of STIs symptoms. For all fours groups, the knowledge of the symptoms was slightly better when it comes to identifying women-related symptoms compared to those of men. However, in both categories, adequate knowledge was less than 30%.

The data reflects, as well, that these risk groups are more likely to engage in multiple sexual activities with both usual and casual partners. They are characterized by significant low use of condoms. The majority indicated drinking alcohol and a high percentage actually reported injecting drug use (ranging between 11-22%). Injection drug use was also characterized to be combined with other medications like sleeping pills and Valium. Hence, the four groups are heavily engaged in high-risk behaviors that will further exacerbate their risk of contracting HIV/AIDs as well other STDs.

As far as stigma to PLHIV, we see a high level of stigma across the four MARPs. The majority has indicated that they will not share food with someone who has HIV; nor they will buy food from them. Also, the majority noted that they feel ashamed to disclose the status of relative having HIV. In addition, both the majority of MSMs and IDUs indicated that a PLHIV should be quarantined.

Based on these findings, huge and intensive harm reductions efforts should be conducted in order to: reduce HIV/AIDs risks in these populations; decrease engagement in risky behaviors (like alcohol and substance/drug use); raising awareness about HIV/AIDs as well as decreasing stigma about HIV/AIDs and PLHIV. Encouraging and facilitating periodic testing for HIV/AIDs in these risk groups should be prioritized coupled with the provision of easy and free access of condoms as well as protecting the rights of these groups from being assaulted or raped.

Recommendations

Two sets of recommendations will be suggested. The first set relates to those that should comprehensively address the needed policy as well as institutional measures for an integrated as well as holistic management of MARPs to prevent HIV/AIDs and other STDs. The second set recommends immediate measures that are more feasible, cost effective by taking into account the current status of the ongoing conflict in the country and the deterioration in the basic health infrastructure at all levels of services.

a. Policy and Institutional Recommendations for Effective Harm Reduction Strategies

1. Addressing the underlying societal problems such as war, poverty, lack of education and gender imbalance;

2. Developing collaborative prevention and care models that includes all possible stakeholders such as, religious scholars, academics, expert health professionals, policymakers, non-governmental organization, community- based organizations, and HIV positive persons);

3. Lobbying and advocacy for reforming the existent national policies, laws and sanctions in the country in order to enhance regular screening, detection and treatment for MARPs at need

4. Development and provision of appropriate healthcare resources, harm reduction programs and infrastructure including:

   - Appropriate surveillance and reporting mechanisms
   - Periodic testing for MARPS- particularly FSWs and Prisoners (because of the existent infrastructure in Syria that facilitates this)
   - Provision of Drug abuse prevention and rehabilitation services including syringe exchange programs and not only for those in prisons
   - Provision of adequate medical care and social support including HIV counseling, testing and treatment facilities
   - Empowerment of health care workforce across its broad spectrum: social workers, nurses, psychologists, nurse aids, medical physicians and primarily those working with the public section, etc.
   - Provision of appropriate reproductive and sexual health care programs
   - Instilling broader efforts directed at enhancing information, education and communication on sexual and reproductive health including impacts of addiction.
   - Provision of non-medical aspects of care including psychosocial support, income generating and livelihood activities, language classes, and legal support (should be included in a comprehensive package of services with the potential of being facilitated by both NAP and NAC)
   - Encouragement and scaling up of Peer education should be continued and scaled up to be facilitated by relevant NGOs that have direct link with the different MARPs.

b. Practical Recommendation given the Current Status of the Syrian Crisis

1. Improving HIV knowledge and the awareness of HIV risks among all four MARPS, through NGOs activities and targeted information and prevention campaigns.

2. Scaling up Free and anonymous HIV testing, including information about HIV and free condoms should be distributed at all different primary care as well as VCT sites.

3. Prioritizing and improving condom availability as well as strengthening condom use. This is significantly needed to reduce the current level of vulnerability to HIV infection.

4. Periodic implementation of these Bio-behavioral HIV surveillance surveys among FSWs, MSMs, IDUs and Prisoners at regular intervals (every 2-3 years), preferably using probability sampling.

5. Implementation of Future surveillance surveys in order to monitor intervention outcomes. Although, these studies will not replace those of evaluation research, they could provide valuable information on the scope and efficiency of the intervention programs introduced in between the surveillance waves- at a faster and more cost-effective rate.

6. Incorporation of and Targeting FSWs, MSM, IDUs and Prisoners in all future stigma reduction activities among health care providers. More emphasis should be targeted for MSMs and IDUs due to their higher levels of stigma- as shown in this report.

CHAPTER 1: INTRODUCTION & BACKGROUND

1. Introduction & Background

In the following section, an overview about the demographic and socio-cultural background of Syria will be provided, followed by presenting the over all burden of HIV in the county. The remaining sections will focus on the burden of HIV/AIDs including STIs in four MARPs: Prisoners, FSWs, MSM and IDUs in Syria. This section will also address the implications of HIV/AIDs burden in Syria among these four MARPs and will hint at potential harm reductions strategies that can be of use.

a. Overview on Syria

Syria is a lower middle-income country, with a total estimated population of 22.5 million. It is located on the Mediterranean Sea and surrounded by Lebanon, Occupied Palestinian Territory, Turkey and Iraq. It is characterized by a diverse ethnic and religious makeup. Seventy-four percent of the population is Sunni Muslim, 11% Alawite, 10% Christian, 3% Druze, with the remaining 2% being smaller Muslim minority sects. While 90% of the population is ethnically Arab, the largest ethnic minority is the Kurds (7%), followed by Armenians, and a smaller numbers of Assyrians, Circassians, and Turkmen. After its independence in 1946 and the rise of the secular Syrian Baath party in 1963, "secular Arab nationalism was the most successful ideology in filling the identity vacuum because it best cemented the Syrian "mosaic," bringing together the Arab-speaking minorities, most significantly the Alawites and Christians, with Sunni majority (albeit excluding non-Arabs such as the Kurds)" (Hinnebusch, 2014).

In general, the country is divided into 14 main governorates. According to the General Census of the Syrian Central Bureau of Statistics in 2008, Syria's total population was estimated at 19,880,000 at year 2008 (General Census, Syrian Central Bureau of Statistics, 2008). In all governorates except Sweida, male numbers supersede females'. Below is a table of statistics concerning populations actually living in Syria in 2008 per the 2008 general census.

Estimates of population actually living in Syria in 31/12/2008 by governorates and sex (000)*

Registration of governorates	Males	Females	Total
Damascus	862	828	1690
Damascus Rural›	1323	1247	2570
Aleppo	2322	2185	4507
Homs	862	824	1686
Hama	776	748	1524
Lattakia	484	475	959
Deir-ez-Zor	571	557	1128
Idleb	712	681	1393
Al-Hasakeh	709	700	1409
Al-Rakka	462	414	876
Al-Sweida	172	180	352
Dar ‹ a	479	464	943
Tartous	386	376	762
Quneitra	42	39	21 81
Total	10162	9718	19880

*** The number doesn't include Syrian population abroad**
Source: Syrian Bureau of Statistics, 2008 http://www.cbssyr.sy/index-EN.htm

According to the available statistics, Damascus, Damascus Rural (Rif Dimashq), Tartous and Lattakia where this survey was conducted compose 17% of the total Syrian population. However, this data contains notable flows in calculations.

In general, more than 50% of the population is considered urban, where by the total estimated urbanized population in 2004 was estimated at 9,587,972 from all compared to 8,332,872 rural populations. The most urbanized governorates are: Aleppo, Damascus, and Rif Dimashq with 2,524,503, 1,552,161, & 1,477,727 populations respectively (Syrian Bureau of

Statistics, 2004). Moreover, Damascus is by far the most urbanized lacking any rural areas; while, Al Qunaitra is least urbanized with absolutely no rural community (Syrian Bureau of Statistics, 2004).

A more recent statistics on urbanization in Syria, provided by the Central Intelligence Agency (CIA), indicated that urbanization accounts for 56.1% of the total Syrian population in 2011. Given the important influence of urbanization on the spread of HIV and other infectious diseases, this factor is worth accounting for, when tailoring prevention and control programs for HIV/AIDs as well as STDs(Dyson, 2003).

Prior to the conflict (1980-2010), Syria enjoyed adequate maternal, sexual and reproductive health achievements because of its strong national primary health care system, which was implemented throughout the country. The estimated per capita income in 2009 was 3900 US$ and over 80% of its health system was publically managed, with a national primary health care coverage. More than 90% of its pharmaceutical medicines were locally produced. Syria was considered an outlier in the Middle East for its health outcomes in relation to the per capita expenditure spent on health ($79US) (Sen K., Al Faisal W., Al Saleh Y. 2012).

The current conflict in Syria (since 2011) is having detrimental impacts on these achieved accomplishments in maternal, sexual and reproductive health -whether for the population remaining in Syria or those displaced. The war together with the imposed economic sanctions are leading to the collapse of the monetary exchange rates and subsequently the collapse of the health care system, and increasing the prices of medications and essential food supplies as well as other basic life commodities. This is predicted to have long-lasting consequences, even after the conflict subsides (Sen K., Al Faisal W., Al Saleh Y. 2012). In light of this, prioritizing prevention and control programs for the MAPs becomes at times challenging and at other times out of context. It is hoped that the current survey will help pave a dialogue in this direction in spite the importance of other pressing priorities.

b. HIV/AIDs Burden in Syria

The first HIV positive case in Syria was detected in the early 1980s. Since then, the epidemic continued to expand. It is fairly established that accurate and reliable information on the distribution and trends of HIV infection and risk behaviors in the population as well as the coverage of prevention, care and treatment interventions are essential for rational decision-making concerning HIV/AIDS. Although, the prevalence in the country remains rather low; yet, evidence indicates that the epidemic is gaining hold - specifically-in sub-groups of the population at highest risk, i.e. those associated with injecting drug use or risky sexual behaviors. This is also challenged by the fact that major gaps in knowledge with regard to the local HIV/AIDs dynamics exist.

In Syria, a total of number of an estimated 799 cases of HIV has been reported between 1987 to 2012 (353 of which were AIDS cases); with an estimated rise of 50-70 HIV cases annually, since 2006 (UNAIDS, 2012). Over fifty-eight percent of all cases were reported among Syrian citizens. About one quarter of all HIV/AIDS cases occurred among those aged between 25 and 29 years, in 2011. The male to female ratio of those infected with HIV is estimated at approximately 3: 1 (World Health Organization, Regional Office for Eastern Mediterranean [WHO EMRO], 2010, p.21). Also, as per statistics in 2011, the overall HIV positive population in Syria is composed of 58% Syrians and 42% foreigners (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2012). Further, in the light of lack of testing the population at large, especially high-risk groups, the estimated HIV rates are projected to be 5-6 times greater than those reported (UNAIDS, 2012).

As far as the geographic clustering of cases, the reported HIV cases in Syria are mainly distributed in urbanized areas. Actually, Damascus hosts as much as two-thirds of people living with HIV (41% of cases; (75 cases - prevalence rate based on number of reported cases: 1.9/100 000)), followed by Aleppo (23%- 41 cases, prevalence rate based on number of reported cases: 1.0/100 000). While, nearly 10% of HIV cases reside in Homs, and 5% were found in Al Sweida "which has the highest number of cases compared to its number

of inhabitants (2.7 per 100,000-9 cases, prevalence rate: 2.7/100 000)" (UNAIDS, 2012, p.12).

The most common reported transmission mode is heterosexual (around 70%), followed by homosexual route and injecting drugs. Homosexuality and bisexuality accounts for 10.5% of the cases, blood transfusion accounts for 8%, IDUs accounts for (5%), and mother-to-child transmission (5%) (UNAIDS, 2012).

According to data provided by the WHO's Global Health Observatory Data Repository, 130 people were reported to be receiving ARV therapy in the year 2012. Other data about eligibility for ARV therapy, as per the 2010 guidelines, remain largely missing. As for other STIs, few data exists. A study conducted in 2011 uncovered 268 cases of urethral discharge and 56 of genital ulcer among men. On the other hand, women had much more genital ulcer cases reaching up to 1553 cases. However, this might be the result of surveillance bias of service centers accessed by women (WHO, 2012).

In Syria, sexuality remains highly stigmatized for both religious as well as cultural reasons. Thus, stigma and discrimination as well as legislations contribute to the vague picture of the HlV infection in the country, and to the inefficiency of scarce preventive efforts targeted towards Most-at-risk populations (MARPs). Civil society organizations have a modest role in targeting vulnerable populations and working with them. Only two Non-Governmental Organizations (NGOs) are known for their active role in HIV/AIDS control efforts at the country; they are mainly the Syrian Association of Red Crescent (SARC) and the Family Planning Association (who are the main stakeholders in the current survey). These MARPs include: female sex workers (FSW), heterosexual men with multiple sexual partners, men who have sex with men (MSM), young people, injecting drug users (IDU), truck drivers, merchant marines, prisoners and refugees. The section below will highlight the trend of HIV/AIDs infections as pertinent to those population groups in Syria.

c. HIV/AIDs Risks in MARPs in Syria: FSWs, MSM, IDUs, & Prisoners

• Female Sex Workers (FSWs):

In spite of scarcity of available data, a study conducted among FSWs in 2005 in Syria showed that FSWs perceive themselves at low risk of contracting HIV/AIDs. Condom use was also low, unsatisfactory, as well as occasional at best (UNAIDS, 2012). Reasons attributed to lack condom use by FSWs in this study were mainly because of customers' refusals (in 45% of cases). This study also showed that, although, 46% of FSWs perceived themselves at risk of contracting HIV, yet still, 28% lacked interest in using condoms.

The vast majority of FSWs reported having multiple clients in one day, and half of them reported having suffered from STDs in the past year (UNAIDS, 2012). Considering that 71% of women's HIV rates are attributed to heterosexuality; this might highlight the role of the sex industry in the spreading the disease- given its size in the country, which is estimated at 15,000 - 25,000 sex workers (UNAIDS, 2012).

Most of these sex workers start sex work at a very young age; where, appropriate knowledge about sexual protection and HIV/AIDs prevention is either lacking or inexistent. This is further burdened when the prime reason for sex work is economic. Consequently, the economic need and hardship places women at weak negotiation powers with customers, when its comes to protection and prevention, like condom use. It is also well known that much of human trafficking occur in this industry, where women have no control over their situation, which also places them at higher risk (UNAIDS, 2012).

• Men who have sex with men (MSM):

According to the Global AIDS Response Progress Report 2012 by UNAIDS, 14% of HIV registered cases (during 1987-2010) are MSM. This rate, however, is an underestimate of the real prevalence of HIV/AIDs among MSM in Syria. This is attributed to the fact that many MSM in Syria are

married, and less likely to easily admit being infected from relationships with men, for the dire social consequences of this admission.

With no programs targeting MSMs in the country, MSMs are at a higher risk of contracting STDs, including HIV. What makes them even more vulnerable to these infectious diseases is the rarity and refusal of condom use for the majority of MSM in Syria, coupled with the higher likelihood of viral transmission as a result of anal sex. Also, certain misconceptions about the susceptibility of risk associated with "passive" and "active" roles prevailed further increases the risk (UNAIDS 2012).

According to another conducted study, results showed that in Syria certain groups of MSMs also get paid for sex work. This group is, additionally, predisposed to the same weak negotiation powers as those observed among FSWs, regarding safety of sexual practices (UNAIDS, 2012). Although, no accurate data on prevention services for MSM is available, the fact that HIV testing among MSM constituted only 0.23% of all tests conducted in Syria in 2011 clearly reflects the lack of MSM-friendly services. This will also have severe consequence on HIV/AIDs prevention, transmission and control among this subgroup in the country (UNAIDS, 2012).

• Injecting Drug Users (IDUs):

In Syria, HIV among IDUs constitutes 4.9% of all HIV cases (during the years: 1987-2010) (UNAIDS, 2012). Left without needle-and-syringe-exchange programmes (NSEP), IDUs are at increased risk of HIV infection through contaminated syringes. Adding to this, there exists only one rehabilitation center in the country, which is coupled with low utilization of drug rehabilitation programs, due to both social stigma and accessibility challenges (UNAIDS, 2012).

A study conducted in 2006 demonstrated that 90% of IDUs are sexually active, and the vast majority of them indicate having sex with an average of seven partners the last month (UNAIDS, 2012). Although, IDUs in this study had adequate knowledge of the importance of using condoms, a very

minimal number of them reported using it. Reasons associated with lack of use included decreased sexual pleasure and partner's refusal. The constant need of IDUs for drugs has led many of them to exchange sex for drugs and money, which is an evil loop concerning HIV and other STDs acquisition. Although, the 2006 study revealed that only one person among 204 sampled IDUs was HIV positive, this study suffered major designs in the sample associated with selection bias and not being representative of the general IDU population (UNAIDS, 2012).

As far as re-using of syringes and disinfection, the data available is extremely worrisome. In one study, 46% of IDUs shared injecting needles, 40% of them didn't consistently clean the syringes, and the rest reported inefficient cleaning practices. In this study, also, less than half of IDUs sampled actually knew that syringes can transfer HIV (UNAIDS, 2012).

- **Prisoners:**

A study conducted among prisoners in Syria estimated that HIV rates in Syrian prisons ranged between 0-0.2% (UNAIDS, 2012). Actually, many of the prisons' population tend to be IDUs. In a study on IDUs, half of the sampled IDUs indicated being imprisoned in the past. 50% of these IDUs indicated that they continued to inject drugs through syringes in prisons. These prisoners also reported rape and unsafe sexual practices during imprisonment (UNAIDS, 2012).

In another study, results showed that 5% of prisoners admitted to having sex inside the prison, with an average of three partners and without using condoms (UNAIDS, 2012). Overcrowded prisons, the unavailability of condoms, and the violent nature of rape (that causes more bodily friction) all contribute to a substantially higher risk of contracting STDs in prisons in Syria (Averting HIV & AIDS: Global Epidemic [AVERT], n.d., para .10).

Overall, the data in Syria on the above- described MARPs is lacking and suffers from serious design flaws that hampers a representative understanding of the dynamics of HIV and STDs acquisitions in these groups in the

country. It can be concluded, however, that the most common risk behavior for these four high -risk groups is sexual behavior. While, FSWs, MSMs and IDUs are directly involved in risky sexual behaviors (sex without using condoms) (UNAIDS, 2012), prisoners, who are also IDUs, are also more prone to sexual acts, which places them at double the risk of infection due to both contaminated syringes and male -to-male sexual relations (that often carry higher risks for infection) (UNAIDS, 2012). The multiplicity of sexual partners as well as committing sex for money or drugs is another common factor that can co-exist in all these MARPs, which also imposes a greater risk for contracting STDs and HIV (UNAIDS, 2012). Another equally significant factor that increases the likelihood of contracting the disease is the lack of appropriate HIV/STDs programs and HIV-friendly services. For all these four risk groups, stigma constitutes an important driver that prevents from coming forward for HIV and STDs screening and testing (UNAIDS, 2012).

d. Overview on Harm Reduction Strategies and Control Programs (relevant for MARPs) for HIV/STDs in Syria

The above data pertaining to the MARPs clearly indicate the higher risk for the spread of STDs, including HIV in Syria in these subgroups, particularly because of the absence of a concrete national commitment to fight HIV among these subgroups (specifically when its comes to the established of adequate surveillance systems and harm reduction programs).

The *political support and leadership* in the country for the prevention and control of HIV and STDs (among MARPs) is still largely lacking, and focuses primarily on education and prevention for the general population (rather than among MARPs) (UNAIDS, 2012). Moreover, there exist no policies that can protect the basic human rights of People Living with HIV (PLHIV) or allows for their provision of job opportunities (UNAIDS, 2012).

At the *institutional level*, the National AIDS Programme (NAP) and the National AIDS Committee (NAC) are the two main national entities concerned

with HIV related matters. The NAP has contributed very actively at *policy level*; where, it has established the National Strategic and Operational Plan for the years 2011-2015 (UNAIDS, 2012). These plans contain important harm reduction programs tailored for the afore-mentioned MARPs. These plans, however, have not been implemented yet, because of limited available funding (UNAIDS 2012). Along the same lines, in spite of the progress made, the NAP's role remains inefficient- as a result of being seriously crippled with administrative issues related to: staff, skills, and resources. These factors interplay to hamper the NAP from implementing important programs (UNAIDS, 2012). Consequently, NAP's funding has been mainly concentrated on catering for HIV therapy and some surveillance activities, rather than for the provision of interventions and prevention programs for high-risk groups (UNAIDS, 2012).

Also, when it comes to the adequacy of the set surveillance activities, biological data on HIV infections are mainly available from standard HIV and AIDS case reporting, sentinel surveillance among TB and STI patients, laboratory-based surveillance of HIV tests among high-risk (e.g., arrested sex workers, MSM and IDUs), low-risk categories (e.g., blood donors, immigrants and out-migrants), and results from VCT centres. However, there is no systematic biological surveillance among the key populations at risk, hence; there exists no reliable HIV-prevalence data for these key groups.

Similarly, behavioral data on key populations at risk is limited to a small number of Knowledge, Attitude and Practice (KAP) studies that were conducted by NAP. These studies lack subsequent follow-up studies that would allow for identifying HIV trends over time. In addition, the research samples of these KAP studies were usually not representative of the different at-risk populations. This makes the provision of an accurate picture of HIV risks among these MARPs to be further hampered by the lack of adequate size estimations. Overall, the results of these KAP studies can be summarized by the following main findings:

- Overall lack of knowledge about HIV/AIDS, modes of transmission and methods of prevention.
- Unsafe sexual relations are relatively frequent among youth, MSM, FSWs, sailors and long distance truck drivers.
- Condom use level is not satisfactory among all groups.
- Negative attitudes related to discrimination of people affected by HIV and AIDS are still prevalent.

As for the availability of integrated bio-behavioral surveillance surveys (IBBSS) for MARPs in the country (World Health Organization, 2013), this survey is the first to be conducted in Syria. This IBBSS is also hampered by the inability of the existent surveillance system to accurately determine estimates for population sizes and facility-based surveillance for these groups (WHO, 2013). Lacking size estimates for MARPs will directly result in inaccurate monitoring and evaluation of the implementation of any harm reduction programs in the country.

