HIV and STI service provision in Syria: A study of contradictions
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BACKGROUND

While the Middle East remains a low HIV/STI prevalence region, there is evidence that disease incidence is increasing. There also is evidence for a growing presence of social-economic conditions that have preceded HIV outbreaks in other regions of the world: (1) opening of borders to immigration and tourism; (2) growing global economy: (3) growing pockets of poverty among marginalized subgroups; (4) increased exposure to western culture and sexuality; (5) a youth-dominated population; and (6) increased visibility of CSW, MSM, and IDU populations. Thus, there is a window of opportunity to identify strategies to prevent the widespread outbreak of HIV/STIs in this region. In order to develop effective intervention approaches, it is necessary to (1) document the range of HIV/STI risk behavior, and (2) gain insight into the factors facilitating or impeding HIV/STI risk behavior and disease transmission. It also is necessary to gain awareness of structural barriers likely to impede HIV/STI prevention efforts

With this in mind, a 3-day summit was held in Egypt in 2006 to develop a strategic plan for keeping HIV incidence low in the Middle East-North Africa (MENA) region. From this meeting, the National Institute of Mental Health issued a program announcement to develop HIV prevention infrastructure and conduct pilot studies in the MENA region. A partnership between the Syrian Center for Tobacco Studies, the Medical College of Wisconsin, and the University of Memphis became the first applicant to ever be funded under this announcement (HIV Prevention Research and Infrastructure Development in Syria and Middle East; PI: D Seal)

STUDY AIMS

This phase 1 formative study had 3 primary aims:

1. To identify HIV/STI risk and preventive behaviors, mediators, and moderators that will need to be addressed in a prevention intervention for (a) people living with HIV; (b) people seeking STI-related services; (c) female commercial sex workers; (d) men who have sex with men; and (e) injection drug users.
2. To document the feasibility of strategies to access and enroll these groups.
3. To tailor and refine the wording and content of a quantitative risk behavior survey

METHODS

We conducted qualitative interviews with 21 HIV/STI service providers (6 women, 15 men) in Damascus (N=14) and Aleppo (N=7) Syria to (1) explore structural and systemic factors impacting access to, and delivery of, HIV/STI-related education, testing, and treatment; (2) obtain information about the services clinic provided and details about standard operating procedures for HIV/STI testing and treatment; (3) understand barriers to and facilitators of testing, treatment, and consultation; (4) elicit recommendations about the format, content, and delivery of HIV/STI risk reduction interventions for people living with HIV and for those at-risk for HIV infection; and (5) identify optimal ways to recruit people into an HIV/STI-related study. Interviews, collected during Spring 2011, were thematically content coded by two raters

KEY FINDINGS

1. Distinct differences emerged with regard to (1) HIV versus STI testing and treatment; and (2) standard practice in public versus private STI clinics. People who suspected that they have been infected with an STI are much more likely to seek medical help and services than people who suspected they may have been infected with HIV. Most physicians do not ask STI patients to get an HIV test unless there is strong suspicion the person may have been infected with HIV.

2. By law, HIV/AIDS patients are tested and treated exclusively by the National AIDS Program (NAP) clinics. Patients rarely visit a private clinic unless they are referred for specific consultation.
3. HIV confirmatory testing and treatment adhere to standardized protocols for (a risk assessment, (b) information provision, and (c) treatment follow-up.
4. High standards of privacy and confidentiality are maintained. HIV medical records are primarily stored in electronic form. HIV/AIDS patient privacy and confidentiality are rarely violated and only with patient approval (e.g., to receive a military service exemption).
5. STI testing and treatment occur in private and public clinics. People who seek STI testing or treatment prefer to visit private clinics, but may not be able to afford it.
6. Most physicians treat STI patients based on clinical manifestations. Rarely do patients get referred to a laboratory for specimen testing. Condylomas (genital warts) are the main STIs seen by doctors
7. Providers described STI test labs as (a) outdated, (b) lacking skilled technicians, and (c) having high rates of false negatives.
8. Public clinics (a) served primarily low-income males, and (b) followed standardized protocols, including educational counseling. Patient privacy and confidentiality were a low a priority.
9. Private clinics served primarily middle- to upper-income patients of both genders. Protocols varied widely across clinics and focused on diagnosis and treatment only. High emphasis was given to patient privacy and confidentiality reflecting social stigma concerns, including (a) refusal to adhere to mandated reporting requirements, (b) recording false diagnoses in patient files, and (c) providing misinformation to sexual partners of STI patients.
10. Female STI patients prefer to see female doctors. Physicians believed that male patients were less concerned about whether they saw a male or female doctor.
11. Physicians think that HIV patients suffer from stigma much more than STI patients. Most physicians think that people consider HIV/AIDS to be a death statement. Many think that HIV patients will be quarantined.
12. Private physicians said that they rarely ask about a patient's **sexual behavior** in detail- even if they are sure that he/she has an STI- in order to avoid embarrassing the patient. In contrast, doctors believed that STI patients typically do not have a problem talking about their **medical** condition.

CONCLUSIONS AND POSTLOGUE

1. There is need for increased connection between HIV and STI services and use of standardized testing and treatment protocols. STI patients in public clinics received better treatment but at the cost of privacy. Stigma remains a challenge to quality patient care.
2. Study had to be discontinued in September 2012 due to conflict in Syria during the middle of Aim 2 (interviews with HIV-positive and STI patients). Thus, study findings may reflect a historical pre-conflict context rather than have future utility for HIV/STI prevention and treatment efforts.

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