Therefore, the challenges facing the HIV/AIDS surveillance system in Syria are many and they include issues of representativeness, under-reporting, questionable quality of KAP surveys, as well as the lack of cooperation/ involvement of private sector.

As for the NAC, it has been actively involved with the different sectors in the Syrian government, but an actual practical HIV program is still lacking. Very limited trials were conducted by NAC in institutions/facilities (such as prisons) to assess HIV burden (UNAIDS, 2012). Also, no prevention programs are currently operating that target these MARPs. In the absence of clear and active NGOs' roles, the Syrian Family Planning Association and the Red Crescent are the only two existent national bodies involved in HIV harm reduction activities throughout the country. Their implemented harm reduction efforts are also considered less than efficient or optimal, because they are not conducted systematically and are not specifically tailored for MARPs (UNAIDS, 2012).

Having said this, IDUs population has some exceptions to the above, where by some harm reduction services that are specifically directed for them exist. A drug-treatment service located in Damascus is one example. Nevertheless, the low coverage and high relapse rates limit the favorable results of these services (UNAIDS, 2012).

The lack of serious harm reduction programs has its repercussions on the spread of HIV and other STDs in the country at large, and particularly among MARPs. Being concentrated on changing behavior, awareness, and providing safe alternatives, the absence of harm reduction programs can result in exacerbating harmful behaviors and misconceptions that drive the spread of these infections. This is especially so-given the high stigma attached to HIV/AIDs and STDs testing that drive the population (including MARPs) to shy away from seeking knowledge and services. In fact, harm reduction programs play a major role in asserting the importance of using condoms and clearing away any misconceptions prevalent among high-risk groups, along with how to adequately use the protection measures and apply them (UNAIDS, 2012).

The current situation in Syria with the ongoing conflict, rising poverty, destruction of basic health services and infrastructure, and increased number of inmates set out the alarm pertaining to the spread of HIV/AIDs and STDs as well as unsafe sex and drugs. The unavailability of essential medical treatments and protection methods (like condoms and safe drug syringes) is another risk factor that will facilitate the spread of HIV and STDs in the country. This is further compounded with the heavy burden of stigma that accompanies HIV testing in the absence of HIV-friendly system, which contributes to higher rates of infection and lack of appropriate treatment.

Harm reduction programs pave the way for mandatory and regular HIV testing for MARPs to control infection rates and provide proper services. Harm reduction programs also impose the establishment of efficient surveillance system in order to ensure their proper implementation and

evaluation. The given situation in the county including the absence of harm reductions programs (as already indicated) will have its repercussions on the infection rates in the country- given the current state of chaos and war.

In spite of the dim picture, there are also some international as well as regional plans to enhance the status of harm reduction strategies facilitate funds for high-risk groups in the country (UNAIDS, 2012). Two most recent endeavors include those by the: Middle East and North Africa Harm Reduction Association (MENAHRA) that will be conducting harm reduction plans for setting out some programs, and the commitment of GFATM to develop surveillance and help build prevention services for MARPs (UNAIDS, 2012).

II. IBBSS Goal & Objectives

This is the first Integrated Bio-Behavioral Survey (IBBS) in Syria. The goal of this survey is to estimate the prevalence of HIV and other STIs among most at risk populations (MARPs): FSWs, MSM, IDUs and Prisoners. The survey was conducted between Nov., 2013- Sept., 2014. It is focused on assessing the MARPs behaviors, by collecting biological as well as behavioral information.

It is hoped that the survey's findings will provide baseline to monitor bio-behavioral data in Syria over time; as well as to measure the effectiveness of intervention programs aimed at reducing the "at risk" behavior of the most-at-risk populations. With repeated surveys, changes as well as trends over time can be observed and evaluated.

In particular, the survey assessed the prevalence of HIV and viral Hepatitis B&C among FSWs, MSMs, IDUs and Prisoners. It also analyzed relevant risk-taking behaviors in these most- at-risk populations.

This survey will also be used as a tool to provide the UNGASS related indicators for Syria.

The specific objectives for this IBBS survey in Syria revolved around collecting data on:

a) Prevalence of HIV, hepatitis B and C among MARPs
b) Patterns of sexual risk taking among MARPs,
c) Injecting drug use,
d) HIV testing among MARPs,
e) Self-reported symptoms associated with STIs among MARPs,
f) HIV knowledge among MARPs, and
g) Stigma toward PLHIV among MARPs.

CHAPTER 2: METHODOLOGY

a. Formative Stage

The formative stage of this research was carried out using methods of operational research; mainly qualitative methods. The stage aimed to build partners and consult with them on sub-groups most at risk as well as to discuss and predict the feasibility of conducting the survey. This stage evolved around the following:

- Identifications of experts and key informants that was carried out in consultation with UNFPA, GF, National AIDS Programme and NGOs working on HIV/AIDS.
- Interviews with key informants that allowed to get relevant information on: the populations at risk; accessibility and potential barriers
- Interviews with gatekeepers from populations at risk that allowed getting relevant information: on their networks; the potential seeds (referred to the initial respondents who will initiate the recruitment of additional respondents through their networks as a must requirement for "Respondent-driven sampling" used in this study; their willingness to assist in recruitment and potentials threats to research.

During this stage that following issues were discussed as well as resolved with partners: the sampling and its feasibility and whether or not it can be used among the different study MARPs; the sampling approach can be used in the population (i.e. the population is networked) and how best to implement the study in the field. These issues assisted in the identification of the adequate network size, network density, level of incentives and selection of seeds that facilitated the study sampling.

In particular, key informants were asked to describe the typical size and structure of the networks in the different study sub-population. This facilitated the quantification of the network size as precisely as possible the size of the network for each individual seeds. (See Interview guide in Appendix III that was used to guide selection of priority groups for HIV surveillance).

The formative stage also aided to identify and set the ground for participation of the main field stakeholders, which included: Syrian Red Crescent, Syrian Family Planning Association and Sham for Health. It also assisted in conjunction with the HIV/AIDs epidemiology in Syria to identify the MARPs for this survey, which included: FSWs, MSM, IDUs and Prisoners.

In addition, the geographical coverage of this survey was also determined during this stage. It was based on vivid discussions with the field stakeholders (indicated above) as well as based on evidence-based data that assisted in the identification of the major cities the MARPs are most likely to cluster in. These included: Damascus, Suburbs of Damascus (Rif Damascus), Lattakia and Tartous. These cities as well were known to have received a significant amount of displaced Syrians who fled their cities as a result of the ongoing conflict, such as Idleb, Homs, Aleppo, etc. (See Appendix III- Interview Guide).

b. Survey Design

This IBBSS is a cross-sectional survey that used a respondent-driven sampling method, extending over four main cities in Syria: Damascus, Suburbs of Damascus (Rif Damascus), Lattakia and Tartous. As indicated, the Most-at-Risk Populations making up the survey population included: FSWs, IDUs, MSM and Prisoners. This is the first integrated bio-behavioral survey in the country. This survey will provide the base-line data on HIV prevalence as well as other sexually transmitted diseases among the MARPs. Repeated IBBSS surveys will hopefully strengthen the surveillance of HIV in the country.

c. Sampling

A total sample of 400 FSWs, 400 MSM, 400 Prisoners and 394 prisoners were selected. The sample was selected using respondent-driven sampling (RDS). The RDS involved a long chain-referral process (similar to snowball sampling), where by the members of the most-at-risk population recruited

peers from their own social networks. The number of referrals was maintained to be limited in order to ensure that recruitment chains are fairly effective in penetrating the diverse social circles.

Hence, the RDS involved direct recruitment of peers by their peers. It also made use of a dual system of incentives, and a coupon system. Recruitment started with an initial set of participants known as "seeds", and continued in waves, with "seeds" recruiting first-wave respondents, first-wave respondents recruiting the second wave respondents, and so on, until the final sample size was achieved. The Respondents were compensated for both: interview completion as well as for each peer that they successfully recruit. A coupon system was used to monitor the recruitment quota (i.e. the number of peers one can recruit into the study) and recruitment information was used to link recruiters to recruits.

d. Data collection

The survey tools were based on the FHI-published manual Behavioral Surveillance Surveys: Guidelines for Repeated Behavioral Surveys in Populations at Risk for HIV. The questionnaires were translated into Arabic. Necessary modifications and adaptation were made to ensure cultural relevance and adequacy to the Syrian context as well as to the study populations. They were later on back translated into English language in order to make sure that no changes in context and construct validity were incurred. Four different questionnaire versions were used for each of the MARPs subgroups (See Appendix III for the 4 different set of questionnaires and Appendix IV for Information Sheet and Informed Consent).

Multiple field teams were recruited in order to collect the data among the four different MARPs in each of the four different cities. The teams consisted of: a supervisor, community liaison staff, a laboratory technician, and interviewers. Data was collected using face-to-face interviews, in a private location specifically set up for the interview. The location of the interviews varied depending on the MARP subgroup.

A three- days training workshop was held to Intensive training will take place to all field to orient the various field staff on their specific roles, and on issues such as community sensitization, ethical issues, and the basics about HIV/AIDS. The Laboratory staff were also trained on good laboratory practices (GLP), and data handling.

Prior to the start of the survey, a one-week pilot test was held. The pilot testing involved testing the various parts of the survey process, including the study protocol, the methodology, training and data collection. Following the pilot-test, the different study stakeholders were invited to discuss improvements to the survey process, methodology and instrument based on the outcome of the pilot.

In particular, data collection on MSM (n=400) and IDUs (n=394) was conducted by the Syrian Red Crescent and Sham for Health. A total of 24 interviewers collected the data. Data collection for MSM took place mainly in Lattakia (total number of interviewers involved= 8 women), Damascus (total number of interviewers involved= 8 women), and Tartous (total number of interviewers involved= 7 women). Data collection took place in public gardens, SPAs, hotel rooms, coffee shops as well as movie theaters. This diversity in data collection venues was made intentional in order to ensure as well as maintain anonymity, confidentiality and privacy. The data collection took 2.5 months to complete

A total of 20 interviewers collected the data for IDUs. Data collection took place mainly in Lattakia (total number of interviewers involved= 10 women), Damascus (total number of interviewers involved= 6women), and Tartous (total number of interviewers involved= 4 women). Data collection took place in public gardens, one chalet room, hotel rooms, and on streets. This diversity in data collection venues was also made intentional in order to ensure as well as maintain anonymity, confidentiality and privacy. The data collection lasted for four months and it was the hardest to complete, given the high risk for criminalization of the study subjects if located by the police forces.

The data collection for both FSWs (n=400) and the Prisoners (n=400) was conducted by the Syrian Family Planning Association and Sham for Health. Data collection took place in the four cities: Lattakia (total number of interviewers involved= 12 women), Damascus and Rif Damascus (total number of interviewers involved= 14 women), and Tartous (total number of interviewers involved= 10 women). Data collection took place mainly in hair salons, VCT clinics, health centers and one chalet room. This diversity in data collection venues was also made intentional in order to ensure as well as maintain anonymity, confidentiality and privacy. The data collection lasted for three months and it was also hard to complete, given their night schedule, which hampered coming to the interviews in the mornings on time.

The data collection on prisoners took five days to complete (at a rate of 11 interviews per interviewer per day). It was conducted in the Central Syrian Prison in Damascus. This prison is considered the largest in the country. It has a total capacity ranging between 10,000-12,000 prisons but is currently running at around of 25,000-30,000 prisoners, as a result of the ongoing conflict. It covers different types of crimes including: theft, rape, assault, homicide, drugs, etc. The data collection was coordinated with NAP, the head of the prison as wells some of the staff in charge. Data collection took place in the reading rooms and the library. Three men interviewers collected the data.

The interviewers selected were social workers, psychologists and/or physicians. They all had previous experience in data collection in sensitive population. The interviews lasted between 35-90 minutes. Data collection took place simultaneously for each subgroup and questionnaires along with the laboratory specimens were transferred every week to Damascus facilitated by the responsible focal points in each city for each subgroup. Laboratory specimens were collected following the completion of the face-to-face interviews. All laboratory specimens were analyzed at the Ministry of Public Health-Central Laboratory.

e. Laboratory Procedures:

Sero-prevalence of HIV infection was determined by using the standard diagnostic algorithms in place by the National AIDS Programme. Tests for Hepatitis B and C, were as well carried out according to the national standards.

The following section below summarizes the laboratory protocol implemented.

Blood samples were collected by vein-puncture in a dry tube with no anti-coagulant. Sera will be separated from the blood samples as soon as possible and kept at 2-4 degrees centigrade.

The serum samples were tested for HIV/AIDS, HBV and HBC. Second or third generation EIA is used for detecting, HIV1 and HIV2 antibodies, Hepatitis B surface antigen and Hepatitis C antibodies. All positive cases were confirmed by Western Blot technique at the reference laboratory.

Participants with negative results were informed about their result through the VCT center at the Governorate; while, participants with positive markers for HIV, HBV and/or HCV were informed by the National AIDS Programme at the Ministry of Health and they will be followed up for treatment and further testing.

Participants were all given codes, which were used to identify the participants' samples and any further intervention. No samples were used for any other purposes including research and/or further studies without a written consent of the participant.

f. Quality Control

Comprehensive efforts were conducted in order to ensure that the survey was being implemented with strict adherence to the approved survey protocol. Frequent surprise visits to check quality and consistency of various aspects of fieldwork including: sampling, selection of respondents, the consent process, biological sample collection by technicians, and storage/transport/ processing of samples at the field laboratories were conducted. The quality of

the collected field data was also checked for completeness. Inconsistencies were, consequently, checked and corrected at the site itself by the field team.

g. Data Management, Analysis & Indicators

Data was entered, managed, cleaned and analyzed using the Statistical Packages for Social Sciences (SPSS) version 22. The software was used to generate population proportion estimates and confidence intervals. These estimated population proportions and their corresponding confidence intervals provide a method for characterizing the larger MARPs.

The key Indicators for this IBBSS included:

- HIV prevalence
- STD prevalence
- Knowledge about HIV/STI (individual components and UNGASS knowledge indicator for most-at-risk populations)
- Knowledge of prevention ways
- Self-reported STI symptoms
- Sex with non-marital partners by type
- Duration of sex work and injecting drug use
- Condom use at last sex in commercial sex
- Condom use at last sex with non-commercial partners by type
- Consistent condom use with commercial and non-commercial partners
- Sharing of injecting equipment among IDU
- Receiving HIV testing and results
- Condom use in anal sex among MSM by type of partner (commercial and noncommercial)
- Attitudes towards PLWHA
- Exposure to interventions

e. Ethical Issues and Consent process

The research protocol was and approved submitted to the Institutional Review Board (IRB) of the University of Damascus (See Appendix II for the IRB approval memo). Particular caution was made in order to maintain

ethical conducts at its highest, given the fact that survey is dealing with marginalized groups using a challenging sampling strategy (RDS). This was particularly maintained by the following:

- Informed consent: All respondents were informed of, and asked for their consent for filling out the face to face interviews as well as the laboratory tests. The informed consent highlighted for the participants the purpose and procedures for the study and asked for consent. It ensured that participation is completely voluntary with the option to withdraw at any time. In addition, Payment of incentives (5-6 US$) were perceived rather low to impact any decision to participate in the study.
- Harm Minimization Measures: Because, the high-risk populations involved in this IBBSS are often marginalized and stigmatized, protection of respondents in all phases was given high priority. All steps were taken by the research team in order to protect the rights of respondents including confidentiality of the data, personal privacy and anonymity. On the other hand, participants with positive results on the biological tests were referred for free treatments as per the protocols in place by the National AIDS Programmes and other sexually transmitted diseases. Counseling for those people was also emphasized.

See Appendix IV for Informed Consent.

CHAPTER 3: RESULTS

a. FSWs

A total of 400 female sex workers (FSW) were recruited, 49.8% were recruited from Damascus, 25% from Tartous and 25.2% from Lattakia. Mean age was 29.04 (7.9) with the bulk of the sample clustered between 20-25 years old. The majority had either elementary (42%) or Intermediate level education (26.8%). 86% noted that they were ever married (Table 1).

No HIV positive cases were found among the FSWs. The HBV prevalence was 5.3% (21 cases). The HCV prevalence was 0.8% (3 cases) (Table 2).

Average age at first marriage was 15.3 (+8.2) years. Average age of sexual activity was 17.8 (+ 4.1) years. Age at first sexual activity for profit was 21.9 (+8.8). Average number of sexual partners during the past week was 5.3 (+5.8) and the average number of sexual partners for profit was 4.8 (+6.2) (Table 3).

95.5% indicated that they ever heard of condoms. 91.5% expressed that they know where to get condoms from. 10% noted that they ever hear of female condoms. Frequency of condom use in the last six months with a partner was 10.5% for every time, 14% for most of the time and 10.5% for sometimes. Frequency of condom use with a customer was 31.3% for every time, 14.2% for most of the time and 16% for sometimes. The most common reported reason for not using condoms was that partner rejected (20.8%). Moreover, Less than 30% indicated consistent condom use with clients during the past six months (Table 3).

Over all knowledge of STI related symptoms for women were better among the FSWs compared to their knowledge of men related symptoms. 70.5% correctly indicated that discharge was a common STI related symptom among women, followed by itch (47.5%) and bad odor (42.5%). 55.5% correctly indicated that discharge was a common STI related symptom among men, followed by burning (46%) and bad ulcer (24%). 53% of the FSWs noted that they have suffered from genital secretions in the past 12 months (Table

4a). 56.8% noted that they had a previous history of ulcer or discharge. In addition, 56% noted that they were ever prescribed treatment for an STI, among which 54.5% noted using the prescribed treatment (Table 4.b.)

96% of FSWs indicated that they have heard of HIV/AIDs. 4.8% indicated that they have a friend with HIV and 3% indicated that they have a relative with HIV. The average HIV/AIDs knowledge score of risk factors (answering correctly to all 10 standard questions assessing HIV knowledge) was 5.6 (+2.2) compared to a perfect score of 10. The most correctly cited answers about HIV knowledge of risk factors of transmission were: Injection drug use (87%), mother to child transmission (82%), a health person can have HIV (69%) and a monogamous relationship can protect from HIV (59%) (Table 5).

Only 35.3% indicated that they have ever tested for HIV/AIDs, among which only 22.8% were voluntarily tested (Table 5).

64.8% of the FSWs indicated that they drink alcohol; among which, 13% indicated that they drink on daily basis and 33% indicated that they drink more than once per week. 11% indicated drug use. The most common types of drugs used included weeds (7%) and prescription medications (2.8%) (Table 6).

In regard to their attitudes towards people living with HIV (PLHIV), 74% indicated that they will not share food with some who has HIV, 75.8% indicated that they will not buy food from someone who has HIV. 62% indicated that they will feel shameful to disclose the status of a relative suffering from HIV, and 33% indicated that they will not take care of a relative suffering from HIV/AIDs. Hence, the FSWs' attitude towards PLHIV can be considered rather stigmatizing. 35.8% indicated that they have been forced to have sex (Table 7).

b. MSM

A total of 400 men having sex with men (MSM) were recruited, 53.8% were recruited from Damascus, 31.2% from Tartous and 15% from Lattakia. Mean age was 25.2 (+10.9) with the bulk of the sample clustered between

20-34 years old. The majority had Intermediate level education (20.8%), Secondary level education (23%) and university education (23.3%). Overall, the educational background of MSMs was higher than that of the FSWs, as well as other MARPs to be described in the later sections. Only, 18% noted that they were ever married (Table 1).

Two cases of HIV positive (0.5%) were found among the MSMs. The HBV prevalence was 2.3% (9 cases). The HCV prevalence was 0% (Table 2).

98 % of the MSM indicated that they had any type of sex in the last six months (oral, anal, or hand foreplay). 87% indicated that they had oral sex in the past six months. 58% indicated that they had sex with a woman. 13.8% indicated that they forced to have sex in the past year. Average mean number of sexual partners whom they had oral sex with in the last six months was 8.5 (+17.2). Average mean number of sexual partners whom they had anal sex with in the last six months was 14 (+66.2). Average number of times for having anal sex with profit during the past month was 4 (+17.1). Average number of times for having anal sex without profit during the past month was 7.4 (+ 9.7). The overall average number of sexual partners for profit was 10.3 (+21.5) (Table 8).

98% of the MSMs indicated that they ever heard of condoms. 97.8% expressed that they know where to get condoms from. 66.5% indicated that they use condoms in general. Frequency of condom use in the last six months with a partner was 10.8% for every time, 16.5% for most of the time and 13.3% for sometimes. Frequency of condom use with a woman was 29.8%. 32% indicated that they used condoms during the last anal sex. The most common reported reason for not using condoms during the last anal sex encounter was that partner rejected (9.8%). Moreover, 44% indicated that they have ever discussed HIV/AIDs and other STDs with partners (Table 8).

Knowledge of STI related symptoms for women were better among the MSMs compared to their knowledge of men related symptoms. 52.3% correctly indicated that discharge was a common STI related symptom

among women, followed by burning (35%) and ulcer (32%). 55.3% correctly indicated that discharge was a common STI related symptom among men, followed by ulcer (41.3%) and burning (40%). 5.3% of the MSMs noted that they have suffered from genital secretions in the past 12 months. 10.8% noted that they have suffered from an anal ulcer in the past 12 months (Table 4a). 93.5% noted that they had a previous history of ulcer or discharge. In addition, 17% noted that they were ever prescribed treatment for an STI, among which 16.5% noted using the prescribed treatment (Table 4.b.)

95.5% of MSMs indicated that they have heard of HIV/AIDs. 8% indicated that they have a friend with HIV and 1.5% indicated that they have a relative with HIV. The average HIV/AIDs knowledge score of risk factors (answering correctly to all 10 standard questions assessing HIV knowledge) was 6.2 (+1.8) compared to a perfect score of 10. The most correctly cited answers about HIV knowledge of risk factors of transmission were: Injection drug use (92%), a healthy person can have HIV (74%), sharing of food will not transmit HIV (65.5%) and a monogamous relationship will protect from HIV (64.3%) (Table 5).

Only 31.8% indicated that they were ever tested for HIV/AIDs, among which only 20.5% were voluntarily tested (Table 5).

67.5% indicated drinking alcohol, among which 11% indicated that they drink on daily basis, and 27.4% indicated that they drink more than once per week. 12.3% indicated drug use. The most common types of drugs used included weeds (5.8%) and prescription medications (4.0%), and Valium (2%) (Table 6).

In regard to their attitudes towards people living with HIV (PLHIV), 56.3% indicated that they will not share food with some who has HIV, 72.5% indicated that they will not buy food from someone who has HIV and 59.5% indicated that they will feel shameful to disclose the status of a relative suffering from HIV. Hence, the MSMs' attitude towards PLHIV can be considered rather stigmatizing. 35.8% indicated that they have been forced to have sex (Table 7).

c. IDUs

A total of 394 Intra-venous drug users (IDUs) were recruited, 11.9% were recruited from Damascus, 61.9% from Tartous and 26% from Lattakia. Mean age was 32.1 (+9.9) with the bulk of the sample clustered between 20-24 years old. The majority had either elementary (26.4%) or Intermediate level education (33.3%). 57.4% noted that they were currently married (Table 1).

No HIV positive cases were found among the IDUs. The HBV prevalence was 0.5% (2 cases). The HCV prevalence was 3.3% (13 cases) (Table 2).

Average age of first sexual activity was 23.1 (+ 17.1) years. Average number of sexual partners in the past 12 months was 11.2 (+21.7). Average number of sexual encounters with men in the past 12 months was 10.8 (+27.9). Average number of times of having sex with a usual partner (spouse) in the last 30 days was 10.6 (+20). Average number of times having sex with a casual partner in the past 30 days was 37.4 (+40) (Table 9).

94.7% of IDUs indicated that they ever heard of condoms. 94.2% expressed that they know where to get condoms from. 62.4% indicated that it takes then less than half an hour to get a condom, while, 27.9% indicated that it takes them around one hour. 6.1% indicated that they use a condom during the last sexual encounter. The main reason cited for not using a condom was that the partner rejected (17.5%). Frequency of condom use during the last six months was not favorable, where by only 3.6% reported using a condom every time, 4.8% reported using a condom most of the time and 16.5% reported using a condom sometimes. Average number of condoms used during the last 12 months was 19.5 (+26.7). 40.6% of IDUs indicated that they have discussed HIV/AIDs and other STDs with their sexual partners (Table 9).

Over all knowledge of STI related symptoms for women were better among the IDUs compared to their knowledge of men related symptoms. 64.7% correctly indicated that discharge was a common STI related symptom among women, followed by itch (38.6%) and bad odor (35.3%). 63.5% correctly indicated that discharge was a common STI related symptom among men,

followed by burning (61.4%) and ulcer (31.2%) (Table 4a). 19.8% noted that they had a previous history of ulcer or discharge. In addition, 18% noted that they were ever prescribed treatment for an STI, among which 19% noted using the prescribed treatment (Table 4.b.)

98% of IDUs indicated that they have heard of HIV/AIDs. 7.4% indicated that they have a friend with HIV and 0.8% indicated that they have a relative with HIV. The average HIV/AIDs knowledge score of risk factors (answering correctly to all 10 standard questions assessing HIV knowledge) was 6.7 (+2.1) compared to a perfect score of 10. The most correctly cited answers about HIV knowledge of risk factors of transmission were: Injection drug use (95.2%), a health person can have HIV (78.7%) and a monogamous relationship can protect from HIV (74.9%) (Table 5).

Only 43.4% indicated that they were ever tested for HIV/AIDs, among which only 26.9% were voluntarily tested.

93.9% of IDUs indicated that they drink alcohol, among which 27.4% indicated that they drink on daily basis and 53.3% indicated that they drink more than once per week. The majority noted that they drink alcohol both at home and in a public place (52.8%), followed by at home (34%) (Table 6).

The average age of drug abuse initiation was 24.1 (+7.1) years. The most common types of drugs used included: Heroin (86%), Heroin and Cocaine (8.4%), and Cocaine (3%). 31.1% indicated using drugs more than once a day. 19.5% indicated that they have used a syringe used by someone else the last time they injected, and 11.2% reported using a syringe used by someone else during the last month. The average number of people shared with the same syringe in the last month was 28.3 (+43.8). 23.9% indicated sharing the syringe with a friend during the last month, 18% with a casual sexual partner and 3.3% with a usual sexual partner. 28% indicated cleaning the syringe before use in the past month (either every time (14%) or often (14%)). 38% cleaned the used syringes with either alcohol or water. 97.9% indicated their ability to get used syringes when needed. 19.3% indicated their use

of prepackaged syringes where the source is unknown. 24.9 % indicated using cottons, filters, water or other substances when using syringes in the past month. Only 20.3% indicated receiving management/rehabilitation for their addition (current or past), among which 5.1% indicated the type of management to be medications while 9.4% indicated using more than one type of management combined (Table 10).

In regard to their attitudes towards PLHIV, 72.1% of IDUs indicated that they will not share food with someone who has HIV, 82% indicated that they will not buy food from someone who has HIV and 76.6% indicated that they will feel shameful to disclose the status of a relative suffering from HIV. 72.8% think that a PLHIV should be quarantined. Hence, the IDUs' attitude towards PLHIV can be considered rather stigmatizing. 22.3% indicated that they have been forced to have sex (Table 7).

d. Prisoners

A total of 400 prisoners were recruited. All were recruited from Damascus, the Syrian Central Prison. Mean age was 32.8 (+10.9), with the bulk of the sample clustered either between 20-34 years old or older than 40 years of age. The majority had either elementary (44.5%) or Intermediate level education (21%). 54.3% noted that they were ever married (Table 1).

No HIV positive cases were found among the prisoners. The HBV prevalence was 2.5% (10 cases). The HCV prevalence was 1.5% (6 cases) (Table 2).

Average age of first sexual activity was 14.5 (+ 9.3) years. 18.8% reported ever having sex in the past year. The average number of sexual partners during the past year was 16.7 (+122). The average number of casual sexual partners was 2.1 (+6.2). The average number of MSM partners was 1.97 (+0.18). The average number of times has sex with a spouse or partner during the past month was 2 (+12.4) (Table 11).

22.8% of the prisoners indicated general condom use. 70.8% indicated that they have ever heard of condoms. 71.3% expressed that they know where

to get condoms from. Average time need to get a condom between work and home was noted to be 20.9 (+39.4) minutes. Frequency of condom use during the last sex was 10.5%. The most common reported reason for not using condoms was that it was not though of (12.5%). Frequency of condom use with a wife during the last six months was low (2% every time, 3.5% most of the time, and 2.8% sometimes). Frequency of condom use with a casual partner during the past six months was also low and followed the same trend as that with a wife (1.8% every time, 1.5% most of the time, and 2.3% sometimes). 21% indicated getting paid to have sex with a casual partner. 23.5% indicated that they have ever discussed HIV/AIDs and other STDs with sexual partners (Table 11).

Knowledge of STI related symptoms for women were slightly better among the prisoners compared to their knowledge of men related symptoms. 22.3% correctly indicated that discharge was a common STI related symptom among women, followed by bad odor (14%), and ulcer (10.5%). 21% correctly indicated that discharge was a common STI related symptom among men, followed by burning (13%) and ulcer (11.3%). 6% of the prisoners indicated that they have suffered from any types of secretions and/or ulcers in the past 12 months (Table 4a). 11.3% noted that they had a previous history of ulcer or discharge. In addition, 8.5% noted that they were ever prescribed treatment for an STI, among which 7.8% noted using the prescribed treatment (Table 4.b.)

96.3% of prisoners indicated that they have heard of HIV/AIDs. 2.5% indicated that they have a friend with HIV and 1.3% indicated that they have a relative with HIV. The average HIV/AIDs knowledge score of risk factors (answering correctly to all 10 standard questions assessing HIV knowledge) was 5.5 (+1.6) compared to a perfect score of 10. The most correctly cited answers about HIV knowledge of risk factors of transmission were: Injection drug use (78%), mother to child transmission (82%), a health person can have HIV (65.3%), sharing food will not transmit HIV (53%), and a monogamous relationship will protect from HIV (46%) (Table 5).

Only 40% indicated that they have ever tested for HIV/AIDs, among which only 41.8% were voluntarily tested (Table 5).

46.3% indicated drinking alcohol, among which 8.5% indicated that they drink daily and 8.5% indicated that they drink more than once per week. 22% of the prisoners indicated drug use (Table 6).

In regard to their attitudes towards people living with HIV (PLHIV), 67.5% of the prisoners indicated that they will not share food with some who has HIV, 74.3% indicated that they will not buy food from someone who has HIV and 50.7% indicated that they will feel shameful to disclose the status of a relative suffering from HIV. Hence, the prisoners' attitude towards PLHIV can be considered rather stigmatizing. 10.3% indicated that they have been forced to have sex (Table 7).

CHAPTER 4: DISCUSSION & CONCLUSION

For the four MARPs, the average age ranged between 20-24 years old, except for prisoners who were slightly older. Although, the majority of the subgroups have heard about HIV/AIDs; yet, their overall knowledge of risk factors was not sufficient as well as their exposure to HIV/AIDs awareness campaigns was limited. This necessitates intensifying HIV/AIDs awareness efforts among these groups, whose risk is 5-6 times greater than that of the general population. The same holds true for knowledge of STIs symptoms. For all fours groups, the knowledge of the symptoms was slightly better when it comes to identifying women-related symptoms compared to those of men. However, in both categories, adequate knowledge was less than 30%.

This limited knowledge fairly places these different MARPs at a higher risk for HIV/AIDs as well as other STDs acquisition. Added to that, their lifestyle, which harbors a series of combined risk taking behaviors that further compounds this risk.

As reflected from the data, these different MARPs were more likely to engage in multiple sexual activities with both usual and casual partners. They were characterized by significant low condom use. The majority indicated drinking alcohol and a high percentage actually reported drug use (ranging between 11-22%). Drug use was also characterized to be combined with the use of other prescription medications, like sleeping pills and Valium. Hence, the results of this survey indicated that the four groups were heavily engaged in high-risk behaviors that will further exacerbate their risk of contracting HIV/AIDs as well other STDs.

Furthermore, an overview of their sexual history and sexual activities, the data show that the four different MARPs were heavily sexually active, more likely to have combined sexual partners both casual and regular. A significant proportion reported receiving money for sex. A limited percentage reported continuous use of condom, during each sexual encounter-minding that the majority of the four different MARPs indicated that: they have heard of condoms, that condoms

could protect them from HIV/AIDs, as well as the condoms' accessibility was not perceived problematic. Moreover, a considerable proportion indicated being forced to have sex without their will (ie. assaulted or raped).

As far as stigma to PLHIV, surprisingly, high level of stigma towards PLHIV was observed among the different four MARPs themselves. The majority indicated that they will not share food with someone who has HIV; nor they will buy food from them. Also, the majority noted that they feel ashamed to disclose the status of relative suffering frm HIV. In addition, both- the majority of MSMs and IDUs- indicated that a PLHIV should be quarantined.

Based on these findings, huge and intensive harm reductions efforts should be conducted in order to: reduce HIV/AIDs risks in these populations; decrease engagement in risky behaviors (like alcohol and substance use); raising awareness about HIV/AIDs as well as decreasing stigma about HIV/AIDs. Encouraging and facilitating periodic testing for HIV/AIDs in these risk groups should be prioritized coupled with the provision of easy and free access to condoms, as well as protecting the rights of these groups from being assaulted or raped- because they are perceived with higher levels of stigma compared to the general population, which predisposes them at a greater likelihood from coming forward to make use of available prevention and early screening services.

In the sections below, we will highlight a series of evidence-based recommended harm reduction strategies (HRSs) for each of the different MARPs, as well as we will conclude by recommending specific HRSs that could be relevant in terms of being practical and feasible given for the Syrian consuming crisis.

a. FSWs:

Globally, successful HRSs concerning sex work were often the ones that involved sex workers themselves and provided them with suitable services (Jana, Rojanapithayakorn, & Steen, 2006). These HRSs usually start with prevention and follow a hierarchical approach: "preventing entry into sex work, protecting those involved in sex work, and assisting those leaving

sex work" (UNAIDS, 2006, p.9). In Eastern Europe and Central Asia, the comprehensive services offered by HRSs aimed at sex workers themselves and usually included: educational, medical, economic, legal and social services to contain the spread of HIV and other STDs. These efforts were proven to be both cost effective and efficient. Focusing on Muslim countries, in particular, data show that effective HRS should take into account the cultural and social specificities, where the Islamic values should be intertwined to those strategies in order to gain embargo by the different stakeholders involved in the field. From this perspective, according to Hasnain et al., effective HRS should be multidisciplinary and integrated enough to involve the implementation of all the below dimensions (Hasnain, 2005):

- **Outreach:**

Outreach aims at establishing trust bonds between FSWs and the community. Moreover, outreach should involve getting sex workers out of isolation by providing adequate medical, educational and legal services for those unable to attain them (UNAIDS, 2006).

- **Drop-in centers and project hotlines:**

These centers assist HRS in delivering education and counseling as well as materials such as condoms and syringe exchange. These also take into consideration FSWs' working hours and accessibility (UNAIDS, 2006).

- **Information, education and communication materials:**

Information, education and communication materials about HIV and other STDS as well as legal and social issues should be provided to sex workers in a culturally acceptable manner and taking into account the type of sex work practiced (UNAIDS, 2006).

- **Peer education:**

It has been found that former sex workers have important role in influencing the knowledge and behavior of current sex workers. Peer education can involve informal talk or continuous training and supervision over sex workers (UNAIDS, 2006).

• Medical care:

Medical services including STD testing and treatment are a necessity for effective control of HIV as well as other STDs. Quality is ensured through training of staff and timely supply of medications. Instead of direct provision of services, referral networks are established and strengthened. Usually, sex workers are accompanied by peers, staff or pimps to help them overcome their fear of discrimination in seeking medical services (UNAIDS, 2006).

• Support for injecting drug using sex workers:

As a considerable proportion of sex workers are drug users, HRS should target them with specific services. These services include: safe exchange of syringes, substitution therapy, detoxification, and injection injuries and infection management. Referral to other harm reduction services is provided as well. Many pimps discourage their sex workers from using drugs and unsafe sexual practices, but this is still inefficient as many sex workers hide their use of drugs (UNAIDS, 2006).

• Support for People Living with HIV

Sex workers already living with HIV should also be addressed- on the level of alternative livelihood -as well as services and treatment, including psycho-social support. This remains largely lacking in the Middle East, Eastern Europe and Central Asia (UNAIDS, 2006).

• Involving sex workers' clients and pimps:

Because clients are the main reason behind not using condoms in sex work, activities that are focused on convincing clients of the importance of condom use become very necessary. Decreasing the demand on commercial sex is another approach that can be worked on with clients, who sometimes demand more harmful practices such as anal sex (UNAIDS, 2006). On the other hand, involving pimps can lead to effective results because they have direct influence on their sex workers. This approach, however, carries some ethical implications associated with being viewed as legitimizing their work (UNAIDS, 2006).

• **Working with law enforcement:**
This involves education of both the sex workers and the internal security forces (police), which is aimed to inform them about the law as well as to train sex workers on how to deal with the police. In some cases, a lawyer attends police raids to watch over human rights violations (UNAIDS, 2006).

• **Strengthening individual and institutional capacity:**
The weakness of institutions and individual power towards HIV projects are remedied through building capacities. One important method of building capacities involves training sex workers to participate in projects by gathering and utilization of data. However, this approach also has challenges pertinent to sex workers' limited educational backgrounds. As for institutional capacity building, training of staff, surveillance projects, and raising awareness among sex workers are usually common utilized approaches. Nonetheless, adequate monitoring and evaluation mechanisms for these efforts remain a challenge, as a result of great staff turnover in NGOs, which hinders effective and sustainable capacity building (UNAIDS, 2006).

• **Mobilizing public, political and institutional support:**
The challenge of involving NGOs working with HIV in the HRS has been frequently related with the unfavorable milieu they work in. To improve this, certain activities are encouraged to be carried out, such as: "participation in political committees, public awareness campaigns, and building partnerships and referral networks with nongovernmental organizations and government organizations" (UNAIDS, 2006, p.14). Yet, data clearly shows that tremendous barriers of trust and comfort regarding collaboration between governments and NGOs prevail (UNAIDS, 2006).

A number of different projects have been implemented and demonstrated the effectiveness of some of these combined HRS. For example, one project was conducted in India, entitled: the Sonagachi Project of India. This

project culminated in the formation of an association called Durbar Mahila Samanwaya Committee (DMSC), which is the largest association of sex workers in the world (Nag, 2005).

The project revolved around the promotion of awareness among sex workers, creation of a hotline that sex workers can call to, as well as creating potential occupational and regulatory platforms. Peer educators were responsible for increasing FSWs' awareness. Through these efforts, the FSWs not only gained knowledge on how to protect themselves from HIV, but also on how to save/make money in a manner that frees them from slavery and abuse (Nag, 2005). Of the activities that sex workers were encouraged to engage in, in order to raise money, was selling condoms at a lower price than the market. Moreover, credit loans were created for sex workers to either start their own businesses or to use it in case of emergencies (Newman, 2003). In addition, the association provided certain entertainment platforms for sex workers to express artistic talents and socialize in, as well as provided school educational services, in the cases where FSWs had children (Nag, 2005). Also, education of FSWs in this project involved training on negotiation skills with clients on condom use.

This project utilized "conscientization", which means that individuals see themselves as part of the system rather than victims of fate (Newman, 2003). Self-esteem and self-value were enhanced to empower FSWs to protect themselves from STDs and to encourage them to call for their rights (Newman, 2003).

As indicated, a hotline for the center/project was also created to provide HIV- positive FSWs with medical and psychological services and to mobilize them to attain their rights (Nag, 2005).

To monitor the application of sex trade, self-regulatory boards in this project were formed as well. The project also fostered publications that were dissiminated at conferences and written by projects' staff, sex workers and others about the project and sex work in general (Nag, 2005).

At pimps' level, pimps were also involved in this project, after convincing them that ignoring the spread of HIV will lead to destroying their business. One important outcome generated from this project is that owners and managers of brothels became advocates of safe sexual practices and distributed condoms to their sex workers (Nath, 2000).

Another interesting example that demonstrates the important impacts of law enforcement in regulating and protecting the health of FSW is in Thailand. Studies have showed that when Thailand started imposing sanctions on the sex industry- in cases where condoms were not used -as well as coupled with intensive public media campaign efforts that encouraged men to use condoms with sex workers, these efforts led to a 94% increase in condom use at national levels coupled with a 79% decrease in STD rates among men (Hannenberg, Rojanapithayakorn, Kunasol, & Sokal, 1994; Hanenberg et al., 1994).

b. MSM

One meta-analysis paper comparing studies to reduce HIV/AIDs among African American MSM concluded that to be effective, HRS should combine health behavior modification with available, accessible and affordable health care services such as: HIV testing, STDs screening, STDs treatment, etc. (Maulsby et al., 2013). Also, it was recommended by this study that social and management interventions should be integrated together in order to achieve better results. Another study found that treatment from substance abuse as a potential HRS can have favorable implications in reducing risky sexual behavior among MSM who inject drugs, such as having multiple sexual partners (Carrico et al., 2007). In MSM in general, it is essential to reduce the number of sexual partners and consistently use condoms. Sero-sorting (blood tests to know the HIV status of the sexual partner) is a major concern as well (Azad, 2010). These are essential given the more intrusive sexual intercourse in this population, which leads to a higher risk of HIV as well as other STDs acquisitions.

c. IDUs

Global evidence clearly indicates that importance of HRS among IDUs in decreasing the burden of HIV/AIDs among IDUs. Some data actually show in many countries, a consequent 50% decrease in HIV transmission rates among IDUs. Using medically assisted treatments (as another HRS) such as methadone, buprenorphine, and buprenorphine/naloxone (suboxone)/ naltrexone have also been associated with reducing HIV transmission rates (President's Emergency Plan for AIDS Relief [PEPFAR], n.d.). Also, needle and syringe programs (NSPs) have led to decreasing risky sexual behaviors, such as multiple sexual partners. Since the risk of unprotected sex is associated with drugs. Other important HRS that showed importance for IDU included HIV counseling and testing, community outreach, ART for HIV positive IDUs, condom distribution, and raising awareness. The evaluation data of these HRSs show a direct association of these practices with decrease in injection drug use. For these outlined HRSs for IDUs to become effective at national levels, the civil society should be encouraged to develop legislations and policies that support as well as facilitate the implementation of these strategies.

In poor countries, HRSs that target different IDU audiences also exist. These included enforcing: positive behaviors, adequate biomedical, structural as well as social interventions (AIDS Support and Technical Assistance [AIDSTAR], n.d.). Studies in poor countries also show that the punitive approach and reducing drug demand had resulted in failures to control both drug use and infectious diseases. Reducing drug use in poor countries is often recommended to be targeted through governmental services, by setting up and promoting: appropriate legislations, program monitoring and evaluation, civil society coordination with the government, surveillance systems, building capacities, political commitment, and supporting similar regional initiatives aiming at reducing harm for IDUs (United Nations Office on Drugs and Crime [UNODC], 2010). Another important applicable HRS includes encouraging drug users to switch to

inhaling drugs rather than injection. This strategy carries lower risk of transmission and acquisition of HIV and other infectious diseases (HIV/ AIDS Unit, Ministry of Public Health, & Demand Reduction Section, Ministry of Counter Narcotics, 2005).

Success in accomplishing these different strategies will result in transcending the values of HRSs among IDUs to not merely reducing HIV and STDs in IDUs, but to protect their families and society at large from these diseases. Noted also is the importance of publishing documents on shaping policy makers' decisions (Afghanistan Ministry of Public Health & Ministry of Counter Narcotics, 2005). A multi-sectoral approach, including the religious institutions is often and always highly warranted for the success of implementing these HRSs (Afghanistan Ministry of Public Health & Ministry of Counter Narcotics, 2005).

d. Prisoners:

Data assessing the importance of HRSs among prisoners is fairly limited. One study conducted among Iranian prisoners, showed the importance of HIV education and needle exchange programs as front line HRSs in the prisons in order to limit the risk of HIV transmission inside the prison (Eshrati et al., 2008). It is logical that the basics of preventing HIV among IDUs and MSMs should be addressed at prisons- as prisons often combine the risks of both risky groups' behaviors.

CHAPTER 5: RECOMMENDATIONS

Prevention remains the ultimate cost-effective strategy for curbing HIV/AIDs transmission globally as well as in Syria-especially given the current conflict situation. For example, Vickerman et al. (2006) demonstrates the cost-effectiveness of education of IDUs about safe syringe use rather than syringes' distribution.

To minimize costs, education can be done by one person targeting a large audience of risk groups, preferable that one person is a peer. Peer educators should be trained to first try to prevent all those groups from engagement in their risky behaviors, and second to raise awareness about methods of HIV transmission, protective measures such as condom use, HIV testing, reducing sexual partners, etc. In turn, the trained risk groups should commit to a process called "snowballing", which is known to be efficient in transmitting information without incurring costs. The trained groups would inform their peers about condom use, HIV service locations and types, and other safety practices. The newly trained peers would inform their peers and the snowball will increase.

Involving risk groups in work of rebuilding institutions that should follow the conflict might also be a proper alternative for keeping them away from their risky behaviors on one hand, and helping them to support themselves financially in a non-risky work on the other hand.

In addition establishing, or activating centers that deal with HIV/AIDs patients in a confidential and friendly manner, psychological counseling and support should be planned to sustain any favorable changes. However, in the case where these risk groups are unwilling or unable to quit risky their risky sexual behaviors, the alternative could be the promotion of engagement in visual sex where no physical contact is done. One of the mains reasons behind emphasizing prevention of risky behavior as a frontline HRS is attributed with its cost effectiveness in preventing STDs. Among MSMs, for example, all studies demonstrate that the lack of use condoms was common

when applying them was considered uneasy, if men were under the influence of alcohol or drugs, and if they considered the relationship as trustworthy and intimate (Azad, 2010).

Facilitating access and use of protective materials like condoms coupled with information to referrals to service-friendly centers are also also another practical HRS that can be used in the Syrian context. If funds are consistent, condoms and printed materials can be deployed at brothels and places where risky behaviors take place.

The promotion of IDUs needle programs among all high risk groups (and not only among prisoners- as is the current case) should be enforced under controlled circumstances since all of these groups are prone to drug use.

A very important approach to prevent HIV in these risk groups that is highly recommended and should be deployed (if funds become available) in brothels at low cost is the use of Pre-Exposure Prophylaxis (PrEP) pill. Combined with condom use, PrEP can significantly reduce the transmission of HIV and particularly among MARPs (Centers for Disease Control and Prevention [CDC], n.d.). The pill should be taken once per day, as per the CDC recommendations, before any sexual activity encounter. It should be supplemented with another pill, post exposure prophylaxis, or PEP, if the sexual activity was conducted within 72 hours of exposure. As such, the availability and accessibility of these two pills are of crucial importance in curbing the spread of HIV- if funds are available for their purchase and distribution at national level in high risk areas as well as NGOs facilities that deal with these MARPs (CDC, n.d.).

In Syria also, the UNAIDS report of 2012 recommended few steps to overcome obstacles facing existent organizational challenges. These steps included: proper investments in surveillance and building capacities for NAP staff. It also stressed upon the importance of partnering with UN organizations, MENAHRA, other international organizations, the civil

society, community leaders like religious men and politicians in order to lobby for political endorsement, enforcement and implementation of the below outlined two types of recommendations (UNAIDS, 2012).

Given the above, two sets of recommendations will be suggested. The first set relates to those that comprehensively address the needed- "State of the Art" policy as well as institutional change measures for an integrated as well as holistic management of MARPs to prevent HIV/AIDs and other STDs. The other set recommends immediate measures that are more feasible, cost effective, by taking into account the current status of the ongoing crisis in the country and the deterioration in the economical revenues as well as basic health infrastructure at all levels of services.

It should be noted that below recommendations were put forward very carefully by taking into account several important determinants pertinent to the Syrian context, which are: 1) the war that exploits resources and increase poverty, 2) the low prevalence of HIV, and 3) the Syrian Islamic culture that can't absorb much of legalizing sexual activities outside marriage. Given this, these recommendations focus more on HRSs that involve policies that focus on the prevention of risky behaviors rather than "healing" those who are involved in committing them; combined with preventing the transmission of HIV and other STDs through protective measures among sexually active groups.

a. Policy and Institutional Recommendations for Effective Harm Reduction Strategies

1. Addressing the underlying societal problems such as war, poverty, lack of education and gender imbalance;

2. Developing collaborative prevention and care models that includes all possible stakeholders such as, religious scholars, academics, expert health professionals, policymakers, non-governmental organization, community- based organizations, and HIV positive persons);

3. Lobbying and advocacy for reforming the existent national policies, laws and sanctions in the country in order to enhance regular screening, detection and treatment for MARPs at need

4. Development and provision of appropriate healthcare resources, harm reduction programs and infrastructure including:

   - Appropriate surveillance and reporting mechanisms
   - Periodic testing for MARPS- particularly FSWs and Prisoners (because of the existent infrastructure in Syria that facilitates this)
   - Provision of Drug abuse prevention and rehabilitation services including syringe exchange programs and not only for those in prisons
   - Provision of adequate medical care and social support including HIV counseling, testing and treatment facilities
   - Empowerment of health care workforce across its broad spectrum: social workers, nurses, psychologists, nurse aids, medical physicians and primarily those working with the public section, etc.
   - Provision of appropriate reproductive and sexual health care programs
   - Instilling broader efforts directed at enhancing information, education and communication on sexual and reproductive health including impacts of addiction.
   - Provision of non-medical aspects of care including psychosocial support, income generating and livelihood activities, language classes, and legal support (should be included in a comprehensive package of services with the potential of being facilitated by both NAP and NAC)
   - Encouragement and scaling up of Peer education should be continued and scaled up to be facilitated by relevant NGOs that have direct link with the different MARPs.

b. Practical Recommendation given the Current Status of the Syrian Crisis

1. Improving HIV knowledge and the awareness of HIV risks among all four MARPS, through NGOs activities and targeted information and prevention campaigns.

2. Scaling up Free and anonymous HIV testing, including information about HIV and free condoms should be distributed at all different primary care as well as VCT sites.

3. Prioritizing and improving condom availability as well as strengthening condom use. This is significantly needed to reduce the current level of vulnerability to HIV infection.

4. Periodic implementation of these Bio-behavioral HIV surveillance surveys among FSWs, MSMs, IDUs and Prisoners at regular intervals (every 2-3 years), preferably using probability sampling.

5. Implementation of Future surveillance surveys in order to monitor intervention outcomes. Although, these studies will not replace those of evaluation research, they could provide valuable information on the scope and efficiency of the intervention programs introduced in between the surveillance waves- at a faster and more cost-effective rate.

6. Incorporation of and Targeting FSWs, MSM, IDUs and Prisoners in all future stigma reduction activities among health care providers. More emphasis should be targeted for MSMs and IDUs due to their higher levels of stigma- as shown in this report.

CHAPTER 6: STUDY CHALLENGES, LIMITATIONS & STRENGTHS

a. Study Challenges

The study challenges included:

- Lack of a conducive enhancing social, cultural and policy environment for research dealing with marginalized populations like MARPs
- Lack of trust- particularly a result of the existent legal structure that sanctions MSMs, IDUs and FSWs
- Insecurities during data collection as a result of the ongoing conflict
- Confirming the accurate status of MARPs

b. Study Limitations

The study limitations included:

- Reporting bias associated with Social desirability: The issue of under-reporting risky behaviors among participants of this study due to social stigma should be considered. Example of some behavior include: condom use, anal sex and multiple partnerships- may be under-reported (or over-reported in the case of condom use)
- Recall Bias: attributed to the cross-sectional nature of the survey. Certain practices and behaviors are probable not be recalled adequately; particularly, pertaining to frequency of condom use, alcohol intake, Drug use, etc.
- Missing out on most the "affluent" MARPs. For example, Affluent IDUs and MSMs are less likely to participate -because of their preference to remain anonymous. Similarly, more "affluent" FSWs could have been missed out because they could not perceive the incentives provided by this study as valuable

c. Study Strengths

The study strengths included:

- Representativeness: Sufficient sample size for each of the four different MARPS
- Adequate Validity of the RDS sampling Approach: the four RDS studies carried out among FSWs, MSMs. IDUs and prisoners seemed to fulfilled basic methodological requirements: Sufficiently networked population, strict recruitment quotas, long enough recruitment chains, and reliable recording of personal network size
- No missing data & very high Response Rate

REFERENCES

1. AIDS Support and Technical Assistance (AIDSTAR). (n.d.). Harm Reduction for
   Injecting Drug Users. Retrieved from
   http://www.aidstar-one.com/focus_areas/prevention/pkb/combination_approaches/ harm_reduction_injecting_drug_users

2. Averting HIV & AIDS: Global Epidemic (AVERT). (n.d.). Men who have sex with men (MSM) and HIV/AIDS. Retrieved from
   http://www.avert.org/men-who-have-sex-men-msm-hiv-aids.htm

3. Averting HIV & AIDS: Global Epidemic (AVERT). (n.d.). Prisoners and HIV/AIDS.
   Retrieved from http://www.avert.org/prisoners-hivaids.htm

4. Azad, Y. (2010). *Partnership patterns and HIV prevention amongst men who have sex with men (MSM)*. UK, London: National AIDS Trust (NAT).

5. Carrico, A. W., Flentje, A., Gruber, V. A., Woods, W. J., Discepola, M. V., Dilworth, S. E., Neilands, T. B., Jain, J., & Siever, M. D. (2007). Community-Based Harm Reduction Substance Abuse Treatment with Methamphetamine-Using Men Who Have Sex with Men. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, *91*(3): 555-567.

6. Central Intelligence Agency (CIA): The World Factbook. (n.d.). *Urbanization*.
   Retrieved from
   https://www.cia.gov/library/publications/the-world-factbook/fields/2212.html

7. Centers for Disease Control and Prevention [CDC], n.d. HIV/AIDS, HIV Basics, PrEP 101. Retrieved from http://www.cdc.gov/hiv/basics/prep.html

8. Dyson, T. (2003). HIV/AIDS and Urbanization. *Population and Development Review*, *29*(3): 427-442.

9. Eshrati, B., Asl, R. T., Dell, C. A., Afshar, P., Millson, P. M. E., Kamali, M., & Weekes, J. (2008). Preventing HIV transmission among Iranian prisoners: Initial support for providing education on the benefits of harm reduction practices. *Harm Reduction Journal*, *5*(21): 1-7.

10. Hannenberg, R. S., Rojanapithayakorn, W., Kunasol, P., & Sokal, D. C. (1994). Impact of Thailand's HIV-control programme as indicated by the decline of sexually transmitted diseases. *Lancet*, *344*(8917): 243-5.

11. Hasnain, M. (2005). Cultural Approach to HIV/AIDS Harm Reduction in Muslim
Countries. *Harm Reduction Journal*, *2*(23): 1-8.

12. Hinnebusch, Raymond. "Syria." In *The Middle East 13th edition,* edited by Ellen Lust, 764-788. US: CQ Press, 2014

13. HIV/AIDS Unit, Ministry of Public Health, & Demand Reduction Section, Ministry of Counter Narcotics. (2005). *Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan.* Retrieved from www.ahrn.net/library_upload/uploadfile/file2495.pdf

14. Jana, S., Rojanapithayakorn, W., & Steen, R. (2006). Harm reduction for sex workers. *Lancet*, *367*: 814

15. Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). *Country Progress Report Syrian Arab Republic. Syrian Arab Republic - Global AIDS Response Progress Report 2012*. Retrieved from www.unaids.org/.../knowyourresponse/countryprogressreports/2012countries/ce_SY_Narrative_Report[1].pdf

16. Joint United Nations Programme on HIV/AIDS (UNAIDS). (2006). *HIV and sexually transmitted infection prevention among sex workers in Eastern Europe and Central Asia*. Retrieved from http://data.unaids.org/publications/IRC-pub07/jc1212-hivpreveasterneurcentrasia _en.pdf

17. Maulsby, C., Millett, G., Lindsey, K., Kelley, R., Johnson, K., Montoya, D., & Holtgrave, D. (2013).A systematic review of HIV interventions for black men who have sex with men (MSM). *BMC Public Health*, *13*(625): 1-13.

18. Nag, M. (2005). Sex Workers in Sonagachi: Pioneers of a Revolution. *Economic and Political Weekly*, *40*(49): 5151-5156.

19. Nath, M.B. (2000). Women's Health and HIV: Experience from a Sex Workers' Project in Calcutta. *Gender and Development*, *8*(1): 100-108.

20. Newman, P. (2003). Reflections on Sonagachi: An Empowerment-Based HIV-Preventive Intervention for Female Sex Workers in West Bengal, India .*Women's Studies Quarterly*, *31(*1/2): 168-179.

21. Sen K., Al Faisal W., Al Saleh Y. 2012. "Syria: effects of conflict and sanctions on public health." Journal of Public Health: doic10.1093/pubmed/fds090.

Syrian Central Bureau of Statistics. (2008). *General Census*. Retrieved from .22 http://www.cbssyr.sy/index-EN.htm

23. Syrian Central Bureau of Statistics. (2004). *General Census*. Retrieved from http://www.cbssyr.sy/General%20census/census%202004/pop-str.pdf

24. United Nations Office on Drugs and Crime (UNODC). (2010). *Harm reduction in Asia: progress towards universal access to harm reduction services among people who inject drugs.* Retrieved from www.unodc.org/.../southeastasiaandpacific//.../harmreduction/UNRTF_report_ 2009_update_of_harm_reduction_in_Asia_FINAL.pdf

25. World Health Organization, Regional Office for Eastern Mediterranean (WHO EMRO). (2010). *The Country Cooperation Strategy for WHO and the Syrian Arab Republic 2008-2013*. Retrieved from www.emro.who.int/docs/CCS_Syrian_Arab_Republic_2010_EN_14478.pdf

26. World Health Organization (WHO). (2013). *HIV Surveillance in the WHO Eastern*
Mediterranean Region: Regional update 2012. Geneva, Switzerland: WHO

27. World Health Organization (WHO). (n.d). *Global Health Observatory Data Repository: Antiretroviral therapy coverage Data by country*. Retrieved from
http://apps.who.int/gho/data/node.main.574?lang=en

28. Vickerman, P., Kumaranayake, L., Balakireva, O., Guinness, L., Artyukh, O., Semikop, T., Yaremenko, O., & Watts, C. (2006). The Cost-Effectiveness of Expanding Harm Reduction Activities for Injecting Drug Users in Odessa, Ukraine. *Sexually Transmitted Diseases*, *33*(10): S89-S102

DISCLAIMER

This Integrated Bio-Behavioral Surveillance Survey (IBBSS) is designed as a research tool, by which most at risk populations (MARPs: FSWs, MSMs, IDUs and Prisoners) capture data on their experiences and perceptions regarding their sexual practices, sexual and reproductive health knowledge as well as sexual risky behaviors.

In this regard, the results can be said to comprise a snapshot of the current situation of MARPs in Syria in a certain place and time. Through its implementation, this survey is hoped to also serve, educate and empower MARPs in Syria.

The survey questions, therefore, focus on experiences and perceptions and do not represent factual investigations, with follow up questions, into particular allegations, incidents or events nor are the answers to the questions subject to independent verification. As research participants, interviewees have the right to anonymity and to confidentiality regarding their responses.

In addition to the empowerment function, appropriate uses of the data are for advocacy and in order to inform stigma/discrimination reduction programming and policy harm reduction strategies to prompt a national response to HIV/AIDS as well as other STDs.

The data is not available as a source of allegations of individual instances of wrong-doing.

ANNEXES

Annex I: Results

Table 1. Socio-demographic Characteristics of Respondents

	FSW N=400	IDU N=394	MSM N=400	Prisoners N=400
Place of Residence				
Damascus	199(49.8%)	47(11.9%)	215(53.8%)	400(100%)
Tartous	100(25.0%)	244(61.9%)	125(31.3%)	0(0%)
Lattakia	101(25.2%)	103(26.1%)	60(15.0%)	0(0%)
Age				
Less than 19	42(10.5%)	12(3.0%)	74(18.5%)	41(10.3%)
20-24	89(22.3%)	84(21.3%)	129(32.3%)	54(13.5%)
25-29	98(24.5%)	93(23.6%)	94(23.5%)	85(21.3%)
30-34	82(20.5%)	85(21.6%)	51(12.8%)	77(19.3%)
35-39	44(11.0%)	44(11.2%)	28(7.0%)	42(10.5%)
40-44	29(7.2%)	18(4.6%)	17(4.3%)	45(11.3%)
45+	16(4.0%)	58(14.7%)	7(1.8%)	56(14.0%)
Mean Age				
Mean (SD)	29.04(7.9)	32.12(9.9)	25.92(10.9)	32.82(10.9)
Educational Level				
Elementary	168(42.0%)	104(26.4%)	76(19.0%)	178(44.5%)
Intermediate	107(26.8%)	131(33.2%)	83(20.8%)	84(21.0%)
Secondary	40(10.0%)	83(21.1%)	92(23.0%)	49(12.3%)
Occupational	15(3.8%)	23(5.8%)	43(10.8%)	12(3.0%)
University	11(2.8%)	14(3.6%)	93(23.3%)	45(11.3%)
Legal License	(0%)	0(0%)	0(0%)	1(.3%)
Don't know	(0%)	2(.5%)	0(0%)	0(0%)
Marital Status				
Yes	344 (86.0%)	226(57.4%)	72(18.0%)	217(54.3%)
No	56 (14.0%)	168(42.6%)	325(81.3%)	183(45.8%)
Divorced	0(0%)	0(0%)	1(.3%)	0(0%)

Table 2. Distribution of Serological Data: HIV, HBV, HCV

	FSW (n=400)	MSM (n=400)	IDUs (n=394)	Prisoners (n=400)
	N (%)	**N (%)**	**N (%)**	**N (%)**
Serological Results				
HIV	0(0%)	2 (0.5%)	0(0%)	0(0%)
HBV	21(5.3%)	9(2.3%)	2(.5%)	10(2.5%)
HCV	3(.8%)	0 (0 %)	13(3.3%)	6(1.5%)

Table 3. Overview of Sexual History & Condom Use among FSWs

a. History of Sexual Activity		
Age at First Marriage	Mean (SD)	15.3(8.2)
Age at first sexual activity	Mean (SD)	17.8 (4.1)
Age at first sexual activity you got paid for profit	Mean (SD)	21.9(8.8)
What is the number of individuals family	Mean (SD)	2.38 (2.4)
Number of sexual partners during the past week	Mean (SD)	5.3 (5.8)
Number of sexual partners without profit	Mean (SD)	1.1 (2.8)
Number of sexual partners for profit	Mean (SD)	4.8 (6.2)
Number of Sexual partners on the last day of work	Mean (SD)	1.8(1.3)
Number of times had sex with men in the past year	Mean (SD)	.33(3.2)
Amount of money in Syrian pounds earnt on that last day	Mean (SD)	3611.8 (5069.6)
b. Condom Use		
Condom Use in General	N (%)	262 (65.5%)
Ever heard of Condoms	N (%)	382(95.5%)
Knowledge of Where to get condoms	N (%)	366(91.5%)
Heard of Female Condoms	N (%)	40(10.0%)
Use of Female Condoms	N (%)	1(.3%)
Knowledge of where to get Female condoms	N (%)	16(4.0%)
Time needed to get condom between work and home	Mean (SD)	2.19(8.5)
How many condoms available	Mean (SD)	4.3 (10.7)
Use of Condoms with a sexual partner not a customer	N (%)	81(20.3%)
Who Suggested use of condoms		
Me	N (%)	72(18.0%)
Partner	N (%)	15(3.8%)
Both	N (%)	2(.5%)

Frequency of Condom use in the last six months with partner		
Every time	N (%)	42(10.5%)
Most of the time	N (%)	56(14.0%)
Sometimes	N (%)	42(10.5%)
Few times	N (%)	53(13.3%)
Never	N (%)	8(2.0%)
Depends on Preference		155(38.8%)
Frequency of Condom use with a customer		
Every time	N (%)	125 (31.3%)
Most of the time	N (%)	57 (14.2%)
Sometimes	N (%)	64 (16.0%)
Few times	N (%)	50 (12.5%)
Never	N (%)	91 (22.8%)
Reasons for no condom use	N (%)	84(21.0%)
Condom not available	N (%)	14 (3.5%)
Partner does not want to	N (%)	83(20.8%)
Did not cross my mind	N (%)	43(10.8%)
No need for it	N (%)	39 (9.8%)

Table 4a. Knowledge of STIs Symptoms for Women and Men

	FSW (n=400)	MSM (n=400)	IDUs (n=394)	Prisoners (n=400)
	N (%)	N (%)	N (%)	N (%)
Symptoms for women				
Discharge	282 (70.5%)	209 (52.3%)	255 (64.7%)	89 (22.3%)
Ulcer	96 (24.0%)	128 (32.0%)	101 (25.6%)	42 (10.5%)
Burning	103 (25.8%)	141 (35.3%)	132 (33.5%)	28 (7.0%)
Itch	190(47.5%)	89 (22.3%)	152 (38.6%)	38 (9.5%)
Bad Odor	170 (42.5%)	95 (23.8%)	139 (35.3%)	56 (14.0%)
Symptoms for men				
Discharge	220 (55.0%)	214 (53.5%)	250 (63.5%)	84 (21.0%)
Ulcer	96 (24.0%)	165 (41.3%)	123 (31.2%)	45 (11.3%)
Burning	184 (46.0%)	4 (40.0%)	242 (61.4%)	52 (13.0%)
Itch	0 (0%)	160 (1.0%)	0 (0%)	0 (0%)
Bad Odor	1 (0.3%)	4 (1.0%)	1 (.3%)	1 (.3%)
Fever	3 (0.8%)	3 (.8%)	6 (1.5%)	1 (.3%)
Suffer from any Genital ulcers in the past 12 months	82 (20.5%)	37 (9.3%)		
Suffer from any Oral Ulcers in the past 12 months				
Suffer from any Genital Secretions in the past 12 months	212 (53.0%)	21 (5.3%)		
Suffer from any Anal Ulcer in the past 12 months		43 (10.8%)		
Suffer from any secretions or ulcers in the past 12 months				24 (6%)

Table 4 b. Previous Exposure and Management of STIs

	FSW (N=400)	IDU (N = 394)	MSM (N=400)	Prisoners (N=400)
Previous History of Suffer from Ulcer or Discharge	227(56.8%)	78(19.8%)	374(93.5%)	45(11.3%)
Prescription of treatment	224(56.0%)	71(18.0%)	68(17.0%)	34(8.5%)
Use of Prescribed Treatment/ Medication	218(54.5%)	75(19.0%)	66(16.5%)	31 (7.8%)

Table 5. HIV/AIDs related Knowledge

	FSW (n=400)	MSM (n=400)	IDUs (n=394)	Prisoners (n=400)
	N (%)	N (%)	N (%)	N (%)
Ever Heard of HIV/AIDs	384(96.0%)	382(95.5%)	388(98.5%)	385(96.3%)
Know of a Friend who has HIV	19(4.8%)	32(8.0%)	29(7.4%)	10 (2.5%)
Know of a Relative who has HIV	12(3.0%)	6(1.5%)	3(.8%)	5(1.3%)
Heard of any HIV/AIDS-related Awareness campaign		370(92.5%)	355(88.8%)	376(95.4%)
Knowledge of Risk Factors				
Condoms protect from HIV	179 (44.8%)	239 (59.8%)	274(69.5%)	155(38.8%)
MOSQUITO bite	128(32.0%)	192 (48%)	206(52.3%)	96(24.0%)
Sharing of Food	219 (54.8%)	262 (65.5%)	263(66.8%)	212(53.0%)
Monogamous relation	236 (59.0%)	257 (64.3%)	295(74.9%)	184(46.0%)
Abstinence	184 (46.0%)	157 (39.3%)	213(54.1%)	113(28.2%)
Injection Drug Use	348 (87.0%)	371 (92.8%)	375(95.2%)	312(78.0%)
A Healthy Person can have HIV	257 (64.3%)	296 (74%)	310(78.7%)	261(65.3%)
Mother to child transmission during pregnancy	328 (82.0%)	358 (89.5%)	331(84.0%)	292(73.0%)
Pregnant women can prevent transmission to child	121 (30.3%)	104 (26%)	108(27.4%)	79(19.8%)
Breastfeeding can transmit HIV to child	226 (56.5%)	232 (58.1%)	272(69.0%)	151(37.8%)
Mean HIV/AIDs RF Score (perfect Score =10)				
Mean (SD)	5.6(2.2)	6.2 (1.8)	6.7(2.1)	5.5(1.6)
Testing				
Tested for HIV	141(35.3%)	127(31.8%)	171(43.4%)	162(40.5%)
Tested Voluntary	91(22.8%)	82(20.5%)	106(26.9%)	167(41.8%)
Treatment Prescribed for an STI	224(56.0%)	68(17.0%)	71(18.0%)	34(8.5%)
Used Treatment for an STI	218(54.5%)	66(16.5%)	75(19.0%)	31(7.8%)

Table 6. Distribution of Alcohol and Substance Abuse

	FSW (N=400)	MSM (N = 400)	IDU (N=394)	Prisoners (N=400)
Alcohol Intake	259 (64.8%)	270(67.5%)	(93.9%)	185 (46.3%)
Frequency of Alcohol Intake	224(56.0%)	71(18.0%)	68(17.0%)	34(8.5%)
Daily	52 (13.0%)	44 (11.0%)	108 (27.4%)	34 (8.5%)
More than once per week	132(33.0%)	150(37.5%)	210 (53.3)	35(8.8%)
More than once per month	73 (18.3%)	75 (18.8%)	51 (12.9)	20(5.0%)
Venues used for drinking Alcohol (Only for UDUs) - n=394				
			Home	134 (34.0%)
			Public place	21 (5.3%)
			Home & Public place	208 (52.8%)
			Special Places & Parties	5 (1.3%)
			WORK	2(.5%)
Drug Use	44 (11.0%)	49 (12.3%)		88(22%)
Types of Drugs Used				
Weeds	28 (7.0%)	23 (5.8%)		
Cocaine	0(0%)	1(.3%)		
Valium	5(1.3%)	8(2.0%)		
Other Drugs	11(2.8%)	16(4.0%)		

Table 7. Distribution of Stigma among Participants

	FSW (n=400)	MSM (n=400)	IDUs (n=394)	Prisoners (n=400)
	N (%)	N (%)	N (%)	N (%)
Stigma related questions				
Will not share food with someone who has HIV	296 (74.0%)	225(56.3%)	284(72.1%)	270(67.5%)
Will not take care of a relative with HIV	132 (33.0%)	111(27.8%)	147(37.3%)	86(21.5%)
Will buy food from someone who has HIV	303 (75.8%)	290(72.5%)	323(82.0%)	297(74.3%)
Will feel shameful to disclose the status of a relative suffering from HIV	248 (62.0%)	238(59.5%)	302(76.6%)	203(50.7%)
Think a person with HIV/ AIDS should be quarantined	0(0%)	217(54.3%)	287(72.8%)	0(0%)
Has been forced to have sex without their own will	143 (35.8%)	0(0%)	88(22.3%)	41(10.3%)

Table 8. Overview of Sexual History & Condom Use among MSMs

a. History of Sexual Activity		
Had any type of sex with a male during the Last six months whether anal or oral sex or foreplay hand	N (%)	392 (98.0%)
Had Oral sex during the last six months	N (%)	348 (87.0%)
Had sex with a woman	N (%)	232 (58.0%)
Forced to have sex by force in the past year	N (%)	55 (13.8%)
Number of partners had oral sex with the last six months	Mean (SD)	8.5 (17.2)
Number of partners had anal sex with the last six months	Mean (SD)	14 (66.2)
Number of times had anal sex for profit the last month	Mean (SD)	4 (17.1)
Number of times had anal sex without profit the last month	Mean (SD)	7.4 (9.7)
Number of all sexual partners had sex with over all for profit	Mean (SD)	10.3 (21.5)
b. Condom Use		
Condom Use in General	N (%)	266 (66.5%)
Ever heard of Condoms	N (%)	392 (98.0%)
Knowledge of Where to get condoms	N (%)	389 (97.3%)
Use of Creams during sex	N (%)	335 (83.8%)
Know where to get creams from	N (%)	355(88.8%)
Use of Condoms during last anal sex	N (%)	128(32.0%)
Reasons for no condom use during last anal Sex		
Condom not available	N (%)	14(3.5)%
Partner does not want to	N (%)	39(9.8)%
Decrease Pleasure	N (%)	7(1.75%)
Frequency of Condom use in the last six months with Partner		
Every time	N (%)	43 (10.8%)
Most of the time	N (%)	66(16.5%)
Sometimes	N (%)	53 (13.3%)
Few times	N (%)	32 (8.0%)
Never	N (%)	67 (16.8%)
Use Condoms with a woman during the past six months	N (%)	119 (29.8%)
Discussed HIV/AIDs and other STDs with Partners	N (%)	176 (44.0%)

Table 9. Overview of Sexual History & Condom Use among IDUs

a. History of Sexual Activity		
Age at First Sexual Activity	Mean (SD)	23.10 (17.1)
Number of sexual partners in the past 12months	Mean (SD)	11.2 (21.7)
What is the usual number of sexual partners	Mean (SD)	25.9 (2.4)
How many sexual partners, non-usual	Mean (SD)	31.1 (40.8)
How many sexual practices with men during the 12 month	Mean (SD)	10.8 (27.9)
How many times you had sex with your partner usual (Spouse) during the past 30 days	Mean (SD)	10.6 (20)
How many times you had sex with your partner non-usual during the past 30 days	Mean (SD)	37.4 (40.0)
Ever Had Sex	N (%)	377 (95.7%)
Ever Had Sex in the past 12 months	N (%)	351 (89.1%)
Ever had sex with men in the past 12 months	N (%)	76 (19/3%)
Got paid for having sex with non-usual partner	N (%)	218 (55.3%)
b. Condom Use		
Ever heard of Condoms	N (%)	373 (94.7%)
Knowledge of Where to get condoms	N (%)	371 (94.2)
Time needed to get condom		
Less than half an hour	N (%)	246(62.4%)
Around an hour	N (%)	110(27.9%)
More than one hour	N (%)	8(2.0%)
Always Available with me	N (%)	5(1.3%)
Use of Condoms during last sex	N (%)	24(6.1%)
Reasons for no condom use during last sex	N (%)	
Condom not available	N (%)	5(1.3%)
Partner does not want to	N (%)	69(17.5%)
Decreases pleasure	N (%)	1(.3%)
Frequency of Condom use in the last six months	N (%)	
Every time	N (%)	14(3.6%)
Most of the time	N (%)	19(4.8%)
Sometimes	N (%)	65(16.5%)
Few times	N (%)	59(15.0%)
Never	N (%)	130(33.0%)
Discussed HIV/AIDs and other STDs with Partners	N (%)	160(40.6%)
Frequency of condom use in the last 12 months	Mean (SD)	19.53 (26.7)

Table 10. Distribution of Drug Injection Practices by IDUs (n=394)

Age at drug abuse initiation	**Mean (SD)**	24.1 (7.1)
		N (%)
Types of Drugs Used		
Heroin		338 (86)
Heroin + Cocaine		33 (8.4%)
Cocaine		12 (3%)
Weeds or Crystals		2(0.5%)
Other Drugs (Valium, Sleeping Pills, Pain Medications etc)		7 (1.8)
In the Past month, Number of times injected drugs		
Once a month		39 (9.9%)
Two or three times a month		72 (18.3%)
Once per week		34 (8.6%)
Two or three times per week		101 (25.6%)
Once a day		123 (31.2%)
More than once a day		16(4.1%)
During last Injection, shared a syringe used by someone		77 (19.5%)
During the last month, Number of times shared syringes used by others		
Every time		18 (4.6%)
Often		26 (6.6%)
During Last Month, Number of people whom share with syringes	**Mean (SD)**	28.3 (43.8)
During the last month, individuals shared with Syringes		
	Friend	94 (23.9%)
	Unusual sexual partner	71(18.0%)
	Sexual partner unusual	13(3.3%)
	A family member	1(0.3%)
	Seller	1(0.3%)
	No one	110(27.9%)
During the last month, Cleaning shared syringes before use		
	Every time	55 (14.0%)
	Often	55 (14.0%)

Continue- Table 10. Distribution of Drug Injection Practices by IDUs (n=394)

Material used to clean Syringes with	
Cold water	10 (2.5%)
Hot water	7(1.8%)
Sometimes	14(3.6%)
Alcohol	130(33.0%)
Detergent	18(4.6%)
Hot Water, Alcohol	4(1.0%)
The last month, Number of times used the unused syringe of others	
Every time	271(68.8%)
Often	61(15.5%)
Last month, number of times sold or borrowed syringes used by others	
Every time	4(1%)
Often	8(2%)
Ability to get used Syringes when needed	385 (97.7)
	N (%)
Use of Prepackaged Syringe with out knowing the source	76 (19.3)
During the Last Month, Number of times use cotton or filter, water or other tools when used syringes last month	
Every time	33 (8.4%)
Often	65 (16.5%)
During the last month, number of times took drugs from explosive used by others	
Every time	15 (3.8%)
Often	24 (6.1%)
Currently undertaking any treatment for addition	
Currently under treatment	46(11.7%)
Previously under treatment	34(8.6%)
Not subjected to the treatment	297(75.4%)
Type of Addiction Treatment	
Advice	8(2.0%)
Medication	20(5.1%)
Rehabilitation	1(0.3%)
More than one type	37(9.4%)
Rehabilitation, Medication	2(0.5%)
Treatment - the number of months Mean (SD)	1.1307(3.3)

Table 11. Overview of Sexual History & Condom Use among Prisoners

a. History of Sexual Activity		
Age at first sexual activity	Mean (SD)	14.46(9.3)
Number of sexual partners during the past year	Mean (SD)	16.67(122.2)
Number of regular partners	Mean (SD)	.79(2.2)
Number of casual partners	Mean (SD)	2.06(12.5)
Number of MSM partners	Mean (SD)	1.97(.18)
Number of times had sex with men in the past year	Mean (SD)	.33(3.2)
Number of times had sex with wife or partner during the last 30 days	Mean (SD)	2.00(12.4)
Number of times had sex with a casual partner in the last 30 days	Mean (SD)	.09(.8)
Ever Had Sex in the past 12 months	N (%)	75(18.8%)
b. Condom Use		
Condom Use in General	N (%)	91 (22.8%)
Ever heard of Condoms	N (%)	283(70.8%)
Knowledge of Where to get condoms	N (%)	285 (71.3)
Time needed to get condom between work and home	Mean (SD)	20.93(39.4)
Less than half an hour	N (%)	
Around an hour	N (%)	
More than one hour	N (%)	
Always Available with me	N (%)	
Use of Condoms during last sex	N (%)	42 (10.5%)
Reasons for no condom use during last Sex		
Condom not available	N (%)	5(1.3%)
Partner does not want to	N (%)	8 (2.0%)
Did not cross my mind	N (%)	50 (12.5%)
Frequency of Condom use in the last six months with Wife		
Every time	N (%)	8 (2.0%)
Most of the time	N (%)	14 (3.5%)
Sometimes	N (%)	11 (2.8%)
Few times	N (%)	11 (2.8%)
Never	N (%)	107 (26.9%)

Frequency of Condom use in the last six months with a Casual partner		
Every time	N (%)	7 (1.8%)
Most of the time	N (%)	6 (1.5%)
Sometimes	N (%)	9 (2.3%)
Few times	N (%)	5 (1.3%)
Never	N (%)	84 (21.1%)
Get Paid to have sex with Casual Partners	N (%)	84(21.0%)
Discussed HIV/AIDs and other STDs with Partners	N (%)	94 (23.5%)
Frequency of condom use in the last 12 months	Mean (SD)	95.49(23.6)
Frequency of Condom use during the past 6 months with wife	Mean (SD)	4.33(1.3)
Frequency of Condom use during the past 6 months with casual partner	Mean (SD)	4.41(1.3)

Table (12): list of the Data Collectors and facilitators in the Survey

Ref. No	*Name*	*Implementer*
1	Anas Habib	Syrian Family Planning Association
2	Dr. Souaad Harirah	
3	Dr. Hala Atfeh	
4	Nour Al Sabat	
5	Wafaa Al Sadat	
6	Zahra Al Ladkani	
7	Lama Ebrahim	
8	Dalal Saloukha	
9	Tania AlKhaeir	
10	Nour Sheikh Ebrahim	
11	Ali Ali	
12	Darin Muhammad Youssef	
13	Fadi Fares	
14	Samar Edriss	
15	Zaina Edriss	
16	Boushra Edriss	
17	Dr.Sanaa Ali	
18	Dr.Ghiath Zebouk	
19	Ahmad Nouman	
20	Dr.Hadi Al Eid	
21	Wassim Al Sakhla	
22	Saeda Abbas	
23	Izdihar Orabi	
24	Abd Al Rahman Al Monakel	

25	Omar Abou Nieage	Sham for Health Association
26	Hanan Khalaf	
27	Maysa Melhem	
28	Dr. Wael Ali	
29	Maha Wazan	
30	Rana Suliman	
31	Maysaa Hasan	
32	Fedaa Saleh	
33	Ali Mansour	
34	Alaa Anis	
35	Komet Muhrez	
36	Hanadi Youssef	
37	Nibal Al Awad	
38	Ali Akil	
39	Dr.Rabab Al Hafi	
40	Mohi Aldien Al Halabi	
41	Dr. Kinaz Al Sheikh	Ministry Of Health
42	Dr. Jamal Khamis	Ministry Of Health
43	Dr. Bassam Shammas	National AIDS Committee
44	Dr. Mazen Mugrabi	
45	Dr. Hazem Bakli	Syrian Red Crescent Association
46	Omar Al Malki	
47	Emad Abou Taleb	
48	Mouaz Al Malki	

Annex II: IRB Approval

الجمهورية العربية السورية

جامعة دمشق

كلية الطب البشري

الموضوع: الموافقة الأخلاقية لبحث علمي

السادة الباحثين الذين تقدموا إلى لجنة الأخلاقيات في كلية الطب البشري ببحث علمي (Grant (Number: SYR-011-G02-H وعنوانه:

المسح الأول للسلوكيات والمؤشرات الحيوية المتعلقة بفيروس عوز المناعة/الإيدز في سورية كأداة ممكنة للترصد

The First Integrated Bio-behavioral Survey on HIV/AIDS among Most At-Risk Populations in Syria as a Potential Surveillance Tool 2013-04-11

قامت لجنة الأخلاقيات في كلية الطب البشري بالاطلاع على بحثكم من الناحية الأخلاقية، والذي بعنوان: المسح الأول للسلوكيات والمؤشرات الحيوية المتعلقة بفيروس عوز المناعة/الإيدز في سورية كأداة ممكنة للترصد،

وبضوء المخطط المقدم والمرفقات بما في ذلك الموافقة المستنيرة، يسر اللجنة إبلاغكم بقبولها للمخطط المقدم ولا ترى مانعا من الناحية الأخلاقية لتنفيذ البحث على أن يتم لحظ أمرين:

أولا- تأمين واستخدام نسخة باللغة العربية للموافقة المستنيرة

ثانياً: مراعاة التأكيد على الباحثين الميدانيين بما يختص بالحصول على الموافقة الأخلاقية من الفئات الحساسة الداخلة بالدراسة وتوضيح أن الأمر طوعي لا إجبار فيه.

دمشق في ٢٠١٣/٤/٤

رئيس لجنة الأخلاقيات في كلية الطب البشري

الأستاذ الدكتور صلاح لبابيدي

Annex III: Questionnaires (In Arabic)

** Interview Guide for the Formative Stage (In English)
1: Female sex workers
2: Men who have sex with men
3: Drug users
4: Prisoners

Interview Guide for the formative stage (Key informants)

- What are the drivers of the epidemic
- What are the groups most at risk
- What are the risky behaviours
- What are the potential contributions to the size of the problems
- What is the size of each group
- How accessible each group
- How mobile each group
- How best to reach them
- Who is the gatekeepers for each group
- What are the barriers to get each group
- What best incentive to use

المسح الأول للسلوكيات والمؤشرات الحيوية المتعلقة بفيروس عوز المناعة/ الإيدز في سورية كأداة ممكنة للترصد

الاستبيان الخاص بالعاملات بالجنس

بيانات تعريفية	للترميز
١. المدينة والرمز:	ااا
٢. الرقم التسلسلي للشخص المجيب:	اااا
السيدة منحت الموافقة المطلعة: ١. نعم (تابع) ٢. لا (توقف)	ااا
تذكر: الرمز الخاص بالبيانات التي لا إجابة لها أو لا تنطبق (٩ أو ٩٩) الرمز الخاص بإجابة لا أعرف (٨ أو ٨٨)	

الزيارة	الزيارة الأولى	الزيارة الثانية
التاريخ	ااا ااا ااا	ااا ااا ااا
اسم الباحث/ة والرمز:	ااا	ااا
نتيجة الزيارة: ١. تمت بنجاح ٢. لم تتم بالشكل الكامل ٣. تم التأجيل	ااا	ااا

رقم السؤال	السؤال	الرمز
الجزء الأول: خاص بالمعلومات العامة		
س ١-١	ما هو تاريخ ميلادك	ااا ااا ااا
س ١-٢	ما هو عمرك بالسنوات	ااا
س ١-٣	هل سبق وأن التحقت بأي مرحلة تعليمية؟ ١. نعم (تابع س ٤) ٢. لا (انتقل إلى س ٥)	ااا
س ١-٤	ما هي أعلى مرحلة تعليمية التحقت بها ؟ ١. ابتدائي ٢. إعدادي ٣. أساسي ٤. ثانوي ٥. معهد متوسط ٦. جامعة فأكثر ٨. لا أعرف	ااا
س ١-٥	ما هو عدد سنوات إقامتك هنا (في المدينة/ الجوار)	ااا
س ١-٦	هل عملت بالجنس في مكان آخر ١. مدينة أخرى (تحدد) ٢. دولة مجاورة (تحدد) ٣. غير ذلك تحدد	ااا

س ١-٧	ما هو مكان ولادتك ١. المدينة نفسها ٢. مكان آخر في سورية يحدد ٣. غير ذلك، تحدد	ااا
س ١-٨	هل تتعاطين الكحول ١. نعم (تابع) ٢. لا (انتقل إلى ١٠)	ااا
س ١-٩	كم مرة تعاطيت الكحول خلال الشهر الماضي؟ ١. يومياً ٢. أكثر من مرة في الأسبوع ٣. أكثر من مرة في الشهر	ااا
س ١- ١٠	هل تتعاطين المخدرات؟ ١. نعم (تابع) ٢. لا (انتقل إلى ١٢)	ااا
س ١- ١١	ما هو نوع المادة المخدرة التي تتعاطينها؟ ١. حشيش ٢. غير ذلك، يحدد	ااا
س ١- ١٢	هل تزوجت من قبل ؟ ١. نعم (تابع) ٢. لا (انتقل إلى ١٦)	ااا
س ١- ١٣	في أي عمر تزوجت؟	ااا
س١- ١٤	هل تقيمين حالياً؟ ١. مع زوجك وشريكك بالجنس ٢. مع شريك بالجنس غير الزوج ٣. مع الأهل ٤. غير ذلك، تحدد	ااا
س ١- ١٥	هل يعيش زوجك مع زوجات أخرى؟ ١. نعم ٢. لا	ااا
س ١- ١٦	في أي عمر قبضت مالاً مقابل الجنس لأول مرة	ااا
س١- ١٧	هل تكسبين المال مقابل عمل آخر غير العمل بالجنس ١. نعم (تابع) ٢. لا (انتقل إلى ١٩)	ااا
س ١- ١٨	ما هو هذا العمل: ١. عمل حر ٢. عمل وظيفي ٣. غير ذلك تحدد	ااا
س١- ١٩	هل تعيلين أي من أفراد أسرتك (أولاد، زوج، أهل...) ؟ ١. نعم (تابع) ٢. لا (انتقل إلى ٢١)	ااا
س١- ٢٠	كم عدد الأفراد الذين تعيلينهم؟	ااا
الجزء الثاني: معلومات متعلقة بالممارسة الجنسية الآن سننتقل لمجموعة من الأسئلة خاصة بالممارسة الجنسية		

س٢- ٢١	ما هو عمرك عندما مارست الجنس لأول مرة	ااا
س ٢-٢٢	ما هو عدد الشركاء الجنسيين خلال الأسبوع الماضي؟	ااا
س ٢-٢٣	ما هو عدد الشركاء الجنسيين خلال الأسبوع الماضي من الزبائن الذين يدفعون أجراً؟	ااا
س ٢- ٢٤	ما هو عدد الشركاء الجنسيين خلال الأسبوع الماضي من الزبائن الذين لا يدفعون أجراً (الزوج..)؟	ااا
س ٢-٢٥	ما هو عدد الزبائن في آخر يوم عملت به بالجنس؟	ااا
س ٢-٢٦	ما هو الأجر الذي تلقيته في ذلك اليوم بالليرات السورية؟	اااا
س ٢-٢٧	هل استخدمت واقياً ذكرياً خلال ذلك اليوم ١. نعم (تابع) ٢. لا (انتقل إلى ٢٩)	ااا
س ٢-٢٨	من اقترح استخدام الواقي الذكي؟ ١. أنت ٢. الشريك الجنسي	ااا
س ٢-٢٩	لماذا لم يستخدم الواقي الذكري؟ ١. لم يكن متوفراً ٢. لم يرغب الشريك ٣. تكلفته عالية ٤. لم يخطر ببالك ٥. تستخدمين وسائل أخرى لمنع الحل ٦. غير ذلك يحدد	ااا
س ٢-٣٠	ما هو تكرار استخدامك والزبائن الواقي الذكري ١. كل مرة ٢. أغلب الأحيان ٣. بعض الأحيان ٤. مرات قليلة ٥. أبداً على الإطلاق	ااا
س ٢- ٣١	ما هو عدد مرات ممارسة الجنس مع الشريك الجنسي من غير الزبائن خلال الشهر الماضي؟	ااا
س ٢-٣٢	هل تستخدمين واقياً ذكرياً مع الشريك الجنسي من غير الزبائن ١. نعم (تابع) ٢. لا (انتقل إلى ٣٤)	ااا
س ٢- ٣٣	من اقترح استخدام الواقي الذكي؟ ١. أنت ٢. الشريك الجنسي	ااا
س ٢- ٣٤	لماذا لم يستخدم الواقي الذكري؟ ١. لم يكن متوفراً ٢. لم يرغب الشريك ٣. تكلفته عالية ٤. لم يخطر ببالك ٥. تستخدمين وسائل أخرى لمنع الحل ٦. غير ذلك يحدد	ااا

س ٢- ٣٥	ما هو تكرار استخدامك والشريك الجنسي الواقي الذكري خلال الأشهر الست الماضية؟ ١. كل مرة ٢. أغلب الأحيان ٣. بعض الأحيان ٤. مرات قليلة ٥. أبداً على الإطلاق	ااا
س ٢- ٣٦	هل تستخدمين الواقي الذكري ١. نعم ٢. لا	ااا
س ٢- ٣٧	هل سمعت بالواقي الذكري ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٢- ٣٨	هل تعرفين من أين تحصلين على الواقي الذكري ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٢- ٣٩	ما هي الأماكن التي تحصلين منها على الواقي الذكري (أكثر من إجابة) ١. الصيدلية ٢. السوبرماركت ٣. العيادة الطبية ٤. المركز الصحي ٥. غير ذلك يحدد	ااا ااا ااا ااا ااا ااا
س ٢- ٤٠	هل سمعت بالواقي الأنثوي ١. نعم ٢. لا ٣. لا أعرف	ااا
س ٢- ٤١	هل تستخدمين الواقي الأنثوي ١. نعم ٢. لا	ااا
س ٢-٤٢	هل تعرفين من أين تحصلين على الواقي الأنثوي ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٢- ٤٣	ما هي الأماكن التي تحصلين منها على الواقي الأنثوي (أكثر من إجابة) ١. الصيدلية ٢. السوبرماركت ٣. العيادة الطبية ٤. المركز الصحي ٥. غير ذلك يحدد	ااا ااا ااا ااا ااا ااا
س ٢-٤٤	ما هي المدة التي تحتاجينها للحصول على واقي ذكري من مكان سكنك أو عملك ١. أقل من نصف ساعة ٢. حوالي الساعة ٣. أكثر من ساعة ٤. غير ذلك، يحدد	ااا
س ٢-٤٥	ما هو عدد الواقيات الذكرية المتوفرة بين أيديك حالياً	ااا
الجزء الثالث: الأمراض المنتقلة بالجنس		

س ٣- ٤٦	هل سمعت بأي أمراض يمكن أن تنتقل عن طريق الجنس ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٣-٤٧	ما هي أعراض تلك الأمراض عند المرأة (توضع دائرة على الإجابة المذكورة - أكثر من إجابة ممكنة) ١. ألم بطني ٢. مفرزات تناسلية ٣. قرحات تناسلية ٤. رائحة كريهة ٥. حكة في المنطقة التناسلية ٦. تورم في المنطقة التناسلية ٧. حرقة بولية ٨. غير ذلك يحدد.....	ااا ااا ااا ااا ااا ااا ااا ااا ااا
س ٣-٤٨	ما هي أعراض تلك الأمراض عند الرجل (توضع دائرة على الإجابة المذكورة - أكثر من إجابة ممكنة) ١. مفرزات تناسلية ٢. قرحات تناسلية ٣. تورم في المنطقة التناسلية ٤. حرقة بولية ٨. غير ذلك يحدد.....	ااا ااا ااا ااا ااا ااا
س ٣-٤٩	هل عانيت من مفرزات تناسلية خلال الأشهر الـ ١٢ الماضية ١. نعم (تأكد أن تسأل الجزء الخامس) ٢. لا (لا داع للجزء الخامس) ٨. لا أعرف	ااا
س ٣-٥٠	هل عانيت من قرحة تناسلية خلال الأشهر الـ ١٢ الماضية ١. نعم (تأكد أن تسأل الجزء الخامس) ٢. لا (لا داع للجزء الخامس) ٨. لا أعرف	ااا
الجزء الرابع: المعرفة والمواقف		
س ٤- ٥١	هل سمعت بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٥٢	هل تعرفين أي شخص مصاب بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٥٣	هل لديك أي قريب أو صديق مصاب بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم (قريب) ٢. نعم (صديق) ٣. لا ٨. لا أعرف	ااا
س ٤-٥٤	هل يستطيع الأفراد وقاية أنفسهم من الإيدز أو عدوى فيروس نقص المناعة إذا استخدموا الواقي الذكري بشكل صحيح في كل مرة يمارسون بها الجنس؟ ١. نعم ٢. لا ٣. لا أعرف	ااا

س ٤-٥٥	هل من الممكن الإصابة بفيروس نقص المناعة بسبب عضة البعوض ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٦	هل يستطيع الشخص حماية نفسه من الإيدز إذا استمر بعلاقة جنسية وحيدة مخلصة ومع شخص غير مصاب بالعدوى ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٧	هل يستطيع الشخص حماية نفسه من الإيدز إذا امتنع عن ممارسة الجنس نهائياً ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٨	هل من الممكن الإصابة بفيروس نقص المناعة من مشاركة وجبة طعام مع شخص مصاب ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٩	هل من الممكن الإصابة بفيروس نقص المناعة من مشاركة حقنة مخدرات مع شخص مصاب ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٦٠	هل يمكن أن يكون شخص يبدو سليم ظاهرياً مصاباً بعدوى فيروس نقص المناعة الذي يؤدي للايدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٦١	هل يمكن أن تنقل سسيدة حامل مصابة بعدوى نقص المناعة أو الإيدز المرض إلى وليدها ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٦٢	ماذ يمكن أن تقوم به السيدة الحامل المصابة بعدوى نقص المناعة أو الإيدز لتجنب انتقال المرض إلى وليدها ١. أخذ أدوية ٢. غير ذلك يحدد ٨. لا أعرف	ااا
س ٤-٦٣	هل يمكن أن تنقل سسيدة مرضع مصابة بعدوى نقص المناعة أو الإيدز المرض إلى وليدها عبر الإرضاع الوالدي ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٦٤	هل يمكن الحصول على اختبار لتحري الإيدز بشكل سري دون معرفة الآخرين ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٦٥	لا أرغب بمعرفة النتيجة ولكن هل قمت بفحص تحري الإيدز ١. نعم (تابع) ٢. لا (انتقل إلى ٦٩) ٨. لا أعرف	ااا

س ٤-٦٦	هل قمت بالفحص طوعياً أو برغبة من غيرك ١. طوعياً ٢. برغبة من الغير ٣. غير ذلك، حدد	ااا
س ٤-٦٧	لا أرغب بمعرفة النتيجة ولكن هل قمت بمعرفة نتيجة فحص تحري الإيدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٦٨	منذ متى أجريت الفحص؟ ١. خلال السنة الماضية ٢. منذ ١-٢ سنة ٣. منذ ٢- ٤ سنوات ٤. أبعد من ٤ سنوات	ااا
س ٤- ٦٩	هل سمعت أي رسائل صحية عن الإيدز ١. نعم ٢. لا ٨. غير متأكد	ااا
س ٤- ٧٠	ما هو مصدر المعلومات أو الرسائل ؟ (أكثر من إجابة ممكنة) ١. راديو ٢. تلفزيون ٣. نشرات مكتوبة ٤. المركز الصحي أو العيادة ٥. غير ذلك يحدد،	ااا ااا ااا ااا ااا ااا
س ٤- ٧١	أي من تلك المصادر هو الأكثر توفراً لك؟ (أكثر من إجابة ممكنة) ١. راديو ٢. تلفزيون ٣. نشرات مكتوبة ٤. المركز الصحي أو العيادة ٥. غير ذلك يحدد،	ااا ااا ااا ااا ااا ااا
الجزء الخامس: التدخلات		
س ٥- ٧٢	إذا عانيت من مفرزات أو قرحة تناسلية، هل لجأت لطلب المساعدة من: ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا ااا ااا ااا ااا ااا

س ٥- ٧٣	ممن لجأت أولا لطلب المساعدة: ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٥- ٧٤	هل وصف لك دواء لعلاج الحالة ١. نعم (تابع) ٢. لا (انتقل إلى ٧٧)	ااا
س ٥-٧٥	من أين حصلت على الدواء؟ ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٥- ٧٦	هل استخدمت الدواء الموصوف؟ ١. نعم ٢. لا	ااا
س ٥-٧٧	إذا كان الجواب «لا» لماذا ١. اهمال ٢. عدم توفر الدواء ٣. كلفة الدواء ٤. غير ذلك يحدد	ااا
س ٥- ٧٨	أرغب أن أعرف كم استمرت الأعراض لديك قبل طلب المعالجة ١. أقل من أسبوع ٢. من أسبوع إلى شهر ٣. أكثر من شهر	ااا
الجزء السادس: الوصمة		
س ٦- ٧٩	إذا عرفت أن أحدهم مريض بالإيدز، هل تتناولين الطعام معه ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦- ٨٠	إذا عرفت أن قريب لك مريض بالإيدز، هل تقومين برعايته ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦-٨١	إذا عرفت أن أحد البائعين مريض بالإيدز، هل تستمري بشراء الطعام منه ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦- ٨٢	إذا عرفت أن أحد أفراد عائلتك مريض بالإيدز، هل تتضايقين من البوح بهذا الأمر ؟ ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦-٨٣	هل أجبرك يوماً أحد الشركاء الجنسيين لك على ممارسة الجنس دون رغبة منك ١. نعم ٢. لا	ااا

المسح الأول للسلوكيات والمؤشرات الحيوية المتعلقة بفيروس عوز المناعة/ الإيدز في سورية كأداة ممكنة للترصد

الاستبيان الخاص بالذكور الذين يمارسون الجنس مع الذكور

بيانات تعريفية	للترميز
١. المدينة والرمز:	ااا
٢. الرقم التسلسلي للشخص المجيب:	اااا
الشخص منح الموافقة المطلعة: ١. نعم (تابع) ٢. لا (توقف)	ااا
تذكر: الرمز الخاص بالبيانات التي لا إجابة لها أو لا تنطبق (٩ أو ٩٩) الرمز الخاص بإجابة لا أعرف (٨ أو ٨٨)	

الزيارة	الزيارة الأولى	الزيارة الثانية
التاريخ	ااا ااا ااا	ااا ااا ااا
اسم الباحث/ة والرمز:	ااا	ااا
نتيجة الزيارة: ١. تمت بنجاح ٢. لم تتم بالشكل الكامل ٣. تم التأجيل	ااا	ااا

رقم السؤال	السؤال	الرمز
الجزء الأول: خاص بالمعلومات العامة		
س ١-١	ما هو تاريخ ميلادك	ااا ااا ااا
س ١-٢	ما هو عمرك بالسنوات	ااا
س ١-٣	هل سبق وأن التحقت بأي مرحلة تعليمية؟ ١. نعم (تابع س ٤) ٢. لا (انتقل إلى س ٥)	ااا
س ١-٤	ما هي أعلى مرحلة تعليمية التحقت بها ؟ ١. ابتدائي ٢. إعدادي ٣. أساسي ٤. ثانوي ٥. معهد متوسط ٦. جامعة فأكثر ٨. لا أعرف	ااا
س ١-٥	ما هو عدد سنوات إقامتك هنا (في المدينة/الجوار)	ااا
س ١-٦	هل غادرت مكان الإقامة لمدة طويلة خلال السنة الماضية ١. نعم ٢. لا	ااا

س ١-٧	ما هو مكان ولادتك ١. المدينة نفسها ٢. مكان آخر في سورية يحدد ٣. غير ذلك، تحدد	ااا
س ١-٨	هل تتعاطى الكحول ١. نعم (تابع) ٢. لا (انتقل إلى ١٠)	ااا
س ١-٩	كم مرة تعاطيت الكحول خلال الشهر الماضي؟ ١. يومياً ٢. أكثر من مرة في الأسبوع ٣. أكثر من مرة في الشهر	ااا
س ١- ١٠	هل تتعاطى المخدرات؟ ١. نعم (تابع) ٢. لا (انتقل إلى ١٢)	ااا
س ١- ١١	ما هو نوع المادة المخدرة التي تتعاطاها؟ ١. حشيش ٢. غير ذلك، يحدد	ااا
س ١- ١٢	هل تزوجت من سيدة من قبل ؟ ١. نعم ٢. لا	ااا
س١- ١٣	هل تقيم حالياً؟ ١. مع زوجتك وشريكتك الجنس ٢. مع شريكتك بالجنس غير الزوجة ٣. مع زوجتك دون شراكة بالجنس ٤. غير ذلك، تحدد	ااا
س ١-١٤	هل مارست الجنس مع ذكر آخر خلال الأشهر الست الماضية سواء الجنس عن طريق الفم أو الشرج أو مداعبة الأعضاء التناسلية باليد ١. نعم (تابع) ٢. لا (توقف)	
الجزء الثاني: معلومات متعلقة بالممارسة الجنسية الآن سننتقل لمجموعة من الأسئلة خاصة بالممارسة الجنسية مع الذكور		
س٢- ١٥	هل قمت خلال الأشهر الست الماضية بممارسة الجنس عن طريق الفم ١. نعم (تابع) ٢. لا (انتقل إلى ٢٠)	ااا
س ٢-١٦	ما هو عدد الشركاء الجنسيين الذين مارست معهم الجنس عن طريق الفم خلال الأشهر الست الماضية ؟	ااا
س ٢-١٧	هل استخدمت أو شريكك الواقي الذكري أثناء الممارسة الجنسية عن طريق الفم ١. نعم ٢. لا	ااا

س ٢- ١٨	كم مرة استخدمت وشريكك أثناء الممارسة الجنسية عن طريق الفم خلال الأشهر الست الماضية؟	ااا
س ٢-١٩	هل لجأت أو شريكك للقذف في الفم أثناء الممارسة الجنسية ولو لمرة واحدة خلال الأشهر الست الماضية؟ ١. نعم ٢. لا	ااا
س ٢-٢٠	أريد أن أسألك عن عدد الشركاء الجنسيين الذين مارست معهم الجنس عن طريق الشرج خلال الأشهر الست الماضية ؟	ااا
س ٢-٢١	هل تذكر كم مرة كنت فيها الشخص المتلقي في الممارسة عن طريق الشرج خلال الأشهر الست الماضية؟	ااا
س ٢-٢٢	من جميع أولئك الشركاء الجنسيين الذكور، كم منهم كان بقصد الربح؟	ااا
س ٢-٢٣	خلال السنة الماضية هل أجبرك أحد الشركاء الجنسيين على ممارسة الجنس بالقوة وبدون رغبة منك؟	ااا
س ٢-٢٤	كم عدد المرات التي مارست بها الجنس عن طريق الشرج لقاء ربح مادي خلال الشهر الماضي؟	ااا
س ٢- ٢٥	هل استخدمت واقياً ذكرياً خلال ممارسة الجنس عن طريق الشرج في المرة الأخيرة ؟ ١. نعم (تابع) ٢. لا (انتقل إلى ٢٧)	ااا
س ٢- ٢٦	لماذا لم يستخدم الواقي الذكري؟ ١. لم يكن متوفراً ٢. لم يرغب الشريك ٣. تكلفته عالية ٤. لم يخطر ببالك ٥. غير ذلك يحدد	ااا
س ٢- ٢٧	ما هو تكرار استخدامك والشريك الجنسي الواقي الذكري خلال الستة أشهر الماضية ١. كل مرة ٢. أغلب الأحيان ٣. بعض الأحيان ٤. مرات قليلة ٥. أبداً على الإطلاق	ااا
س ٢- ٢٨	هل ناقشت الإيدز أو الأمراض الأخرى المنتقلة بالجنس مع الشريك؟ ١. نعم ٢. لا	ااا
س ٢- ٢٩	كم عدد المرات التي مارست بها الجنس عن طريق الشرج دون ربح مادي خلال الشهر الماضي؟	ااا

س ٢-٣٠	هل استخدمت واقياً ذكرياً خلال ممارسة الجنس عن طريق الشرج في المرة الأخيرة؟ ١. نعم (تابع) ٢. لا (انتقل إلى ٣٢)	ااا
س ٢- ٣١	لماذا لم يستخدم الواقي الذكري؟ ١. لم يكن متوفراً ٢. لم يرغب الشريك ٣. تكلفته عالية ٤. لم يخطر ببالك ٥. غير ذلك يحدد	ااا ااا ااا ااا ااا ااا
س ٢- ٣٢	هل ناقشت الإيدز أو الأمراض الأخرى المنتقلة بالجنس مع الشريك؟ ١. نعم ٢. لا	
س ٢- ٣٣	الآن سأسألك عن العلاقة الجنسية مع النساء: هل مارست الجنس مع امرأة ١. نعم (تابع) ٢. لا (انتقل إلى ٣٧)	
س ٢- ٣٤	ما هو عدد النساء اللاتي مارست معهن الجنس خلال الأشهر الست الأخيرة	
س ٢- ٣٥	هل استخدمت واقياً ذكرياً خلال ممارسة الجنس مع سيدة خلال الأشهر الست الأخيرة	
س ٢- ٣٦	ما هو تكرار استخدامك للواقي الذكري أثناء ممارسة الجنس مع سيدة خلال الأشهر الست الماضية	
س ٢- ٣٧	هل تستخدم الواقي الذكري؟ ١. نعم ٢. لا	
س ٢- ٣٨	هل سمعت بالواقي الذكري؟ ١. نعم ٢. لا ٨. لا أعرف	
س ٢- ٣٩	هل تعرف من أين تحصل على الواقي الذكري ١. نعم ٢. لا ٨. لا أعرف	
س ٢-٤٠	ما هي الأماكن التي تحصل منها على الواقي الذكري (أكثر من إجابة ممكنة) ١. الصيدلية ٢. السوبرماركت ٣. العيادة الطبية ٤. المركز الصحي ٥. غير ذلك يحدد	
س ٢- ٤١	هل تستخدم أي مطري/ مزلق أثناء ممارسة الجنس ١. نعم (تابع) ٢. لا	
س ٢- ٤٢	ما هو نوع المطري/المزلق الذي تستخدمه غالباً؟	

س ٢- ٤٣	هل تعرف من أين تحصل على المطري/المزلق ؟ ١. نعم ٢. لا ٨. لا أعرف	
س ٢-٤٤	ما هي الأماكن التي تحصل منها على المزلق/ المطري (أكثر من إجابة ممكنة) ١. الصيدلية ٢. السوبرماركت ٣. العيادة الطبية ٤. المركز الصحي ٥. غير ذلك يحدد.....	
س ٢-٤٥	من يقوم عادة بتأمين المزلق/المطري ١. أنت ٢. الشريك الجنسي	
س ٢- ٤٦	ما هي المدة التي تحتاجها للحصول على واقي ذكري من مكان سكنك أو عملك ١. أقل من نصف ساعة ٢. حوالي الساعة ٣. أكثر من ساعة ٤. غير ذلك، يحدد	
الجزء الثالث: الأمراض المنتقلة بالجنس		
س ٣- ٤٧	هل سمعت بأي أمراض يمكن أن تنتقل عن طريق الجنس ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٣-٤٨	ما هي أعراض تلك الأمراض عند المرأة (توضع دائرة على الإجابة المذكورة) (أكثر من إجابة ممكنة) ١. ألم بطني ٢. مفرزات تناسلية ٣. قرحات تناسلية ٤. رائحة كريهة ٥. حكة في المنطقة التناسلية ٦. تورم في المنطقة التناسلية ٧. حرقة بولية ٨. غير ذلك يحدد.....	ااا ااا ااا ااا ااا ااا ااا ااا ااا
س ٣-٤٩	ما هي أعراض تلك الأمراض عند الرجل (توضع دائرة على الإجابة المذكورة) (أكثر من إجابة ممكنة) ١. مفرزات تناسلية ٢. قرحات تناسلية ٣. تورم في المنطقة التناسلية ٤. حرقة بولية ٨. غير ذلك يحدد.....	ااا ااا ااا ااا ااا ااا
س ٣-٥٠	هل عانيت من قرحة تناسلية خلال الأشهر الـ ١٢ الماضية ١. نعم (تأكد أن تسأل الجزء الخامس) ٢. لا (لا داع للجزء الخامس) ٨. لا أعرف	ااا

س ٣-٥١	هل عانيت من قرحة شرجية خلال الأشهر الـ ١٢ الماضية ١. نعم (تأكد أن تسأل الجزء الخامس) ٢. لا (لا داع للجزء الخامس) ٨. لا أعرف	ااا
س ٣- ٥٢	هل عانيت من مفرزات شرجية خلال الأشهر الـ ١٢ الماضية ١. نعم (تأكد أن تسأل الجزء الخامس) ٢. لا (لا داع للجزء الخامس) ٨. لا أعرف	
الجزء الرابع: المعرفة والمواقف		
س ٤- ٥٣	هل سمعت بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٥٤	هل تعرف أي شخص مصاب بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٥٥	هل لديك أي قريب أو صديق مصاب بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم (قريب) ٢. نعم (صديق) ٣. لا ٨. لا أعرف	ااا
س ٤-٥٦	هل يستطيع الأفراد وقاية أنفسهم من الإيدز أو عدوى فيروس نقص المناعة إذا استخدموا الواقي الذكري بشكل صحيح في كل مرة يمارسون بها الجنس؟ ١. نعم ٢. لا ٣. لا أعرف	ااا
س ٤-٥٧	هل من الممكن الإصابة بفيروس نقص المناعة بسبب عضة البعوض ١. نعم ٢- لا ٨- لا أعرف	ااا
س ٤-٥٨	هل يستطيع الشخص حماية نفسه من الإيدز إذا استمر بعلاقة جنسية وحيدة مخلصة ومع شخص غير مصاب بالعدوى ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٩	هل يستطيع الشخص حماية نفسه من الإيدز إذا امتنع عن ممارسة الجنس نهائياً ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٦٠	هل من الممكن الإصابة بفيروس نقص المناعة من مشاركة وجبة طعام مع شخص مصاب ١. نعم ٢. لا ٨. لا أعرف	ااا

س ٤-٦١	هل من الممكن الإصابة بفيروس نقص المناعة من مشاركة حقنة مخدرات مع شخص مصاب ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٦٢	هل يمكن أن يكون شخص يبدو سليم ظاهرياً مصاباً بعدوى فيروس نقص المناعة الذي يؤدي للايدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٦٣	هل يمكن أن تنقل سسيدة حامل مصابة بعدوى نقص المناعة أو الإيدز المرض إلى وليدها ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٦٤	ماذا يمكن أن تقوم به السيدة الحامل المصابة بعدوى نقص المناعة أو الإيدز لتجنب انتقال المرض إلى وليدها ١. أخذ أدوية ٢. غير ذلك يحدد ٨. لا أعرف	ااا
س ٤-٦٥	هل يمكن أن تنقل سسيدة مرضع مصابة بعدوى نقص المناعة أو الإيدز المرض إلى وليدها عبر الإرضاع الوالدي ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٦٦	هل يمكن الحصول على اختبار لتحري الإيدز بشكل سري دون معرفة الآخرين ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٦٧	لا أرغب بمعرفة النتيجة ولكن هل قمت بفحص تحري الإيدز ١. نعم (تابع) ٢. لا (انتقل إلى ٦٩) ٨. لا أعرف	ااا
س ٤-٦٨	هل قمت بالفحص طوعياً أو برغبة من آخر ١. طوعياً ٢. برغبة من آخر ٣. غير ذلك، حدد	ااا
س ٤-٦٩	لا أرغب بمعرفة النتيجة ولكن هل قمت بمعرفة نتيجة فحص تحري الإيدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٧٠	منذ متى أجريت الفحص؟ ١. خلال السنة الماضية ٢. منذ ١-٢ سنة ٣. منذ ٢- ٤ سنوات ٤. أبعد من ٤ سنوات	ااا

س ٤- ٧١	هل سمعت أي رسائل صحية عن الإيدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٧٢	ما هو مصدر المعلومات أو الرسائل؟ (أكثر من إجابة ممكنة) ١. راديو ٢. تلفزيون ٣. نشرات مكتوبة ٤. المركز الصحي أو العيادة ٥. غير ذلك يحدد،	ااا ااا ااا ااا ااا ااا
س ٤- ٧٣	أي من تلك المصادر هو الأكثر توفراً لك؟ (أكثر من إجابة ممكنة) ١. راديو ٢. تلفزيون ٣. نشرات مكتوبة ٤. المركز الصحي أو العيادة ٥. غير ذلك يحدد،	ااا ااا ااا ااا ااا ااا
الجزء الخامس: التدخلات		
س ٥- ٧٤	إذا عانيت من قرحة تناسلية أو شرجية، هل لجأت لطلب المساعدة من: ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا ااا ااا ااا ااا ااا
س ٥- ٧٥	ممن لجأت أولا لطلب المساعدة: ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٥- ٧٦	هل وصف لك دواء لعلاج الحالة ١. نعم (تابع) ٢. لا (انتقل إلى ٧٩)	ااا
س ٥-٧٧	من أين حصلت على الدواء؟ ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٥- ٧٨	هل استخدمت الدواء الموصوف؟ ١. نعم ٢. لا	ااا

س ٥-٧٩	إذا كان الجواب «لا» لماذا ١. اهمال ٢. عدم توفر الدواء ٣. كلفة الدواء ٤. غير ذلك يحدد	ااا
س ٥- ٨٠	أرغب أن أعرف كم استمرت الأعراض لديك قبل طلب المعالجة: ١. أقل من أسبوع ٢. من أسبوع إلى شهر ٣. أكثر من شهر	ااا
الجزء السادس: الوصمة		
س ٦- ٨١	إذا عرفت أن أحدهم مريض بالإيدز، هل تتناول الطعام معه ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦- ٨٢	إذا عرفت أن قريب لك مريض بالإيدز، هل تقوم برعايته ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦-٨٣	إذا عرفت أن أحد البائعين مريض بالإيدز، هل تستمري بشراء الطعام منه ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦- ٨٤	إذا عرفت أن أحد أفراد عائلتك مريض بالإيدز، هل تتضايق من البوح بهذا الأمر ؟ ١. نعم ٢. لا ٨. لا أعرف	ااا

المسح الأول للسلوكيات والمؤشرات الحيوية المتعلقة بفيروس عوز المناعة/الإيدز في سورية كأداة ممكنة للترصد

الاستبيان الخاص بالمدمنين على المخدرات

بيانات تعريفية	للترميز
١. المدينة والرمز:	ااا
٢. الرقم التسلسلي للشخص المجيب:	اااا
الشخص منح الموافقة المطلعة: ١. نعم (تابع) ٢. لا (توقف)	ااا
تذكر: الرمز الخاص بالبيانات التي لا إجابة لها أو لا تنطبق (٩ أو ٩٩) الرمز الخاص بإجابة لا أعرف (٨ أو ٨٨)	

الزيارة	الزيارة الأولى	الزيارة الثانية
التاريخ	ااا ااا ااا	ااا ااا ااا
اسم الباحث/ة والرمز:	ااا	ااا
نتيجة الزيارة: ١. تمت بنجاح ٢. لم تتم بالشكل الكامل ٣. تم التأجيل	ااا	ااا

رقم السؤال	السؤال	الرمز
الجزء الأول: خاص بالمعلومات العامة		
س ١-١	ما هو تاريخ ميلادك	ااا ااا ااا
س ١-٢	ما هو عمرك بالسنوات	ااا
س ١-٣	هل سبق وأن التحقت بأي مرحلة تعليمية؟ ١. نعم (تابع س ٤) ٢. لا (انتقل إلى س ٥)	ااا
س ١-٤	ما هي أعلى مرحلة تعليمية التحقت بها ؟ ١. ابتدائي ٢. إعدادي ٣. أساسي ٤. ثانوي ٥. معهد متوسط ٦. جامعة فأكثر ٨. لا أعرف	ااا
س ١-٥	ما هو عدد سنوات إقامتك هنا (في المدينة/الجوار)	ااا
س ١-٦	هل غادرت مكان الإقامة لمدة طويلة خلال السنة الماضية ١. نعم ٢. لا	ااا

س ١–٧	ما هو مكان ولادتك ١. المدينة نفسها ٢. مكان آخر في سورية يحدد ٣. غير ذلك، تحدد	ااا
س ١–٩	هل تتعاطى الكحول ١. نعم (تابع) ٢. لا (انتقل إلى ١٢)	ااا
س ١–١٠	كم مرة تعاطيت الكحول خلال الشهر الماضي؟ ١. يومياً ٢. أكثر من مرة في الأسبوع ٣. أكثر من مرة في الشهر	ااا
س ١–١١	أين تتعاطى الكحول ١. في المنزل ٢. في مكان عام ٣. في المنزل والأمكنة العامة ٤. غير ذلك يحدد	ااا
الجزء الثاني: تعاطي المخدرات وسلوك الحقن		
س ٢–١٢	منذ متى وأنت تتعاطى الأدوية المخدرة (بالأشهر)	ااا
س ٢–١٣	منذ متى وأنت تتعاطى الحقن المخدرة (بالأشهر)	ااا
س ٢–١٤	كم كان عمرك بالسنوات حينما بدأت بتعاطي المخدرات لأول مرة	ااا
س ٢–١٥	ما هي الأدوية المخدرة التي تعاطيتها خلال الشهر الماضي ١. هيروئين ٢. كوكائيين ٣. منومات ٤. منشطات ٥. غير ذلك يحدد	ااا
س ٢–١٦	خلال الشهر الماضي كم مرة قمت بحقن المخدرات ١. مرة بالشهر ٢. مرتين أو ثلاث بالشهر ٣. مرة بالأسبوع ٤. مرتين أو ثلاث بالأسبوع ٥. مرة يومياً ٦. أكثر من مرة باليوم	ااا
س ٢–١٧	في آخر مرة تعاطيت فيها المخدر هل قمت باستخدام محقنة مستعملة من شخص آخر ١. نعم ٢. لا	ااا
س ٢–١٨	كم مرة خلال الشهر الأخير استخدمت محاقن مستعملة من آخرين ١. كل المرات ٢. أغلب الأحيان ٣. بعض الأحيان ٤. ولا مرة	ااا
س ٢–١٩	هل شاركت المحقنة خلال الشهر الماضي مع: (أكثر من اجابة ممكنة) ١. صديق ٢. أحد أفراد العائلة ٣. بائع ٤. شريك جنسي معتاد ٥. شريك جنسي غير معتاد ٦. غير ذلك يحدد	ااا ااا
س ٢–٢٠	ما هو عدد الأشخاص الذين شاركتهم المحقنة في الشهر الماضي	ااا

س ٢-٢١	في الشهر الماضي عندما شاركت المحاقن مع آخرين، هل قمت بتنظيف المحقنة ١. كل المرات ٢. أغلب الأحيان ٣. بعض الأحيان ٤. ولا مرة	ااا
س ٢-٢٢	هل قمت بتنظيف المحاقن باستخدام: ١. الماء البارد ٢. الماء الساخن ٣. الغلي ٤. الكحول ٥. مادة منظفة ٦. غير ذلك، يحدد	ااا
س ٢-٢٣	خلال الشهر الماضي كم مرة استخدمت محقنة غير مستخدمة من آخر ١. كل المرات ٢. أغلب الأحيان ٣. بعض الأحيان ٤. ولا مرة	ااا
س ٢-٢٤	خلال الشهر الماضي كم مرة أعرت أو بعت المحقنة التي استخدمتها لآخرين ١. كل المرات ٢. أغلب الأحيان ٣. بعض الأحيان ٤. ولا مرة	ااا
س ٢-٢٥	ما هو عدد الأشخاص الذين أعرتهم أو بعتهم المحقنة خلال الشخص الماضي	ااا
س ٢-٢٦	من هم الذين أعرتهم أو بعتهم المحقنة خلال الشهر الماضي: (أكثر من اجابة ممكنة) ١. صديق ٢. أحد أفراد العائلة ٣. بائع ٤. شريك جنسي معتاد ٥. شريك جنسي غير معتاد ٦. غير ذلك يحدد	ااا ااا
س ٢-٢٧	هل باستطاعتك الحصول على محاقن غير مستخدمة عندما ترغب: ١. نعم ٢. لا	ااا
س ٢-٢٨	هل تعرف أي شخص أو مكان تحصل منه على محاقن غير مستخدمة: ١. نعم ٢. لا	ااا
س ٢-٢٩	من أين يمكنك الحصول على محاقن جديدة غير مستخدمة: (أكثر من اجابة ممكنة) ١. الصيدلية ٢. عامل صحي ٣. المشفى ٤. بائع ٥. أصدقاء ٦. شركاء جنسيين ٧. غير ذلك	ااا ااا
س ٢-٣٠	هل استخدمت خلال الشهر الماضي محقنة معبأة سلفاً دون معرفتك مصدرها ١. نعم ٢. لا	ااا
س ٢-٣١	في الشهر الماضي كم مرة قمت باستخدام محاقن مسكوبة من ١. كل المرات ٢. أغلب الأحيان ٣. بعض الأحيان ٤. ولا مرة	ااا

س ٢- ٣٢	في الشهر الماضي عندما استخدمت المحاقن كم مرة شاركت القطن أو الفلتر أو الماء أو غير ذلك من أدوات ١. كل المرات ٢. أغلب الأحيان ٣. بعض الأحيان ٤. ولا مرة	ااا
س ٢-٣٣	في الشهر الماضي كم مرة أخذت المخدر من عبوة يستخدمها آخرين ١. كل المرات ٢. أغلب الأحيان ٣. بعض الأحيان ٤. ولا مرة	ااا
س ٢-٣٤	هل أنت حالياً تحت علاج للإدمان ١. حالياً تحت العلاج ٢. سابقاً تحت العلاج ٣. لم أخضع لعلاج	ااا
س ٢-٣٥	منذ كم شهر وأنت تخضع لعلاج (عدد الأشهر)	ااا
س ٢-٣٦	ما هو نوع العلاج الذي تتلقاه ١. مشورة ٢. علاج دوائي ٣. إعادة تأهيل ٤. أكثر من نوع ٥. غير ذلك حدد	ااا
الجزء الثالث: الزواج والسلوك الجنسي		
س ٣-٣٧	هل تزوجت من قبل ؟ ١. نعم ٢. لا	ااا
س ٣-٣٨	هل تقيم حالياً؟ ١. مع زوجك/ زوجتك والشريك الجنسي ٢. مع الشريك الجنسي دون زواج ٣. مع زوجك/ زوجتك دون شراكة بالجنس ٤. غير ذلك، تحدد	ااا
س ٣- ٣٩	هل مارست الجنس على الإطلاق ١. نعم (تابع) ٢. لا (انتقل إلى الجزء التالي)	ااا
س ٣-٤٠	في أي عمر كنت عندما مارست الجنس لأول مرة	ااا
س ٣ -٤١	هل قمت بممارسة الجنس خلال الأشهر ١٢ الماضية ١. نعم ٢. لا	ااا
س ٣-٤٢	ما هو عدد الشركاء الجنسيين خلال الأشهر ١٢ الماضية	ااا
س ٣-٤٣	ما هو عدد الشركاء الجنسيين المعتادين	ااا
س ٣-٤٤	ما هو عدد الشركاء الجنسيين غير المعتادين	ااا

س ٣-٤٥	للذكور فقط، هل لديك شركاء جنسيين من الرجال	ااا
س ٣-٤٦	ما هو عدد مرات ممارسة الجنس مع الرجال خلال الأشهر ١٢ الماضية	ااا
س ٣-٤٧	كم مرة مارست الجنس مع شريكك المعتاد (الـزوج/ة) خلال الأيام ٣٠ الماضية	ااا
س ٣-٤٨	هل استخدمت واقياً ذكرياً خلال ممارسة الجنس في المرة الأخيرة ؟ ١. نعم (تابع) ٢. لا (انتقل إلى ٥٠)	ااا
س ٣-٤٩	لماذا لم يستخدم الواقي الذكري؟ ١. لم يكن متوفراً ٢. لم يرغب الشريك ٣. تكلفته عالية ٤. لم يخطر ببالك ٥. غير ذلك يحدد	ااا
س ٣-٥٠	ما هو تكرار استخدامك والشريك الجنسي الواقي الذكري خلال الستة أشهر الماضية ١. كل مرة ٢. أغلب الأحيان ٣. بعض الأحيان ٤. مرات قليلة ٥. أبداً على الإطلاق	ااا
س ٣-٥١	ما هو عدد استخدامك الواقي الذكري خلال الأشهر الـ ١٢ الماضية	ااا
س ٣-٥٢	كم مرة مارست الجنس مع شريكك غير المعتاد خلال الأيام ٣٠ الماضية	ااا
س ٣-٥٣	هل استخدمت واقياً ذكرياً خلال ممارسة الجنس في المرة الأخيرة؟ ١. نعم (تابع) ٢. لا (انتقل إلى ٣٤)	ااا
س ٣-٥٤	لماذا لم يستخدم الواقي الذكري؟ ١. لم يكن متوفراً ٢. لم يرغب الشريك ٣. تكلفته عالية ٤. لم يخطر ببالك ٥. غير ذلك يحدد	ااا
س ٣-٥٥	ما هو تكرار استخدامك والشريك الجنسي الواقي الذكري خلال الستة أشهر الماضية ١. كل مرة ٢. أغلب الأحيان ٣. بعض الأحيان ٤. مرات قليلة ٥. أبداً على الإطلاق	ااا
س ٣-٥٦	ما هو عدد استخدامك الواقي الذكري خلال الأشهر الـ١٢ الماضية	ااا
س ٣-٥٧	هل تلقيت أو دفعت أي أجر مقابل ممارسة الجنس مع الشريك غير المعتاد ١. نعم ٢. لا	ااا

س ٣-٥٨	هل تستخدم الواقي الذكري ١. نعم ٢. لا	ااا
س ٣-٥٩	هل سمعت بالواقي الذكري ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٣-٦٠	هل تعرف من أين تحصل على الواقي الذكري ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٣-٦١	ما هي الأماكن التي تحصل منها على الواقي الذكري ١. الصيدلية ٢. السوبرماركت ٣. العيادة الطبية ٤. المركز الصحي ٥. غير ذلك يحدد	ااا ااا
س ٣-٦٢	ما هي المدة التي تحتاجها للحصول على واقي ذكري من مكان سكنك أو عملك ١. أقل من نصف ساعة ٢. حوالي الساعة ٣. أكثر من ساعة ٤. غير ذلك، يحدد	ااا
س ٣-٦٣	هل ناقشت الإيدز أو الأمراض الأخرى المنتقلة بالجنس مع الشريك الجنسي؟ ١. نعم ٢. لا	ااا
الجزء الرابع: الأمراض المنتقلة بالجنس		
س ٤-٦٤	هل سمعت بأي أمراض يمكن أن تنتقل عن طريق الجنس 1- ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٦٥	ما هي أعراض تلك الأمراض عند المرأة (توضع دائرة على الإجابة المذكورة) ١. ألم بطني ٢. مفرزات تناسلية ٣. قرحات تناسلية ٤. رائحة كريهة ٥. حكة في المنطقة التناسلية ٦. تورم في المنطقة التناسلية ٧. حرقة بولية ٨. غير ذلك يحدد.....	ااا ااا ااا ااا ااا ااا
س ٤-٦٦	ما هي أعراض تلك الأمراض عند الرجل (توضع دائرة على الإجابة المذكورة) ١. مفرزات تناسلية ٢. قرحات تناسلية ٣. تورم في المنطقة التناسلية ٤. حرقة بولية ٨. غير ذلك يحدد.....	ااا ااا ااا ااا ااا ااا

س ٤-٦٧	هل عانيت من قرحة أو مفرزات تناسلية/ شرجية خلال الأشهر الـ ١٢ الماضية ١. نعم (تأكد أن تسأل الجزء السادس) ٢. لا (لا داع للجزء السادس) ٨. لا أعرف	ااا
الجزء الخامس: المعرفة والمواقف		
س ٥-٦٨	هل سمعت بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥-٦٩	هل تعرف أي شخص مصاب بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥-٧٠	هل لديك أي قريب أو صديق مصاب بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم (قريب) ٢. نعم (صديق) ٣. لا ٨. لا أعرف	ااا
س ٥-٧١	هل يستطيع الأفراد وقاية أنفسهم من الإيدز أو عدوى فيروس نقص المناعة إذا استخدموا الواقي الذكري بشكل صحيح في كل مرة يمارسون بها الجنس؟ ١. نعم ٢. لا ٣. لا أعرف	ااا
س ٥-٧٢	هل من الممكن الإصابة بفيروس نقص المناعة بسبب عضة البعوض ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥-٧٣	هل يستطيع الشخص حماية نفسه من الإيدز إذا استمر بعلاقة جنسية وحيدة مخلصة ومع شخص غير مصاب بالعدوى ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥-٧٤	هل يستطيع الشخص حماية نفسه من الإيدز إذا امتنع عن ممارسة الجنس نهائياً ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥-٧٥	هل من الممكن الإصابة بفيروس نقص المناعة من مشاركة وجبة طعام مع شخص مصاب ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥-٧٦	هل من الممكن الإصابة بفيروس نقص المناعة من مشاركة حقنة مخدرات مع شخص مصاب ١. نعم ٢. لا ٨. لا أعرف	ااا

س ٥–٧٧	هل يمكن أن يكون شخص يبدو سليم ظاهرياً مصاباً بعدوى فيروس نقص المناعة الذي يؤدي للايدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥–٧٨	هل يمكن أن تنقل سسيدة حامل مصابة بعدوى نقص المناعة أو الإيدز المرض إلى وليدها ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥–٧٩	ماذا يمكن أن تقوم به السيدة الحامل المصابة بعدوى نقص المناعة أو الإيدز لتجنب انتقال المرض إلى وليدها ١. أخذ أدوية ٢. غير ذلك يحدد ٨. لا أعرف	ااا
س ٥–٨٠	هل يمكن أن تنقل سسيدة مرضع مصابة بعدوى نقص المناعة أو الإيدز المرض إلى وليدها عبر الإرضاع الوالدي ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥–٨١	هل يمكن الحصول على اختبار لتحري الإيدز بشكل سري دون معرفة الآخرين ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥–٨٢	لا أرغب بمعرفة النتيجة ولكن هل قمت بفحص تحري الإيدز ١. نعم (تابع) ٢. لا (انتقل إلى ٨٦) ٨. لا أعرف	ااا
س ٥–٨٣	هل قمت بالفحص طوعياً أو برغبة من آخر ١. طوعياً ٢. برغبة من آخر ٣. غير ذلك، حدد	ااا
س ٥–٨٤	لا أرغب بمعرفة النتيجة ولكن هل قمت بمعرفة نتيجة فحص تحري الإيدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٥–٨٥	منذ متى أجريت الفحص؟ ١. خلال السنة الماضية ٢. منذ ١–٢ سنة ٣. منذ ٢– ٤ سنوات ٤. أبعد من ٤ سنوات	ااا
س ٥–٨٦	هل سمعت أي رسائل صحية عن الإيدز ١. نعم ٢. لا ٨. لا أعرف	ااا

س ٥-٨٧	ما هو مصدر المعلومات أو الرسائل ؟ ١. راديو ٢. تلفزيون ٣. نشرات مكتوبة ٤. المركز الصحي أو العيادة ٥. غير ذلك يحدد،	ااا ااا
س ٥-٨٨	أي من تلك المصادر هو الأكثر توفراً لك؟ ١. راديو ٢. تلفزيون ٣. نشرات مكتوبة ٤. المركز الصحي أو العيادة ٥. غير ذلك يحدد،	ااا
الجزء السادس: التدخلات		
س ٦-٨٩	إذا عانيت من قرحة تناسلية أو شرجية، هل لجأت لطلب المساعدة من: ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٦-٩٠	ممن لجأت أولا لطلب المساعدة: ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٦-٩١	هل وصف لك دواء لعلاج الحالة ١. نعم (تابع) ٢. لا (انتقل إلى ٩٤)	ااا
س ٦-٩٢	من أين حصلت على الدواء؟ ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٦-٩٣	هل استخدمت الدواء الموصوف؟ ١. نعم ٢. لا	ااا
س ٦-٩٤	إذا كان الجواب «لا» لماذا ١. اهمال ٢. عدم توفر الدواء ٣. كلفة الدواء ٤. غير ذلك يحدد	ااا

س ٦–٩٥	أرغب أن أعرف كم استمرت الأعراض لديك قبل طلب المعالجة ١. أقل من أسبوع ٢. من أسبوع إلى شهر ٣. أكثر من شهر	ااا
الجزء السابع: الوصمة		
س ٧–٩٦	إذا عرفت أن أحدهم مريض بالإيدز، هل تتناول الطعام معه ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٧–٩٧	إذا عرفت أن قريب لك مريض بالإيدز، هل تقوم برعايته ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٧–٩٨	إذا عرفت أن أحد البائعين مريض بالإيدز، هل تستمري بشراء الطعام منه ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٧–٩٩	إذا عرفت أن أحد أفراد عائلتك مريض بالإيدز، هل تتضايق من البوح بهذا الأمر ؟ ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٧–١٠٠	هل أجبرت يوماً على ممارسة الجنس دون رغبة منك ١. نعم ٢. لا	ااا

المسح الأول للسلوكيات والمؤشرات الحيوية المتعلقة بفيروس عوز المناعة/الإيدز في سورية كأداة ممكنة للترصد

الاستبيان الخاص بالسجناء

بيانات تعريفية	للترميز
١. المدينة والرمز:	ااا
٢. الرقم التسلسلي للشخص المجيب:	اااا
الشخص منح الموافقة المطلعة: ١. نعم (تابع) ٢. لا (توقف)	ااا
تذكر: الرمز الخاص بالبيانات التي لا إجابة لها أو لا تنطبق (٩ أو ٩٩) الرمز الخاص بإجابة لا أعرف (٨ أو ٨٨)	

الزيارة	الزيارة الأولى	الزيارة الثانية
التاريخ	ااا ااا ااا	ااا ااا ااا
اسم الباحث/ة والرمز:	ااا	ااا
نتيجة الزيارة: ١. تمت بنجاح ٢. لم تتم بالشكل الكامل ٣. تم التأجيل	ااا	ااا

رقم السؤال	السؤال	الرمز
الجزء الأول: خاص بالمعلومات العامة		
س ١-١	ما هو تاريخ ميلادك	ااا ااا ااا
س ١-٢	ما هو عمرك بالسنوات	ااا
س ١-٣	هل سبق وأن التحقت بأي مرحلة تعليمية؟ ١. نعم (تابع س ٤) ٢. لا (انتقل إلى س ٥)	ااا
س ١-٤	ما هي أعلى مرحلة تعليمية التحقت بها ؟ ١. ابتدائي ٢. إعدادي ٣. أساسي ٤. ثانوي ٥. معهد متوسط ٦. جامعة فأكثر ٨. لا أعرف	ااا
س ١-٥	ما هو عدد سنوات إقامتك هنا (في المدينة/ الجوار)	ااا
س ١-٦	هل غادرت مكان الإقامة لمدة طويلة خلال السنة الماضية ١. نعم ٢. لا	ااا

س ١–٧	ما هو مكان ولادتك ١. المدينة نفسها ٢. مكان آخر في سورية يحدد ٣. غير ذلك، تحدد	ااا
س ١–٨	ما هو عدد الأشهر التي قضيتها/ ستقضيها في السجن	ااا
س ١–٩	هل تتعاطى الكحول ١. نعم (تابع) ٢. لا (انتقل إلى ١١)	ااا
س ١–١٠	كم مرة تعاطيت الكحول خلال الشهر الماضي؟ ١. يومياً ٢. أكثر من مرة في الأسبوع ٣. أكثر من مرة في الشهر	ااا
س ١–١١	هل تتعاطى المخدرات ١. نعم (تابع) ٢. لا (انتقل إلى ١٣)	ااا
س ١–١٢	كم مرة تعاطيت المخدرات خلال الشهر الماضي؟ ١. يومياً ٢. أكثر من مرة في الأسبوع ٣. أكثر من مرة في الشهر	ااا
الجزء الثاني: الزواج والسلوك الجنسي		
س ٢–١٣	هل تزوجت من قبل ؟ ١. نعم ٢. لا	ااا
س ٢–١٤	هل تقيم حالياً؟ ١. مع زوجك/ زوجتك والشريك الجنسي ٢. مع الشريك الجنسي دون زواج ٣. مع زوجك/ زوجتك دون شراكة بالجنس ٤. غير ذلك، تحدد	ااا
س ٢–١٥	هل مارست الجنس على الإطلاق ١. نعم (تابع) ٢. لا (توقف وانتقل إلى الجزء التالي)	ااا
س ٢–١٦	في أي عمر كنت عندما مارست الجنس لأول مرة	ااا
س ٢–١٧	هل قمت بممارسة الجنس خلال الأشهر ١٢ الماضية ١. نعم ٢. لا	ااا
س ٢–١٨	ما هو عدد الشركاء الجنسيين خلال الأشهر ١٢ الماضية	ااا
س ٢–١٩	ما هو عدد الشركاء الجنسيين المعتادين	ااا
س ٢–٢٠	ما هو عدد الشركاء الجنسيين غير المعتادين	ااا
س ٢–٢١	للذكور فقط، هل لديك شركاء جنسيين من الرجال	ااا

س ٢-٢٢	ما هو عدد مرات ممارسة الجنس مع الرجال خلال الأشهر ١٢ الماضية	ااا
س ٢-٢٣	كم مرة مارست الجنس مع شريكك المعتاد (الـزوج/ة) خلال الأيام ٣٠ الماضية	ااا
س ٢-٢٤	هل استخدمت واقياً ذكرياً خلال ممارسة الجنس في المرة الأخيرة ؟ ١. نعم (تابع) ٢. لا (انتقل إلى ٢٦)	ااا
س ٢-٢٥	لماذا لم يستخدم الواقي الذكري؟ ١. لم يكن متوفراً ٢. لم يرغب الشريك ٣. تكلفته عالية ٤. لم يخطر ببالك ٥. غير ذلك يحدد	ااا
س ٢-٢٦	ما هو تكرار استخدامك والشريك الجنسي الواقي الذكري خلال الستة أشهر الماضية ١. كل مرة ٢. أغلب الأحيان ٣. بعض الأحيان ٤. مرات قليلة ٥. أبداً على الإطلاق	ااا
س ٢-٢٧	ما هو عدد استخدامك الواقي الذكري خلال الأشهر الـ ١٢ الماضية	ااا
س ٢-٢٨	كم مرة مارست الجنس مع شريكك غير المعتاد خلال الأيام ٣٠ الماضية	ااا
س ٢-٢٩	هل استخدمت واقياً ذكرياً خلال ممارسة الجنس في المرة الأخيرة ؟ ١. نعم (تابع) ٢. لا (انتقل إلى ٣١)	ااا
س ٢-٣٠	لماذا لم يستخدم الواقي الذكري؟ ١. لم يكن متوفراً ٢. لم يرغب الشريك ٣. تكلفته عالية ٤. لم يخطر ببالك ٥. غير ذلك يحدد	ااا
س ٢-٣١	ما هو تكرار استخدامك والشريك الجنسي الواقي الذكري خلال الستة أشهر الماضية ١. كل مرة ٢. أغلب الأحيان ٣. بعض الأحيان ٤. مرات قليلة ٥. أبداً على الإطلاق	ااا
س ٢-٣٢	ما هو عدد استخدامك الواقي الذكري خلال الأشهر الـ١٢ الماضية	ااا
س ٢-٣٣	هل تلقيت أو دفعت أي أجر مقابل ممارسة الجنس مع الشريك غير المعتاد ١. نعم ٢. لا	ااا
س ٢-٣٤	هل تستخدم الواقي الذكري ١. نعم ٢. لا	ااا

س ٢-٣٥	هل سمعت بالواقي الذكري ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٢-٣٦	هل تعرف من أين تحصل على الواقي الذكري ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٢-٣٧	ما هي الأماكن التي تحصل منها على الواقي الذكري ١. الصيدلية ٢. السوبرماركت ٣. العيادة الطبية ٤. المركز الصحي ٥. غير ذلك يحدد	ااا ااا
س ٢-٣٨	ما هي المدة التي تحتاجها للحصول على واقي ذكري من مكان سكنك أو عملك ١. أقل من نصف ساعة ٢. حوالي الساعة ٣. أكثر من ساعة ٤. غير ذلك، يحدد	ااا
س ٢-٣٩	هل ناقشت الإيدز أو الأمراض الأخرى المنتقلة بالجنس مع الشريك الجنسي؟ ١. نعم ٢. لا	ااا
الجزء الثالث: الأمراض المنتقلة بالجنس		
س ٣-٤٠	هل سمعت بأي أمراض يمكن أن تنتقل عن طريق الجنس ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٣-٤١	ما هي أعراض تلك الأمراض عند المرأة (توضع دائرة على الإجابة المذكورة) ١. ألم بطني ٢. مفرزات تناسلية ٣. قرحات تناسلية ٤. رائحة كريهة ٥. حكة في المنطقة التناسلية ٦. تورم في المنطقة التناسلية ٧. حرقة بولية ٨. غير ذلك يحدد.....	ااا ااا ااا ااا ااا ااا
س ٣-٤٢	ما هي أعراض تلك الأمراض عند الرجل (توضع دائرة على الإجابة المذكورة) ١. مفرزات تناسلية ٢. قرحات تناسلية ٣. تورم في المنطقة التناسلية ٤. حرقة بولية ٨. غير ذلك يحدد.....	ااا ااا ااا ااا ااا ااا

س ٣-٤٣	هل عانيت من قرحة أو مفرزات تناسلية/ شرجية خلال الأشهر الـ ١٢ الماضية ١. نعم (تأكد أن تسأل الجزء الخامس) ٢. لا (لا داع للجزء الخامس) ٨. لا أعرف	ااا
الجزء الرابع: المعرفة والمواقف		
س ٤-٤٤	هل سمعت بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٤٥	هل تعرف أي شخص مصاب بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤- ٤٦	هل لديك أي قريب أو صديق مصاب بالإيدز أو العدوى بفيروس نقص المناعة ١. نعم (قريب) ٢. نعم (صديق) ٣. لا ٨. لا أعرف	ااا
س ٤-٤٧	هل يستطيع الأفراد وقاية أنفسهم من الإيدز أو عدوى فيروس نقص المناعة إذا استخدموا الواقي الذكري بشكل صحيح في كل مرة يمارسون بها الجنس؟ ١. نعم ٢. لا ٣. لا أعرف	ااا
س ٤-٤٨	هل من الممكن الإصابة بفيروس نقص المناعة بسبب عضة البعوض ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٤٩	هل يستطيع الشخص حماية نفسه من الإيدز إذا استمر بعلاقة جنسية وحيدة مخلصة ومع شخص غير مصاب بالعدوى ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٠	هل يستطيع الشخص حماية نفسه من الإيدز إذا امتنع عن ممارسة الجنس نهائياً ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥١	هل من الممكن الإصابة بفيروس نقص المناعة من مشاركة وجبة طعام مع شخص مصاب ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٢	هل من الممكن الإصابة بفيروس نقص المناعة من مشاركة حقنة مخدرات مع شخص مصاب ١. نعم ٢. لا ٨. لا أعرف	ااا

س ٤-٥٣	هل يمكن أن يكون شخص يبدو سليم ظاهرياً مصاباً بعدوى فيروس نقص المناعة الذي يؤدي للايدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٤	هل يمكن أن تنقل سسيدة حامل مصابة بعدوى نقص المناعة أو الإيدز المرض إلى وليدها ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٥	ماذا يمكن أن تقوم به السيدة الحامل المصابة بعدوى نقص المناعة أو الإيدز لتجنب انتقال المرض إلى وليدها ١. أخذ أدوية ٢. غير ذلك يحدد ٨. لا أعرف	ااا
س ٤-٥٦	هل يمكن أن تنقل سسيدة مرضع مصابة بعدوى نقص المناعة أو الإيدز المرض إلى وليدها عبر الإرضاع الوالدي ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٥٧	هل يمكن الحصول على اختبار لتحري الإيدز بشكل سري دون معرفة الآخرين ١. نعم ٢. لا ٨ . لا أعرف	ااا
س ٤-٥٨	لا أرغب بمعرفة النتيجة ولكن هل قمت بفحص تحري الإيدز ١. نعم (تابع) ٢. لا (انتقل إلى ٦١) ٨. لا أعرف	ااا
س٤-٥٩	هل قمت بالفحص طوعياً أو برغبة من آخر ١. طوعياً ٢. برغبة من آخر ٣. غير ذلك، حدد	ااا
س ٤-٦٠	لا أرغب بمعرفة النتيجة ولكن هل قمت بمعرفة نتيجة فحص تحري الإيدز ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٤-٦١	منذ متى أجريت الفحص؟ ١. خلال السنة الماضية ٢. منذ ١-٢ سنة ٣. منذ ٢- ٤ سنوات ٤. أبعد من ٤ سنوات	ااا
س ٤-٦٢	هل سمعت أي رسائل صحية عن الإيدز ١. نعم ٢. لا ٨. لا أعرف	ااا

س ٤-٦٣	ما هو مصدر المعلومات أو الرسائل ؟ ١. راديو ٢. تلفزيون ٣. نشرات مكتوبة ٤. المركز الصحي أو العيادة ٥. غير ذلك يحدد،	ااا
س ٤-٦٤	أي من تلك المصادر هو الأكثر توفراً لك؟ ١. راديو ٢. تلفزيون ٣. نشرات مكتوبة ٤. المركز الصحي أو العيادة ٥. غير ذلك يحدد،	ااا
الجزء الخامس: التدخلات		
س ٥-٦٥	إذا عانيت من قرحة تناسلية أو شرجية، هل لجأت لطلب المساعدة من: ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٥-٦٦	ممن لجأت أولا لطلب المساعدة: ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٥-٦٧	هل وصف لك دواء لعلاج الحالة ١. نعم (تابع) ٢. لا (انتقل إلى ٧٠)	ااا
س ٥-٦٨	من أين حصلت على الدواء؟ ١. صيدلية ٢. مركز صحي ٣. عيادة طبية ٤. عيادة تنظيم الأسرة ٥. صديق أو صديقة ٦. غير ذلك يحدد	ااا
س ٥-٦٩	هل استخدمت الدواء الموصوف؟ ١. نعم ٢. لا	ااا
س ٥-٧٠	إذا كان الجواب «لا» لماذا ١. اهمال ٢. عدم توفر الدواء ٣. كلفة الدواء ٤. غير ذلك يحدد	ااا

س ٥-٧١	أرغب أن أعرف كم استمرت الأعراض لديك قبل طلب المعالجة ١. أقل من أسبوع ٢. من أسبوع إلى شهر ٣. أكثر من شهر	ااا
الجزء السادس: الوصمة		
س ٦-٧٢	إذا عرفت أن أحدهم مريض بالإيدز، هل تتناول الطعام معه ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦-٧٣	إذا عرفت أن قريب لك مريض بالإيدز، هل تقوم برعايته ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦-٧٤	إذا عرفت أن أحد البائعين مريض بالإيدز، هل تستمري بشراء الطعام منه ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦-٧٥	إذا عرفت أن أحد أفراد عائلتك مريض بالإيدز، هل تتضايق من البوح بهذا الأمر ؟ ١. نعم ٢. لا ٨. لا أعرف	ااا
س ٦-٧٦	هل أجبرت يوماً على ممارسة الجنس دون رغبة منك ١. نعم ٢. لا	ااا

Annex IV: Informed Consent & Information Sheets

A: Information sheet

The information sheet for RDS participants of a study among the target groups

Instructions. This sheet provides information about when and where participants can pick up their test results and how they should distribute coupons. This information sheet is explained and given to a participant by a coupon manager/supervisor once a participant completes all steps of an RDS study.

VCT centre/ name and address

When and where can laboratory tests results be collected?

Test results can be collected *three weeks* after you participate in the survey (i.e. completed a questionnaire and gave specimens). Results can be collected from 12 pm to 2 pm from Sunday to Thursday at the same place as you gave specimens. The code that you have on this sheet is very important for you to keep as you will use it to collect your test results.

When and where can secondary incentives be collected?

You can collect your incentive when a person to whom you gave a coupon is included in the survey. That means that your recruit needs to come to the site, fill out a questionnaire and give specimens for testing. After he completes all the steps in the study, you will be eligible for the secondary incentive. Please tell your peers to whom you give coupons that they need to come to the site before the date that is written on the coupon, which is two weeks from today. It is highly likely that you will be able to collect your incentive when you come to pick up your test results.

Giving out coupons

Please give the coupons to your peers aged 18 and over and who are within your target group. It is written clearly on the coupon when they need to come to the VCT Centre in order to be included in the survey. In order to avoid

waiting, they can make an appointment at the following phone number:. When you give them a coupon, please mention that:

- they will be tested for HIV and sexually transmitted infections for free
- the study is entirely confidential and anonymous
- participation in a study does not cause any risks to health
- those who participate will be reimbursed fully for the time lost and costs of transport.

What if someone refuses to accept a coupon?

If someone refuses to accept a coupon, please ask that person what the reasons for refusal are. Please try to remember this as it is important for the study. When you come back, a staff member will ask you why people refused to accept coupons.

Thank you for participating in the study and distributing coupons!

B: Informed Consent

Name of Research Study: Strengthening HIV prevention among most-at-risk populations (MARPs) in the Syrian Arab Republic -The Integrated Bio-Behavioral Survey (IBBS) in Syria: 2013-2014

Introduction

This Consent Form contains information about the research named above. In order to be sure that you are informed about being in this research study, we are asking you to read (or have read to you) this Consent Form. And sign it yourself after approval or approve participation in front of two witnesses.

Reason for the Research

You are being asked to be in a research study to find out the prevalence of HIV and STDs among some target populations in the country.

General Information about the Research Methods

If you agree to be in this research we will not take your name. We will ask you some questions and take few drops of blood. You will get some coupons to assist identifying around 4 persons around you who come from the same risk group like you.

If you agree to be in the research, you will be asked some questions about your age, education and marriage. We will ask you about your sexual history and behavious and any symptoms related to sexually transmitted infections. You will be told about what the lab tests and the treatments or care available to you.

We will not record your name on any of the questions or the lab tests. They will only be labeled with a code number. The samples will be tested for HIV infection and other STDs.

Possible Risks and Benefits

You will feel uncomfortable while taking blood but it does not harm you and increase the risk of any other problems. There is a chance that some of the questions asked may make you feel not at ease. At any time, you may refuse to answer any question or withdraw from the study.

You may be scared or feel sad by learning your blood test results. If you decide to come in for the results, you will be provided with counseling and treatment.

You will be given the names of places where you will be counseled or treated.

There may be some risk that people may see you associated with the study, either now or when you return for your results.

If you Decide Not to be in the Research

You are free to refuse to be in this research and it will not affect the health care you would normally receive from the study.

Confidentiality

We will protect information about you and your taking part in this research to the best of our ability.

Your name will not be recorded anywhere. Blood specimens will be labeled with a study code number. You will be given a card with your code number. This will allow you to obtain your test results if you wish. We will not be able to identify you and give you your test results without the study ID card.

If the results of this research were published, your name would not be shown because we will not have your name. However, the officials of the Ministry of Health may sometimes look at records of those who take part in the research study.

Compensation

We will provide you a fixed amount of money after completing the study requirements as a compensation for local transportation costs and an additional amount for successful referral of each peer for the study. You may refer up to four peers or friends. We will also give you materials to compensate you for your time.

Leaving the Research Study

You may leave the research study at any time and refuse to answer any questions. If you decide to leave the study you will be asked for the reason to do so.

Contact for Questions

Should you have any questions or problems about this research, please contact: