HIV Bio-Behavioral Survey among Vulnerable Populations

Istanbul, 2010

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SURVEY REPORT

İstanbul, December 2010

AIDS Prevention Society

Human Resource Development Foundation

AMATEM

Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery

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was implemented by financial support of United Nations Population Fund and Implementing Agencies' own resources

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İstanbul 2010

AIDS Prevention Society
Halaskârgazi Caddesi. No: 212 Kat: 8 Şişli, İstanbul - Turkey.
Email: aidssavasim@gmail.com

Compiled and Edited by: Doğan Güneş Tomruk

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Foreword

This report is the result of intensive efforts of more than a year, which are set to continue. The report highlights the findings of the operational research component of an umbrella project named 'HIV Prevention among Vulnerable Populations in İstanbul', which was jointly implemented by a consortium. This CSO led bio-behavioral survey aimed, first, to combine the perspectives of scientific research with those of practice with a view to facilitate discussions on actions needed to more effectively combat the HIV/AIDS epidemic among vulnerable populations. Second, it seeks to make the outcomes and lessons learned from the survey available to those officials and authorities in Turkey who are in decision making positions on national HIV/AIDS program, policies and spending; to international agencies working with the government to facilitate national response and to ensure the country efforts reach the set international targets; to CSOs providing services in HIV/AIDS, reproductive health or health in general, and working particularly with vulnerable groups; and as well as to researchers, health professionals and activists.

Doğan Güneş Tomruk
AIDS Prevention Society
on behalf of Executive Agencies

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The executive agencies would also like to express heartfelt thanks for the strenuous effort put forth by each and every member of the field team: Zero, Asu, Meyra, Mali, İlker, Onur, Turan, we sincerely acknowledge your contribution. Last but not least, we would also like to express heartfelt thanks to all the study participants who provided their valuable time for interviews and shared their personal experiences to make this study possible.

The Study Team

Key Team Members

Doğan Güneş Tomruk - Project Director	AIDS Prevention Society
Muhtar Çokar - Project Coordinator	Human Resource Development Foundation
Cüneyt Evren - Project Coordinator	Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, AMATEM
Nuray Özgülnar - Research Advisor	İstanbul University School of Medicine Public Health Department

Steering Committee Members (*in addition to Key Team Members*)

Berna Eren	Human Resource Development Foundation
Defne Tamar Gürol	Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, AMATEM
Şevval Kılıç	STD Prevention Society
Vuslat Armağan Şayhan	Positives Association
Gökhan Yıldırımkaya (*observer*)	UNFPA

Field Study Team Members

M. Ali Can	AIDS Prevention Society
Asuman Cengiz	STD Prevention Society
İlker Çakmak	AIDS Prevention Society
Turan Çetin	Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, AMATEM
Onur Dağkoçak	Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery, AMATEM
Meyra	Human Resource Development Foundation
Zerrin Sertkalaycı	STD Prevention Society

Qualitative Survey Team Members

İlker Kayı	İstanbul University School of Medicine Public Health Department
Ezgi Gözübüyük	İstanbul University School of Medicine

VCT Center and Laboratory Team

Feyza Dalbay	Şişli Municipality Polyclinics, VCT Center
İrfan Yılmaz	Şişli Municipality Polyclinics, VCT Center
All laboratory staff	Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery

Administration and Logistics Support

Rukiye Akgün - Accountant	Human Resource Development Foundation
Mehmet Sarıaslan - Assistant Accountant	Human Resource Development Foundation
Erol Tokgöz - Driver (MCU)	Human Resource Development Foundation

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List of Acronyms

ABC	Abstain, Be faithful, use Condoms
AIDS	Acquired Immunodeficiency Syndrome
AMATEM	Alcohol and Drug Use Treatment and Research Center
APS	AIDS Prevention Society
ATO	Ankara Chamber of Commerce
BBS	Bio-Behavioral Survey
CPR	Country Progress Report
CSO	Civil Society Organization
DU	Drug User
ELISA	Enzyme-Linked Immunosorbent Assay
EU/ EEA	European Union/ European Economic Area
FGD	Focus Group Discussion
F-SW	Female Sex Worker
GFHAP	National HIV Prevention Program (Global Fund)
GFTAM	The Global Fund to fight AIDS, Tuberculosis, and Malaria
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HRDF	Human Resource Development Foundation
ICQ	Internet Chat Query
IDU	Intravenous Drug User
IE&C	Information Education and Communication
IP	Implementing Partner
IV	Intravenous
KLIMIK	The Turkish Society of Clinical Microbiology and Infectious Diseases
LGBTT	Lesbian, Gay, Bisexual, Transvestite and Transsexual
MCU	Mobile Counseling Unit
MoH	Ministry of Health
M&E	Monitoring and Evaluation
MSM	Men Who Have Sex with Men
NA	Not Applicable
NAC	National AIDS Commission, Turkey
NPF-HA	National HIV/AIDS Programme Framework
NSP	Needle and Syringe Exchange Program
OST	Opioid Substitution Therapy
PSC	Project Steering Committee
SM-VCTC	Şişli Municipality Voluntary Counseling and Testing Center
SPSS	Statistical Package for Social Sciences
SRHP	Sexual and Reproductive Health Programme in Turkey
STD-PS	Sexually Transmitted Diseases Prevention Society
STI	Sexually Transmitted Infection

T-SW	Transgender Sex Worker
TurkStat	Turkish Statistical Institute
SW	Sex Worker
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counseling and Testing
WD	Women's Door

Executive Summary

HIV Bio-Behavioral Survey among Sex Workers, Men Having Sex With Men and Drug Users, Istanbul, 2010

Turkey is still considered a low HIV prevalence country. At the end of 2009, the total reported HIV/AIDS cases reached to 3898, constituting a more than three-fold increase in ten years. With around 500 new cases annually, it is clear that Turkey is facing a steady increase in HIV cases. On the other hand, the numbers are based on the passive surveillance system which reports cases of HIV from health facilities. These reported cases, however, are believed to be considerable underestimates, and the actual number of HIV-infected persons in our country could be estimated to be 4-10 times higher, as is the case for most of the Eastern European countries.

The HIV Prevention among Vulnerable Populations Project was drafted in mid 2009 and launched in December 2009 with technical and financial support of UNFPA. The project targeted initially only sex workers (SWs) and Human Resource Development Foundation (HRDF) & AIDS Prevention Society (APS) acted as the implementing partners. As per the recommendation of the Project Steering Committee, the implementing agencies decided to broaden the project's target populations and looked for ways to include men having sex with men (MSM) and intravenous drug users in order to address HIV prevention needs of all vulnerable populations in İstanbul. Simultaneously with the SWs component which was coordinated by HRDF, APS initiated a similar intervention targeting MSM. Finally, with the involvement of AMATEM in March 2010 as an implementing partner, the joint initiative was able to cover the third vulnerable group as well -the drug users.

A bio-behavioral survey was designed to be implemented as an integral component of this umbrella project which was the second comprehensive survey in Turkey targeting three main vulnerable populations. The survey was expected to provide information for a dynamic strategy development process that will improve project performance, and also to contribute to the development of an evidence based HIV/AIDS policy that will inform Turkey's operational response.

The results of the survey highlight the different factors that could play a role in the development of a future HIV epidemic in Turkey. These include the presence of HIV prevalence up to 5 percent among transgender SWs and MSM, high hepatitis C prevalence among IDUs; and presence of high risk sexual practices, poor knowledge on HIV prevention and poor health-seeking behavior among all vulnerable populations.

High Risk Sexual Behaviors

Early age at first sex: Mean age at first sexual experience was 16.5 and one third of the total sample populations (half of the transgender SWs) reported to have sexual debut before age 15. The youngsters were more likely to start sexual activity at an early age.

Early age at first sex work: Commercial sex work started as early as 13 years old for females and as early as age 7 for transgender group. Twelve percent of transgender group entered in sex business before age 15, and it reached 40 percent before they were 20.

High number of sexual partners: Sex workers reported high number of clients, as in one month the average number of clients were 56 and 49 for female and transgender group, respectively. Having had multiple partners was also prevalent among other vulnerable groups: more than three fourths of MSM and around one third of IDUs had sex with more than one partner during last month.

Low condom use: Unprotected sex is a common practice. More than three fourths of IDUs, half of MSM and a quarter of SWs reported unprotected sex with their most recent partners.

Knowledge and Testing Behaviors

Poor HIV/AIDS knowledge: Only one quarter of the respondents got full score in answering five questions related to basic key concepts on HIV transmission. Drug users had the lowest, whereas MSM had the highest (only one third) percentages of getting full score.

Poor HIV testing behavior: One third of the respondents had never been tested for HIV; only one quarter had an HIV test within the last year and knew the result.

Other Contributing Risk Behaviors

Alcohol use: Almost half of the study population reported frequent alcohol consumption -at least once a week or more frequent- during last month. In addition, one third stated losing self control at least once.

Drug use: One third of SWs and more than half of MSM stated lifetime prevalence.

On the other hand, although HIV prevalence among female SWs and drug users is still apparently very low, with the reported behaviors they engage in, those groups also have all the risk factors that could lead to a future epidemic.

In addition to the above findings, the qualitative data gathered from the members of the study populations demonstrated clear examples of poor working conditions of SWs, and the stigma and discrimination members of the sub-groups face, which in turn, weaken the ability of individuals to protect themselves from HIV.

Finally, the survey results clearly call for an immediate action for all counterparts in Turkey, to develop an active HIV/AIDS prevention intervention programme covering all vulnerable populations. These prevention interventions should offer a full package of services, including outreach education, condom distribution and increased access to VCT services and treatment.

INTRODUCTION

1

HIV BIO-BEHAVIORAL SURVEY AMONG SEX WORKERS, MEN HAVING SEX WITH MEN AND DRUG USERS, ISTANBUL, 2010

1.1. Background

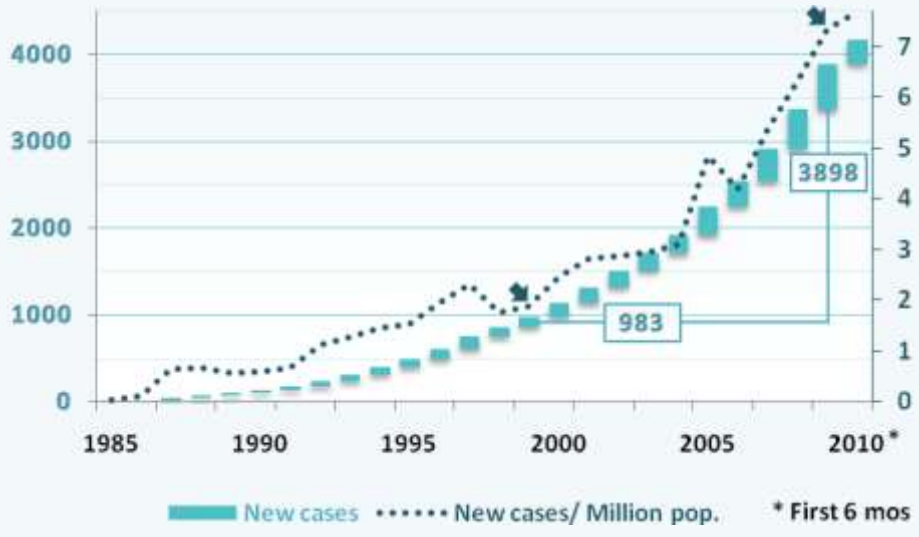
The first two cases of HIV and AIDS in Turkey were identified in 1985. In the first years of the epidemic, the majority of cases were HIV infected foreigners, returning Turkish nationals and blood transfusion cases; and the government was slow to respond to the increasing numbers of HIV transmission. Following this silent rise, it was only in the mid 90s that the government made its first attempt to form a national body to fight against the epidemic. The National AIDS Commission (NAC) was established in 1996 to coordinate national response, chaired by the Ministry of Health (MoH) involving a wide range of public sector institutions and civil society institutions (CSOs), as well. In the same year, the NAC set up a five-year National HIV/AIDS Program Framework (NPF-HA) covering 1996-2001; and developed the second in 2002 to cover the period from 2002 to 2006. Finally, in 2007, Turkey launched a new NPF-HA to cover 2007-2011. During the second and the third program periods, particularly between 2005 and 2008, European Commission and The Global Fund to fight AIDS, Tuberculosis, and Malaria (GFTAM) created significant new opportunities for Turkey to launch second generation surveillance and implement a wide range of active prevention initiatives targeting vulnerable populations. Following these two comprehensive national programs -Sexual and Reproductive Health Programme in Turkey (SRHP) and National HIV Prevention Program (GFHAP), Turkey is now experiencing real silence in HIV prevention efforts.

Epidemic level and trend

A cumulative total of 4,177 HIV infections have been diagnosed in Turkey, by the end of June 2010. This officially reported number considerably understates the true figure because not all HIV infections have been diagnosed or reported, partly because many people do not know that they are infected. Hence, these figures are considerably low compared to many regional countries in Eastern Europe.

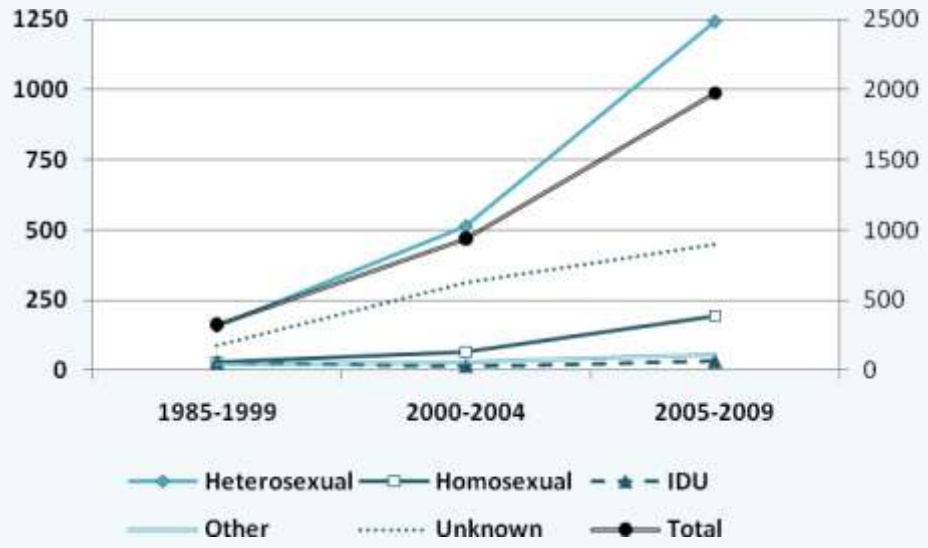
Although Turkey is among countries with low level HIV prevalence rates, it is worth to evaluate the national trends in new HIV cases. **Figure 1.1** summarizes the trend between 1985 and 2010; and indicates a slow but

Figure 1.1 Number of HIV cases and cases per million population by year of diagnosis between 1985 and 2010; and the cumulative totals of the recent ten year period



steady increase. For example, in the recent decade (from 1999 to 2009) the cumulative cases increased from 983 to 3898, in other words almost tripled. These figures also stand for an increase from 1.9 new cases per million population to 7.3 in 10 years.

Figure 1.2 Mode of transmission in reported HIV cases by five year periods in comparison to 1985-1999

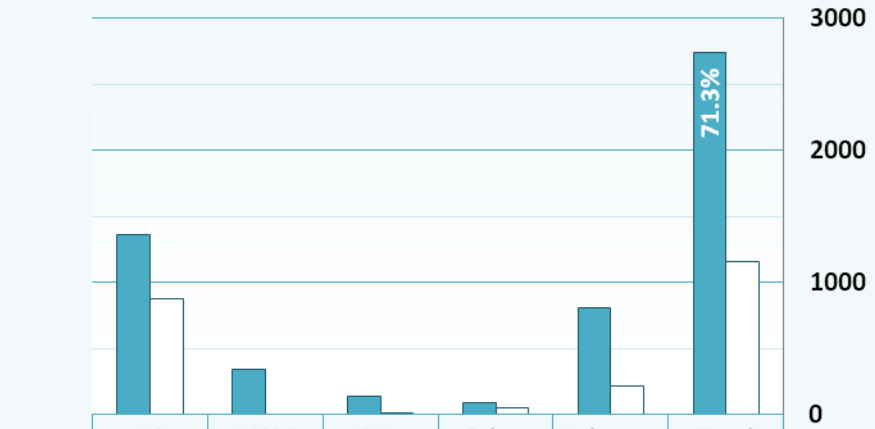


Mode of transmission and gender differences

Heterosexual contact is the main mode of HIV transmission in Turkey; and constitutes 77.8 percent of the cases with a reported mode, followed by sex between men (12.0 percent). On the other hand, the mode of transmission is 'unknown' for more than a quarter (26.3%) of the cumulative cases (**Figure 1.2**).

Gender distribution indicates a male dominance. **Figure 1.3** clearly shows the difference between male and

Figure 1.3 Gender differences in cumulative HIV cases reported by the end of 2009, by mode of transmission



	HS	MSM	IDUs	Other	Unknown	Total
Male	1359	345	134	92	808	2738
Female	877	0	11	55	217	1160

female case for each category of mode of transmission. In total, males constitute 71.3 percent of cumulative cases reported by the end of 2009. For adolescents and young people (age group 15-24), the gender difference indicates a shift in the direction of a balance between male and female positive cases. Females constitute almost two thirds (59.0%) of HIV infected adolescents (15-19 age group), and half (51.0%) of young adults (20-24 age group); whereas males predominate in later ages.

Major vulnerable and affected groups

International experience has shown that in countries with low prevalence rates, the best approach is to concentrate efforts on active prevention initiatives, especially targeting groups who partake in risky behaviors. Sex workers (SWs), men having sex with men (MSM) and intravenous drug users (IDUs) are among most vulnerable populations for HIV/AIDS. Although working with these groups was stated as one of the national program priorities in NPF-HA, not much has been done to work with or to investigate the HIV status and risky behaviors of these groups in order to design appropriate interventions. **Table 1.1** summarizes the little research that has been conducted among these vulnerable groups and the reported HIV prevalence rates.

Table 1.1 HIV bio-behavioral surveys among vulnerable populations, Turkey, 2000-2010

Years	Location	Implementing agency/ institution	Sub-population	HIV prevalence	Sample size	Reference
2002-03	İstanbul	Balıklı Greek Hospital	IDUs	4.3	107	Mırsal H, (2003)
2006-07	Ankara, İstanbul, İzmir	ICON, Hacettepe University, Royal Tropical Institute in Antwerp	SWs	0.8	252	ICON, (2007)
			MSM	1.8	166	
			IDUs	1.5	68	
2006-07	İstanbul	KLIMIK	SWs	2.3	258	KLIMIK (2007)
2009	Ankara	Pink Life	F-SWs	0.0	100	Pink Life (2009)
			T-SWs	5.0	100	

Critical issues and major challenges

This report will not go into detail of the challenges that Turkey face, but highlight the major issues that have already been officially reported. The recent Narrative Country Progress Report (CPR, Turkey, 2010) emphasizes the need of establishing a strong national monitoring and evaluation mechanism to oversee the national response as one of the major challenges; and also announces the good news that 'a national M&E framework is under development'. In addition, there are also issues to be solved concerning the national coordination body and national action plan. Unfortunately, NAC has not even convened since July 2008 and failed to prepare an action plan for the third program period. Without an action plan that would define the detailed activities, with responsible organizations, costs and a timetable, the current NPF-HA couldn't go further than being a wish list. This criticism should be accepted as an objective feedback presenting a civil society perspective, aimed at ensuring programmatic improvement in the fight against HIV/AIDS, which also implies the readiness of the CSOs for a constructive contribution.

1.2. The Objectives

The bio-behavioral survey (BBS) was one of the main components of CSO led HIV prevention intervention targeting three main vulnerable populations, namely SWs, MSM and IDUs. HIV Prevention among Vulnerable Populations in İstanbul Project was designed as a joint effort to support the National HIV/AIDS Program, particularly focusing on prevention activities among these groups regarding the spread of HIV epidemic. The project implemented proactive strategies to inform these vulnerable and hidden populations on HIV/AIDS and safe sex, and to increase their access to basic health services including voluntary counseling and HIV testing (VCT).

The Project activities were directly related and contributed to the following strategies of the NPF-HA for 2007-2011.

A. Prevention

A.1.1.2: initiate and expand preventive activities targeting high risk groups such as commercial SWs, IDUs, MSM and prison inmates, in order to increase awareness and support positive behavioral change

A.2.1: increase access to condoms through social marketing schemes, condom vending machines and free distribution to groups under high risk

B. Voluntary Counseling and Testing

B.1.2: increase access to VCT for the public, with primary focus on high risk groups

D. Supportive Environment

D.3.1: inform, raise awareness and sensitize decision-makers and administrators from all levels to ensure their support through advocacy efforts

E. Monitoring and Evaluation

E.1.2.2: initiate and expand second generation HIV/AIDS surveillance

E.1.3: monitor passive surveillance results and data on HIV and STIs related bio-behavior of women attending ante-natal clinics and high risk groups; and share them with program administrators and decision makers

Finally, the purpose of the bio-behavioral survey component was to gather information on HIV related risk behaviors among vulnerable populations which would allow all stakeholders to develop appropriate strategies on national/ local level active prevention interventions and to better plan their future activities; and to monitor trends in risk behaviors over time, and to compare the results across different geographical areas of the country.

1.3. Execution and Management: The Study Team

The HIV Prevention among Vulnerable Populations in İstanbul Project was drafted in mid 2009 and launched in October 2009 with technical and partial financial support of UNFPA. The project was initially designed to target only SWs. However, during the preparatory phase, the target populations of the project was broadened so as to cover MSM and IDUs, as well, in line with the recommendation of the Project Steering Committee (PSC) with the view to address HIV prevention needs of all vulnerable populations in İstanbul.

Although each component was implemented by different CSOs and a drug treatment institution, a consortium formed by these member organizations has coordinated the overall management of the joint efforts. AIDS Prevention Society (APS), the Human Resource Development Foundation (HRDF) and Alcohol and Drug Use Treatment and Research Center (AMATEM, *Turkish acronym*) of Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery as implementing partners (IPs) and members of the consortium took the lead in reaching and working with MSM, SWs and DUs, respectively. In addition, Sexually Transmitted Diseases Prevention Society (STD-PS), Positives Association, İstanbul University School of Medicine Public Health Department and Şişli Municipality Central District Health Center were involved in the project activities as partner organizations. These partner organizations also contributed to the management and the members represented their organization at the PSC. Under this joint management modality seven field workers from IPs were recruited and participated in the survey activities in order to reach the vulnerable populations, to inform them on HIV/AIDS, to recruit them to take part in the study, and to increase their use of VCT services.

1.4. Study Design, Methodology and Concepts

The bio-behavioral study included a behavioral component to determine the current situation and to estimate the distribution of characteristics in regard to knowledge and behavior on HIV/AIDS, and a biological surveillance which aims to determine HIV incidence among three target populations. In addition, a qualitative component was included for SWs and MSM, and focus group discussions (FGDs) were conducted among these two sub-populations which were expected to provide a better picture to understand their motivation and needs to avoid risk behaviors. As described above, the initiative used the concept of 'coordinated joint efforts' to ensure the involvement of all sectors including the target population in designing process and in the implementation phase to an extent possible, and adopted vulnerability concept in reaching out and working with the target populations.

Behavioral component

The project team drafted survey questionnaires for SWs, MSM and drug users (DUs) in close collaboration with partner organizations during the preparatory phase. The questionnaires were intended to cover all data pertaining to the demographics, history of alcohol and drug use, knowledge on HIV/AIDS, and behaviors related to safe sex and HIV testing practices of the target audience. During the development process the team accepted the ground rules below in constructing survey questionnaires:

- Each question should relate directly to the survey questionnaire objectives
- Every respondent should be able to answer every question
- Each question should be phrased in such a way that all respondents interpret it the same way
- Each question should provide answers to what we need to know

In addition to being brief, using a plain language and limiting the number of questions while constructing the questionnaires, the staff took pains to collect satisfactory and meaningful data in order to inform country progress report on HIV/AIDS and to assure consistency with the international surveys by covering related UNGASS indicators (standard indicators adopted by United Nations General Assembly Special Session on HIV/AIDS) to an extent possible. The development process also involved pretesting draft versions of survey questionnaires with minimum 10 respondents from each target population and making necessary revisions. The draft questionnaires were then discussed at the PSC meetings as the advisory body of the bio-behavioral survey, and approved with minor changes (*see* **Annexes I-III**).

The survey questionnaires consist of five sections and the total number of questions varied from 22 to 31 depending on the target populations (**Table 1.2**). While three to six questions are related to the socio-demographic characteristics of the respondents, the remaining questions concern the knowledge, health history and recent behaviors in regard to HIV-AIDS and related health topics.

Table 1.2 Survey Questionnaire: Number and distribution of questions by topic

	SWs	MSM	DUs
Socio-demographic characteristics	3	3	6
Alcohol and drug use	5	5	13
Sexual history and condom use	6	5	3
HIV/AIDS knowledge	6	6	6
Voluntary counseling and testing	3	3	3
Total number of questions	**23**	**22**	**31**

The survey participants were recruited according to two simple inclusion criteria: defining themselves either as a sex worker, gay or admitted to hospital for heroin addiction; and having agreed to answer the survey

questionnaire. For SWs, whether female or transgender, having supplied sexual services for money at least once within last 30 days; and for MSM, whether homosexual or heterosexual gay, having had sex (any kind of sex: oral or anal, penetrative or not) at least once with another man during the last 12 months preceding the survey were prerequisites. Two exclusion criteria were adopted as under age 15 and already known to be HIV positive.

Qualitative component

During the implementation phase a series of FGDs were conducted among selected target groups in order to obtain in-depth information on concepts, perceptions and ideas regarding knowledge and behaviors on safe sex. While the SWs (both female and transgender) and MSM have participated in the discussions which were held separately (*see* the summary reports in **Annexes IV-VI**), the project did not include drug users upon AMATEM's request.

Biological component

All the HIV tests for SWs and MSM were performed at Şişli Municipality VCT Center (SM-VCTC). The Center run by Şişli Municipality was established in 2006 during the implementation of HIV/AIDS Prevention Programme of MoH, which was supported by the Global Fund. During the preparatory phase of the Project, the parties agreed on the testing protocol below.

> HIV was detected by repeat positives of two different tests: one rapid test and an enzyme-linked immunosorbent assay (ELISA) test; so each sample underwent up to two separate tests at the VCT Center. If the first test (rapid test provided by MoH) showed negative result then no further test was conducted, but if the rapid test showed a positive result then a second test (ELISA) was performed. If the second result too confirmed the first result then no further test was performed at the Center and the case was accepted as positive. But if the second test result contradicted the first one, then a third test would be performed, which never was the case during our survey.
>
> The positive cases were referred to the nearest confirmation center (in our study to Okmeydanı Research and Training Hospital or to Virology Department of İstanbul School of Medicine, İstanbul University). As an additional note, this final referral process was coordinated by the VCT Center itself with no involvement of the field workers of our Project, in line with the agreement with Şişli Municipality.

Serological tests for the drug users were performed at Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery. The majority of the heroin addicts admitted to AMATEM for inpatient treatment were also screened for HBV and HCV, in addition to HIV testing. The rationale for these additional tests was simple: Besides HIV, the infectious diseases such as hepatitis B and C are among the most serious health consequences of drug use. Even in countries with low prevalence rates for HIV, both types of hepatitis, in particular hepatitis C are highly prevalent among IDUs.

Adopting vulnerability concept

In the first decade of the HIV epidemic, the term 'at risk group' was applied to those social groups in which the very first cases of the disease were diagnosed, namely - MSM, SWs and IDUs. Individuals thus labeled were presented as the only ones susceptible to the disease and were considered dangerous which in turn caused an increase in social stigma and prejudice towards these subgroups. On the other hand, the general population failed to identify themselves as 'at risk'. Starting in the early 90s, the term 'at risk group' drew criticism, particularly from the organized gay movement worldwide, because it implied that all members of those groups were at risk, rather than certain 'behaviors' of some group members being risky. Consequently, the concept of 'risk behavior' emerged, pointing to specific characteristics and behaviors that could maximize the susceptibility of individuals to HIV infection. Unfortunately the concept of risk behavior also has limitations. With its focus on the responsibility and protection of individuals, the concept does not take into account the socio-cultural construction of risk.

Finally in mid 90s with the introduction of 'vulnerability' concept the emphasis shifted from the individual towards a careful look at the social/ cultural context in which the subject lives without overlooking his/ her needs or rights. The concept of vulnerability illuminates how inequity, stigma, discrimination, and violence can accelerate the spread of AIDS, as well as the reasons why some individuals or groups are automatically more vulnerable to HIV infection.

According to UNAIDS (UNAIDS, 2006),

> "*risk can be defined as the probability of an individual becoming infected by HIV, either through his or her own actions, knowingly or not, or via another person's actions. For example, injecting drugs using contaminated needles or having unprotected sex with multiple partners increases a person's risk of HIV infection. Vulnerability to HIV reflects an individual's or community's inability to control their risk of HIV infection. Poverty, gender inequality, and displacement as a result of conflict or natural disasters are all examples of social and economic factors that can enhance people's vulnerability to HIV infection. Both risk and vulnerability need to be addressed in planning comprehensive responses to the epidemic*."

In the prevention of HIV/AIDS, the influence of vulnerability is now widely integrated into the elaboration of strategic responses worldwide. Adopting the vulnerability concept in our prevention strategies enabled us first to increase the reach, but more importantly to better understand and effectively address the target groups' behaviors, knowledge and attributes that affect the possibility of preventing HIV infection.

1.5. Ethical Considerations

The study was approved by both Joint Institutional Review Board of the IPs and PSC. The participants provided either written or verbal informed consent depending on the nature of the survey component and the location of the attempt. Since the behavioral component of the survey was implemented mainly through outreach activities, in the natural settings of streets, public parks, and the like where street-based sex work activities are occurring; and at cafes, bars, saunas, and the like where vulnerable subpopulations congregate, in most of the cases a verbal consent was obtained. Verbal consent included all the information provided in the written form regarding the nature, purpose, risks, and benefits of the study. For the interviews conducted at WD, clinics or CSO settings a written informed consent form was used. In any case, the interviewer documented the consent whether the participant has agreed to enroll verbally or obtained a written form with the participant's signature. Individuals participating in structured qualitative interviews went through a similar written informed consent process before interviews were undertaken and FGD notes were recorded.

In regard to the biological component of the survey written informed consent was obtained from the participants either as a part of pretest counseling process (at the VCT Center) or before hospital admission (at AMATEM).

Access to survey respondents as well as the data collected from them remained confidential.

1.6. Reaching Target Populations

Working with hard-to-reach groups poses various challenges in all initiatives worldwide. These challenges arise from the fact that many such groups are 'hidden'. Vulnerable populations targeted by HIV prevention initiatives i.e. SWs, MSM and IDUs are hidden simply because the behaviors in which they engage are either illegal or illicit. On the other hand, these groups are also hidden because of being stigmatized in the society at large. Thus, they generally prefer not to participate in surveillance data collection activities. In Turkey, also, national HIV surveillance experiences targeting vulnerable populations have faced problems in reaching these hidden groups. For example, 'Operational Research on Key STIs and HIV in Turkey, 2006-2007' which was the first national second generation surveillance project, despite wide involvement of institutions from both public, CSO sector, and international technical support, was able to reach a total sample size of 486 in three major cities - İstanbul, Ankara, İzmir; only 215 in İstanbul.

Reaching SWs and MSM

The Project developed various strategies to overcome the reaching issue. First, members of these two vulnerable groups were involved in all stages from the beginning of the initiative. Three members of staff, who had extensive experience in working with SWs, and two members of staff experienced in peer education were recruited as field workers to help engage with members of vulnerable groups. The field workers were trained together for three days before starting outreach activities and a two-day training/ orientation program was repeated twice in the course of the project with a special emphasis on how to reach the target population. Besides, all the members of the project team convened at least once a month to discuss the operational issues, particularly the difficulties they faced in recruiting vulnerable groups to arrive at the study sample and increase their use of VCT services.

Secondly, the Project used both the social center (Women's Door -WD) and various outreach activities to reach the target groups. Since WD has been operational for a long time, most of the SWs and LGBTT groups were used to visiting the Center regularly and they had a chance to discuss social, legal and health related issues, to benefit from education, IE&C (information, education and communication) materials, private counseling sessions and referral services, and obtain free condoms and lubricants. During the course of the project, WD was assigned solely for MSM population, which was set as one day per week. Thus, the field workers had the chance to provide services to their target population during the assigned days. On the other hand, the outreach activities were conducted in places where SWs/ MSM congregate (such as gay bars, parks, saunas, etc) in order to promote safer sexual behavior and to encourage them to use VCT/ STI services. Mobile counseling unit (MCU) was another tool through which HRDF had implemented successful efforts since mid 90s in reaching street-based SWs who work at specific pick-up points of the city center or suburbs and provide sexual services at near-by lodges. The MCU was operated during the first two months of the implementation phase, but this time reached very few SWs due to strict control efforts of security forces over sex work. For this reason the Project stopped the operation of MCU and focused intensively on other outreach activities. In addition the field workers visited CSO's, university gay clubs working with/ serving Lesbian, Gay, Bisexual, Transvestite and Transsexual (LGBTT) groups to ensure their collaboration.

Another strategy was to organize/ involve in advocacy activities i.e. LGBTT parades, remembrance days, panel discussions. Through these activities field workers had a chance to meet with their peers, to introduce and promote project activities which in turn increased the use of WD and helped the recruitment of new members to the survey. The field workers also made use of innovative forms including chat rooms using ICQ aimed at reaching 'hidden' groups with information and support.

Reaching drug users

Drug users were traditionally the hardest-to-reach group according to the national experiences. The project solved the reach issue by simply collaborating with AMATEM, which is the oldest and largest drug treatment center in Turkey.

The above data collection strategies using a combination of venue-based and time-location sampling to recruit vulnerable sub-populations enabled the Project to produce unbiased estimates (or more realistically estimates with minimal levels of bias) for a meaningful surveillance.

1.7. Data Management and Analysis

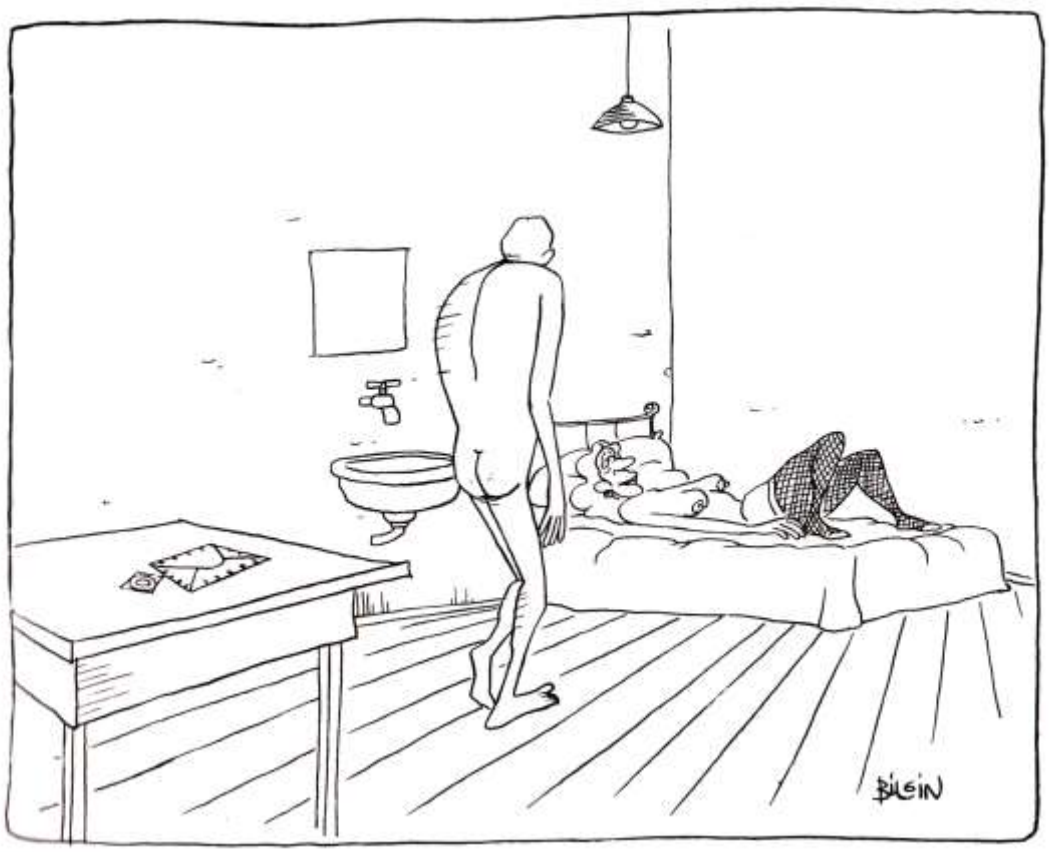
Statistical analyses were determined using Statistical Package for Social Sciences version 15.0 (SPSS 15.0). Data entry process was designed to allow for missing values. When the number of cases of the missing values was extremely small (<5% of the sample) they were omitted from the tables. In cases when the missing values accounted for >5% of the sample, those were displayed in a separate row with the numbers and frequencies [in brackets]. Yet, the frequencies and means in the tables were calculated by excluding those missing values in order to draw an accurate inference for the readers.

The descriptive statistics also include some important results which will provide valuable input for the Country Progress Report on Monitoring the Declaration of Commitment accepted in the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). These results with a reference to the related UNGASS indicator were highlighted in **Chapter 7** for a quick reference.

1.8. Organization of the Report

The bio-behavioral survey report is presented in seven chapters. The present chapter (**Chapter 1**) is the Introduction Chapter of this report. The socio-demographic characteristics of the respondents are described in **Chapter 2**. In **Chapter 3**, the extent of alcohol and drug use among the respondents is presented. Respondents' sexual behavior, types of sexual partners and condom use is discussed in **Chapter 4**. In **Chapter 5**, respondents' knowledge about HIV/AIDS is presented. The main results of the behavioral component are also displayed as a summary table at the end of each chapter where the findings are presented and discussed (**Chapters 2-5**).

Finally, as one of the HIV related behaviors, testing practices have been discussed and test results have been presented in **Chapter 6**. The last chapter (**Chapter 7**) is the summary of the results: interpreting and highlighting the main findings, informing national progress on UNGASS indicators and recommendations of the report.



Mustafa Bilgin

CHARACTERISTICS OF THE STUDY POPULATIONS

2

The present chapter analyses the socio-demographic characteristics of study sample included in our bio-behavioral survey. A total of 655 respondents representing three main vulnerable populations sampled in the survey. Among these 312 (116 female and 196 transgender) were SWs, 230 were MSM and 103 (66 IV and 47 non-IV) were heroin users. The key socio-demographic characteristics analyzed for all subgroups were: gender, age, education, and marital status. In addition, employment status and monthly income were elaborated only for DU subgroups. The results of the key variables are discussed below and summarized in **Table 2.4** at the end of this chapter.

2.1. Gender Identity

While half (50.8%) of the study sample identified themselves as male, the remaining half as female (19.2%) or female-transgender (29.9%).

2.2. Age

The age distribution of the achieved sample is summarized in **Table 2.1** below. The mean age of the total sample was 31.6 years (median 30; range 17.0-62.0). Although the total numbers of each subgroup were not even, when they are compared according to their mean ages, non-IV heroin users represented the youngest and female-SWs the eldest group only with small variations.

Table 2.1 Average age and age range of survey participants

	n	Youngest	Eldest	Mean	Std. Dev.
Female-SWs	115	18	61	37.30	11.192
Transgender-SWs	196	17	62	32.54	10.276
MSM	229	18	54	28.93	6.860
IV heroin users	66	19	55	31.32	8.755
Non-IV heroin users	47	18	56	27.30	8.054
Total	**655**	**17**	**62**	**31.59**	**9.605**

Summary table (**Table 2.4**) presented at the end of the chapter shows the distribution of each subpopulation by age groups. Almost half (48.3%) of the present sample was in 'adolescent and young adult' age category (15-29 years of age). While the percentage of the adolescents and youngsters (15-24 years of age) comprised approximately one third of the respondents (27.9%), one fifth (19.0%) represented the elder age group (40 years and over).

2.3. Education

The majority (58.6%) of the sample was high school graduate or has a higher level of education. This figure shows that our sample has a higher educational level when compared with the general population 15 years of age and over in Istanbul. According to Turkish Statistical Institute's (TurkStat) data based on address-based population registration system for 2009 the same percentage (of at least high school graduate) was 35.6 percent in İstanbul.

Among our sample, the MSM subpopulation was the most educated group as half of them (54.5%) was either a student at or graduated from a university. In contrary, female SWs appeared as the least educated subgroup as half of them (51.7%) was primary school graduate or had a lower level of education.

2.4. Marital Status

The vast majority (84.8%) of the sample population was single. Transgender SWs and MSM had the highest percentages of singles (96.4 and 94.3%, respectively) as expected.

2.5. Employment

The vast majority (72.4%) of drug users was unemployed (**Table 2.2**). Unemployment rate was even higher in IDU sub-group as only less than one fifth (18.2%) of them was currently employed.

Table 2.2 Current employment status of heroin users

	IV DUs		Non-IV DUs		Total DUs	
	n	%	n	%	N	%
Employed	12	18.2	19	40.4	31	27.4
Unemployed	54	81.8	28	59.6	82	72.6
Total	**66**	**100.0**	**47**	**100.0**	**113**	**100.0**

2.6. Monthly Income

The vast majority (63.7%) of drug user respondents stated that they had no income or their income was not constant (**Table 2.3**). When the 'not constant' income group was excluded more than half (52.3%) of drug users appeared to have no income.

Table 2.3 Monthly income of heroin users

	IV DUs		Non-IV DUs		Total DUs	
	n	%	n	%	N	%
None	29	43.9	16	34.0	45	39.8
Not constant	15	22.7	12	25.5	27	23.9
< 500 TL	3	4.5	1	2.1	4	3.5
500-1500 TL	16	24.2	12	25.5	28	24.8
> 1500 TL	3	4.5	6	12.8	9	8.0
Total	**66**	**100.0**	**47**	**100.0**	**113**	**100.0**

Table 2.4 Summary Table: Socio-demographic characteristics of the survey participants

	SWs				MSM		DUs				TOTAL	
	F-SWs		T-SWs				IV		Non-IV			
	n=116	%	n=196	%	n=230	%	n=66	%	n=47	%	N=655	%
Gender identity	**116**		**196**		**230**		**66**		**47**		**655**	
Female	116						6	9.1	4	8.5	126	19.2
Transgender			196								196	29.9
Male					230		60	90.9	43	91.5	333	50.8
Age (years)	**115**		**194**		**229**		**66**		**47**		**651**	
15-19	1	0.9	17	8.8	9	3.9	1	1.5	8	17.0	36	5.5
20-24	13	11.3	35	18.0	70	30.6	18	27.3	10	21.3	146	22.4
25-29	20	17.4	27	13.9	55	24.0	15	22.7	16	34.0	133	20.4
30-34	21	18.3	50	25.8	44	19.2	11	16.7	7	14.9	133	20.4
35-39	17	14.8	20	10.3	29	12.7	11	16.7	2	4.3	79	12.1
40+	43	37.4	45	23.2	22	9.6	10	15.2	4	8.5	124	19.0
Education	**116**		**196**		**229**		**66**		**47**		**654**	
Illiterate	5	4.3	-	0.0	-	0.0	-	0.0	-	0.0	5	0.8
Literate	21	18.1	12	6.1	1	0.4	2	3.0	1	2.1	37	5.7
Primary (5 years)	34	29.3	34	17.3	14	6.1	22	33.3	13	27.7	117	17.9
Secondary (8 years)	13	11.2	39	19.9	23	10.0	20	30.3	17	36.2	112	17.1
High school (11 years)	27	23.3	75	38.3	66	28.8	15	22.7	13	27.7	196	30.0
University student	6	5.2	5	2.6	49	21.4	4	6.1	2	4.3	66	10.1
University graduate	10	8.6	31	15.8	76	33.2	3	4.5	1	2.1	121	18.5
Marital status	**115**		**193**		**229**		**66**		**47**		**650**	
Single	76	66.1	186	96.4	216	94.3	45	68.2	28	59.6	551	84.8
Married	9	7.8	5	2.6	6	2.6	10	15.2	16	34.0	46	7.1
Divorced	30	26.1	2	1.0	7	3.1	11	16.7	3	6.4	55	8.2

Alper Susuzlu

ALCOHOL AND DRUG USE

3

Drug use is a global problem and shared equipment, particularly needle sharing practices for using drugs is a major factor in the spread of HIV infection. But drug related behaviors that put people at risk for HIV transmission go beyond injecting. Studies have also shown that alcohol consumption and drug use are significant predictors of sexual risk-taking which lead to STIs/ HIV transmission. Thus risk assessment must take into account sexual behaviors associated with other drugs such as alcohol and non-IV forms of illicit drugs.

The present chapter attempts to analyze the extent of alcohol and drug use including drug injecting habits among our study population. In addition, awareness of health risks of sharing drug preparation equipment and knowledge of managing overdose were elaborated among heroin user sub-groups. The results of the key variables about alcohol and drug use are discussed below and summarized in **Table 3.7** at the end of the chapter.

Box 3.1 Global facts and figures: Alcohol and drug use

Globally, about two billion people use alcohol. The highest prevalence rates of alcohol use disorders in the population can be found in parts of Eastern and Central Europe (with prevalence rates up to 16% in some countries). Harmful use of alcohol is one of the most important contributors to the global burden of disease and most recently ranked third behind childhood underweight and unsafe sex.

WHO, 2010

UNODC estimated that between 155 and 250 million people aged 15-64 years (3.5 to 5.7% of the given population) had used an illicit drug at least once. There were between 16 and 38 million "problem drug users" (i.e. IDUs or problem users of opioids, cocaine or amphetamine) in 2008 globally.

UNODC, 2010

3.1. Alcohol Use - Frequency

In our study group, one third (32.5%) of the respondents stated that they abstained from alcohol in the last month proceeding the survey (**Table 3.7**). There were huge variations in abstention among subgroups: while non-IV heroin users had the highest abstention rate (72.3%), only 15.5% of MSM had not consumed any alcoholic beverage during the last month. The marked high abstention rates among drug users should be interpreted with caution since the results are attributable to their hospitalization during the interviews. When the heroin user sub-groups were excluded, the abstention rate decreased to one forth (25.6%) for the remaining total and female SWs group had the highest abstention rate with 37.4 percent.

Box 3.2 Recent studies: Alcohol & HIV

In literature various studies found a positive correlation between alcohol use and both engagement in high-risk sexual behavior and condom failure. Two recent meta-analyses confirmed the significant association between alcohol consumption and risk of incident HIV infection.

Baliunas et al, 2010; Shuper et al, 2010

Those who consumed any alcohol were at 77% higher risk for HIV infection compared to abstainers. Frequency of heavy-drinking episodes also counts: for those consuming alcohol in binges, the risk of HIV was over double that of non-binge drinkers.

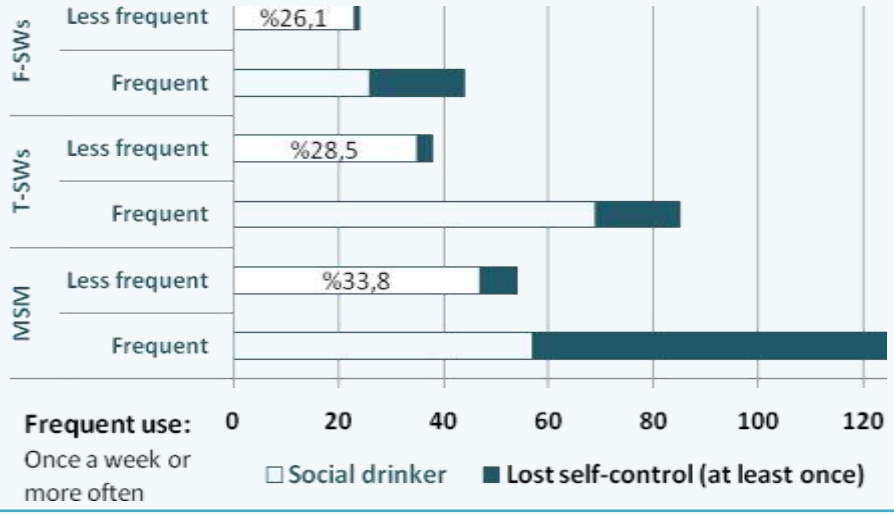
Baliunas et al, 2010

Around half (45.6%) of the respondents has declared frequent -once a week or more often- alcohol consumption in the last month. This figure was not changed (46.6%) when the drug user groups were excluded. In regard to frequency of alcohol use, MSM had the highest percentage of frequent users with 58.6 percent, followed by transgender SWs with 47.6 percent. Transgender SWs had the highest rates (23.8%) of daily alcohol consumption.

3.2. Alcohol Use - Effect

Since quantifying alcohol use is more complex due to differences in the alcohol contents of different beverages, and thus assessment is more difficult than the frequency of use, we asked the target population whether they were only social drinkers or had ever lost self control during the last month to simply assess the effect of alcohol use. Almost one third (29.6%) of the respondents declared

Figure 3.1 Relation of frequency and effect of alcohol consumption in the past month among MSM and SWs



that they lost self control at least once, and when the heroin user sub-groups were excluded this figure increased to 30.6 percent. The highest percentage of losing self control at least once was among MSM (42.2%), whereas it was only 14.9 percent for transgender SWs.

When these two variables related to alcohol consumption -frequency and effect- were assessed together and further analyzed for SWs and MSM the result is: two thirds (68.7%) of all alcohol users and more than half (59.1%) of the social drinkers appeared to be frequent users (**Figure 3.1**). Only slightly more than a quarter (28.3%) of total alcohol users stated less frequent use and also was a social drinker.

3.3. Drug Use

Since drug use, particularly the intravenous (IV) route, is relatively rare in Turkey, the question was formulated so as to determine the participants' lifetime use. The majority (56.5%) stated ever use of any kind of illicit drugs (**Table 3.7**). When heroin user sub-groups were excluded, rate of ever users slightly decreased to 47.3 percent and MSM sample appeared to have the highest rate (56.4%), followed by transgender SWs (44.4%). Among SWs and MSM very few (4.3%) stated ever use of IV drugs: while female SWs had the highest rate with 7.8 percent, only one percent of transgender group tried at least once.

Table 3.1 Lifetime prevalence of illicit drug use of the survey participants

	SWs				MSM		DUs				TOTAL	
	F-SWs		T-SWs				IV		Non-IV			
	n=116	%	n=196	%	n=227	%	n=66	%	n=47	%	N=652	%
Never used	76	65.5	109	55.6	99	43.6	-	0.0	-	0.0	284	43.6
Marijuana	40	34.5	70	60.3	124	53.9	64	97.0	44	93.6	342	52.5
Heroin	6	5.2	1	0.9	16	7.0	66	100.0	47	100.0	136	20.9
Cocaine	28	24.1	18	15.5	73	31.7	55	83.7	31	66.0	205	31.4
Stimulants	16	13.8	23	19.8	67	29.1	58	87.9	33	70.2	197	30.2
Tranquilizers	6	5.2	9	7.8	25	10.9	47	71.2	16	34.0	103	15.8
Other	7	6.0	12	10.3	50	21.7	37	56.1	17	36.2	123	18.9

Table 3.1 shows the illicit drugs ever used by the study population. Marijuana was the most commonly used illicit drug among our sample (by 52.5%), as in other parts of the world; followed by cocaine (31.4%).

3.4. Syringe and Needle Share

The respondents were also asked whether or not they have shared needle/ syringe (hereafter 'syringe') with someone else during the last time they had injected drugs. Among a total of 89 intravenous drug users in our sample, 83 of the respondents answered the question and more than one third (36.1%) stated that they had shared syringes during their last injection (**Table 3.2**). Although the numbers are very small, we should note that almost half of the IV drug using SWs (44.4%) shared syringes with other users, whereas two third (32.8%) of IDUs experienced syringe share.

Table 3.2 Needle and syringe sharing practices during last injection among IV drug users

	SWs				MSM		DUs				TOTAL	
	F-SWs		T-SWs				IV		Non-IV			
	n=9	%	n=2	%	n=12	%	n=66	%	n=NA	%	N=89	%
Shared	4	57.1	-	0.0	5	50.0	21	32.8	-		30	36.1
Not shared	3	42.9	2	100.0	5	50.0	43	67.2	-		53	63.9
Total	**7**		**2**		**10**		**64**		**-**		**83**	
Don't remember/ Missing	2	[22.2]	-		2	[16.7]	2	[3.0]	-		6	[6.7]

The additional questions asked to the heroin user sub-groups allowed us to elaborate the reasons behind syringe sharing practices (**Table 3.3**). Two thirds (68.4%) of the respondents who had shared syringe during last injection stated some sort of a barrier to access to sterile syringes and almost one fifth (21.1%) specified some other reason including trusting the partner that s/he is uninfected, accepting as a social ritual, to get more pleasure and peer pressure. It was interesting that none of the respondents mentioned financial limitations as a reason for syringe sharing.

Table 3.3 Causes of syringe sharing practices among IV heroin users

	n	%
Financial limitations	-	0.0
Barriers to access to sterile syringe	13	68.4
Not caring about the risk	2	10.5
Other	4	21.1
Total	**21**	**100.0**
Don't know/ Missing	[2]	[9.5]

The additional questions (*see* **Annex III**) also assessed heroin users' sharing practices of injection equipment other than syringe, awareness of health risks and knowledge of managing overdose, which will be discussed below.

3.5. Sharing Drug Preparation Equipment

In regard to the sharing of injection equipment other than syringe (including cookers, water, filters, swaps and drugs), two third of IV heroin users sub-group (66.7%) stated sharing practices ever; and the majority (72.1%) shared with at least two more people (**Table 3.4**). The mean number of people they shared injection equipment with was 2.16 (range: 1.0-5.0).

Table 3.4 Practice of injection equipment sharing among IV heroin users; and number of people they had shared with

	n	%	% of IV heroin users sharing
1	12	27.9	
≥ 2	31	72.1	
Total shared	**43**	**100.0**	**66.7**

3.6. Awareness of Health Risks

Almost all IV user respondents (97.0%) were aware of the health risks; while one third of non-IV users (29.8%) were not aware of risk for transmission of hepatitis or HIV (**Table 3.5**).

3.7. Knowledge of Managing Overdose

Two thirds (66.7%) of the IV drug users stated that they were aware of basic resuscitation techniques in case of heroin overdose (**Table 3.6**). But, among these while mouth-to-mouth resuscitation had the lowest knowledge rate (40.9%), a vast majority (86.4%) stated injecting salty water as a method of treatment which is a misconception and should be avoided.

Table 3.5 Awareness of health risks of sharing drug preparation equipment among heroin users

	IV Users		Non-IV Users		Total Heroin Users	
	n	%	n	%	N	%
May cause any health risk	64	97.0	38	80.9	102	90.3
Risk of hepatitis, HIV transmission	62	93.9	70	60.3	95	84.1
Total	**66**		**47**		**113**	

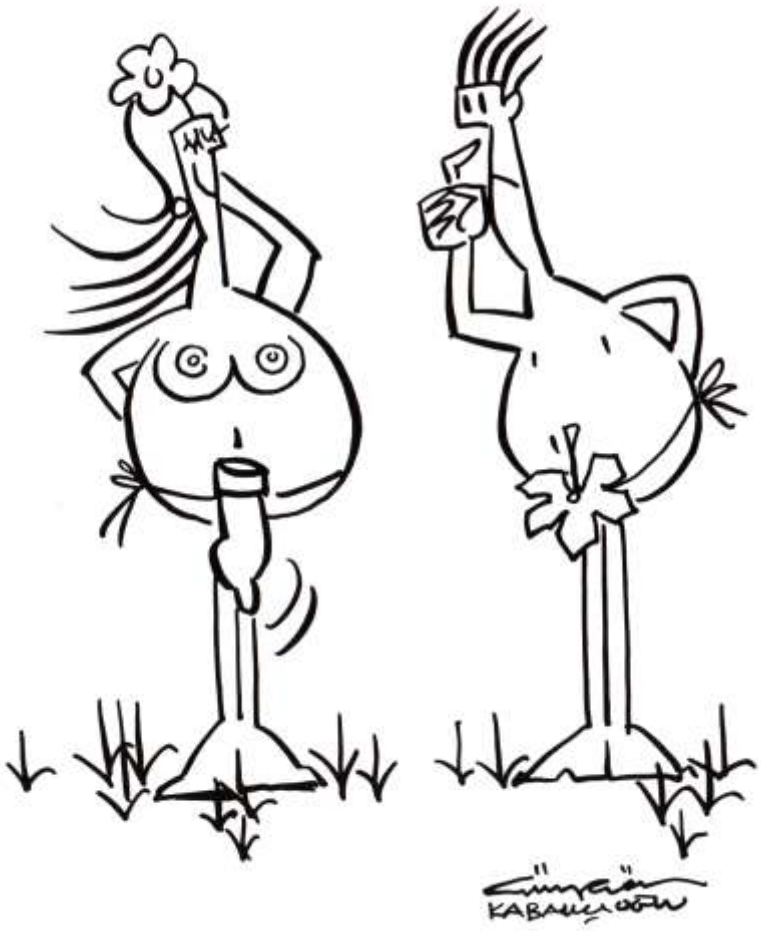
Table 3.6 Knowledge of managing overdose including basic resuscitation among heroin users

	IV Users		Non-IV Users		Total Heroin Users	
	n	%	n	%	N	%
Aware of any precaution	44	66.7	19	40.4	63	55.8
Cardiac massage	21	[47.7]	9	[47.4]	30	[47.6]
Mouth to mouth resuscitation	18	[40.9]	6	[31.6]	24	[38.1]
Clear the airway	24	[54.5]	5	[26.3]	29	[46.0]
Injecting salty water	39	[86.4]	8	[42.1]	47	[74.6]
Other	14	[31.8]	4	[21.1]	18	[28.6]
Total	**44**		**9**		**63**	

Table 3.7 Summary Table: Alcohol and drug use of the survey participants

	F-SWs		T-SWs		MSM		IDUs		Non-IV DUs		TOTAL	
	n=116	%	n=196	%	n=230	%	n=66	%	n=47	%	N=655	%
Alcohol use - Frequency	**115**		**185**		**220**		**63**		**47**		**630**	
None	43	37.4	56	30.3	34	15.5	38	60.3	34	72.3	205	32.5
< Once a week	26	22.6	41	22.2	57	25.9	11	17.5	6	12.8	141	22.4
≥ Once a week, < Everyday	34	29.6	44	23.8	109	49.5	10	15.9	5	10.6	202	32.1
Everyday	12	10.4	44	23.8	20	9.1	4	6.3	2	4.3	88	13.0
Effect of alcohol use	**68**		**131**		**180**		**25**		**13**		**417**	
Never lost self control	49	72.1	120	85.1	104	57.8	22	88.0	9	69.2	304	72.9
Lost self control at least once	19	27.9	21	14.9	76	42.2	3	12.0	4	30.8	123	29.6
Drug use (ever)	**116**		**196**		**227**		**66**		**47**		**652**	
Never used	76	65.5	109	55.6	99	43.6	-	0.0	-	0.0	284	43.6
Ever used (IV)	9	7.8	2	1.0	12	5.3	66	100.0	-	0.0	89	13.7
Ever used (any except IV)	31	26.7	85	43.4	116	51.1	66	100.0	47	100.0	279	42.8

Ümit Müfit Dinçay



Güngör Kabakçıoğlu

SEXUAL HISTORY AND PRACTICES

4

The majority of HIV infections are acquired through unprotected sexual relations which accounts for more than 80 percent of new HIV infections worldwide. But sexual transmission has been the most difficult mode of HIV transmission to address. HIV prevention relies upon individuals practicing protective behavior. Specific sexual behaviors that reduce the risk of infection i.e. avoiding sexual intercourse with infected individuals and using condoms are influenced both by personal factors such as attitudes, knowledge, and abilities; and by environmental factors characterizing the contexts in which individuals' behaviors are carried out.

The present chapter analyzes the respondents' sexual history, recent sexual practices they engage in with a special emphasis to their individual behaviors such as number of sexual partners and condom use which may pose risks for HIV transmission.

4.1. Age at First Sexual Experience

Beginning sexual activity at early ages by either premarital sex or practicing child marriage introduces an individual to the risk of STIs, and the age at first sexual debut has been declining steadily over recent generations. Young people do not always have the negotiation skills to ensure the consistent and effective use of condoms, but as a group, with both higher rates of partner change and more concurrent sexual partnerships, they are already at disproportionate risk of acquiring STIs including HIV. For this reason, delaying the age at first sex and discouraging premarital sexual activity has been a major goal in many countries where extensive programs using ABC [Abstain, Be faithful, use Condoms] approach have been implemented.

This report will not discuss the pros and cons of such program strategies, instead focus on the survey results.

Table 4.1 Average age and age range of the survey participants at their first sexual experience

	n	Earliest	Latest	Mean	Std. Dev.
Female SWs	113	9	25	15.87	2.757
Transgender SWs	195	6	26	14.79	3.460
MSM	228	6	30	15.65	3.060
IV heroin users	64	13	21	16.28	2.058
Non-IV heroin users	46	11	24	16.33	2.486
Total	**628**	**6**	**30**	**15.60**	**3.045**

The mean age at first sexual experience (vaginal/ anal/ oral) was 15.60 years (median 16.0; range 6.0-30.0) for the total sample with minor variances within sub-populations: minimum 14.78 in transgender SWs and maximum 16.33 in non-IV heroin users (**Table 4.1**). According to a global survey carried out in 41 countries in 2005, the average age at first sex was 17.4 years, where Turkey was slightly over the average with 17.8 (Durex Network, 2005). When compared with this survey, our results revealed lower figures for each sub-population, increasing the survey sample's vulnerability.

Slightly more than one third (34.2%) of our sample population have had their first sexual experience before age 15. The transgender SWs had the highest (50.8%) and non-IV drug users had the lowest (19.6) percentages of starting sex before age 15. The data on age at the first sexual experience was further analyzed and disaggregated by age groups of the respondents to inform UNGASS indicator #15 (**Table 4.2**). For young respondents aged 15-24, the percentage of starting sex before age 15 was calculated as 37.9

Table 4.2 Percent distribution of the survey participants who have had sexual intercourse before the age of 15, by age groups

	SWs				MSM		DUs				TOTAL	
	F-SWs		T-SWs				IV		Non-IV			
	n=112	%	n=191	%	n=227	%	n=64	%	n=46	%	N=640	%
15-19	1/ 1	[100.0]	14/ 17	[82.4]	3/ 8	[37.5]	-/ -	[0.0]	-/ 7	[0.0]	18/ 33	[54.5]
20-24	4/ 12	[33.2]	19/ 35	[54.3]	16/ 70	[22.9]	5/ 17	[35.7]	5/ 10	[50.0]	49/ 144	[34.0]
25-39	18/ 56	[32.1]	38/ 96	[39.6]	32/128	[25.0]	8/ 37	[10.8]	4/ 25	[16.0]	100/ 342	[29.2]
≥ 40	17/ 43	[39.5]	26/ 43	[60.5]	8/ 21	[38.1]	1/ 10	[7.1]	-/ 4	[0.0]	52/ 121	[43.0]
Total	**40**	**35.7**	**97**	**50.8**	**59**	**26.0**	**14**	**21.9**	**9**	**19.6**	**219**	**34.2**
15-24	5/ 13	[38.5]	33/ 52	[63.5]	19/ 78	[24.4]	5/ 17	[29.4]	5/ 17	[29.4]	67/ 177	[37.9]
≥ 25	35/ 99	[35.4]	64/139	[46.0]	40/149	[26.8]	9/ 47	[19.1]	4/ 29	[13.8]	152/ 463	[32.8]

(CI%95: 30.68-45.44). Transgender SWs had the highest percentage (63.5%) for the same indicator, whereas MSM had the lowest (24.4%).

The youngsters were more likely to start sexual activity at an early age. Compared to elder respondents (≥ 25 years of age) they had higher percentages of having had their first sexual experience before age 15 in all sub-groups except MSM. This confirms the steady decrease in age at first sex over generations among these vulnerable populations which increase their risk for acquiring STIs including HIV, as discussed above.

4.2. Duration of Sex Work

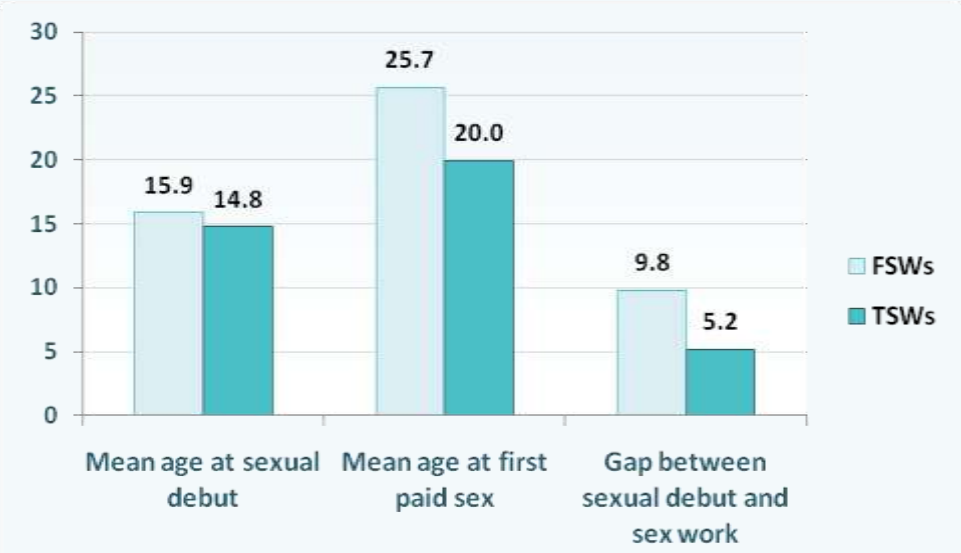
The average number of years spent as a sex worker was 12.0 years (median 10; range 1 month-44 years) for female SWs and 10.8 years (median 8.0; range 2 months-40 years) for transgender group (**Table 4.3**).

Table 4.3 Average and range of duration of sex work among female and transgender SWs

	n	Min (months)	Max (years)	Mean	Std. Dev.
Female SWs	112	1	44	12.02	9.454
Transgender SWs	186	2	40	10.84	9.692
Total	**298**	**1 month**	**44 years**	**11.28**	**9.604**

Similar to early experience of sexual intercourse, starting sex work at early age increases individual's vulnerability as it is associated with larger numbers of sexual partners over a lifetime. The average age that females entered sex work was 25.7 years, and 20 years for transgender group. Both the average age at first sexual experience and at first commercial sex work are shown in **Figure 4.1** in order to present the gap between them. Transgender SWs were more likely to start sex and to engage in sex work earlier, compared to females. The average gap between sexual debut and their entry in sex business stretched from 5.2 years in transgender SWs to 9.8 in females, and the difference was statistically significant ($p<0.05$).

Figure 4.1 Gap between first sexual experience and entering sex work among female and transgender SWs



4.3. Number of Partners

The total number of partners (different people, including their spouse/ regular partner) that the respondents have had sexual activity (vaginal/ anal/ oral) with during the last four weeks are shown in **Table 4.6**. The vast majority (87.4%) of the respondents have had sexual activity in the given period. Among these, 82.4 percent have had more than one partner, probably with the influence of SW sub-group. Following SWs, MSM had the highest rate of having multiple partners (75.2%) and drug users the lowest (12.7%). Again the low rates among drug users should be interpreted with caution since the majority stated that they were sexually inactive for the given period, leaving us a very small number of respondents to comment on their sexual risks in regard to the number of partners. As an implication for the future clinical-based surveys, the question should be reformulated for drug users so as to probe the number of partners in the last month preceding their admission to the hospital.

Table 4.4 Average number and range of sexual partners the survey participants had in the last month, by partner type

		n	Min	Max	Mean	Std. Dev.
Female SWs	Client	108	2	300	55.88	73.840
	Spouse/ partner	26	1	8	1.54	1.476
	Any partner	108	2	301	56.24	73.701
Transgender SWs	Client	155	1	500	48.58	5.171
	Spouse/ partner	66	1	10	2.06	0.244
	Any partner	165	1	503	46.46	4.943
MSM	Male	206	1	25	4.08	4.090
	Female	38	1	7	2.13	1.528
	Any partner	210	1	25	4.39	4.083
IV heroin users		31	1	5	1.54	1.059
Non-IV heroin users		19	1	3	1.37	0.684
	Total	**532**	**1**	**503**	**27.70**	**53.850**

4.4. Partner Types

The survey questionnaire allowed us to differentiate the sex partner types as clients and regular partners for SWs; and male & female partners for MSM sub-groups. **Tables 4.4** and **4.5** summarize these details with mean number and range; and percent distribution of number of partners, respectively.

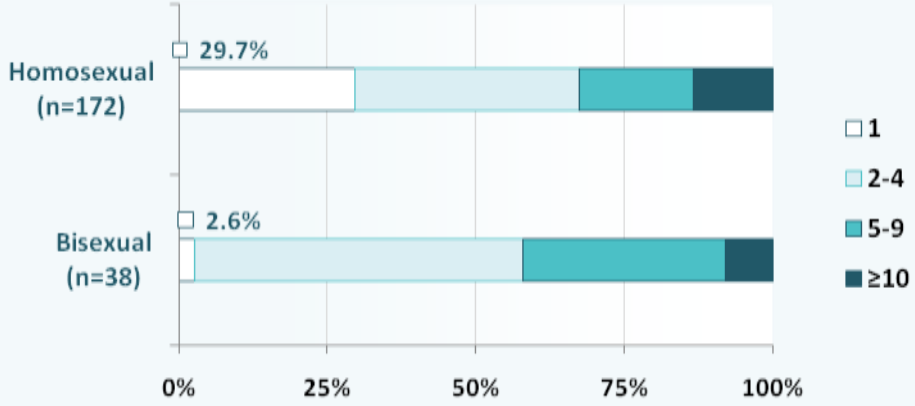
Table 4.5 Percent distribution of number of sexual partners in the last month reported by SWs and MSM, by partner type

	F-SWs				T-SWs				MSM			
	Client		Spouse/ partner		Client		Spouse/ partner		Male		Female	
	n	%	n	%	n	%	n	%	n	%	N	%
1	-	0.0	20	76.9	2	1.3	43	65.2	60	29.1	19	50.0
2-4	5	4.6	5	19.2	17	11.0	17	25.8	83	40.3	16	42.1
5-9	7	6.5	1	3.8	8	5.2	4	6.1	39	18.9	3	7.9
10-19	19	17.6	-	0.0	24	15.5	2	3.0	20	9.7	-	0.0
20-29	31	28.7	-	0.0	17	11.0	-	0.0	4	1.9	-	0.0
30-59	14	13.0	-	0.0	45	29.0	-	0.0	-	0.0	-	0.0
≥ 60	32	29.6	-	0.0	42	27.1	-	0.0	-	0.0	-	0.0
Total	**108**	**100.0**	**26**	**100.0**	**155**	**100.0**	**66**	**100.0**	**206**	**100.0**	**38**	**100.0**

Female SWs had 55.9 clients per month on average, whereas transgender group reported to have 48.6 clients for the same period (**Table 4.4**). In addition to these large number of clients, a significant percentage of SWs [a quarter of female (23.1%) and one third (36.1%) of the transgender sub-groups] also have had sex with their regular partners. The average numbers of non-commercial partners in the last month were 1.54 and 2.06 for female and transgender SWs, respectively. These figures of additional partners of SWs were almost identical to the average number of total partners of the drug user subgroup.

In MSM group, while three fourths have had multiple partners in the last month, among these, 16.2 percent had bisexual relationship. When the number of partners was elaborated, there were significant differences

Figure 4.2 Percent distribution of number of partners in the last month reported by MSM, by respondent's sexual identity



between homosexual and bisexual sub-groups (**Figure 4.2**). While almost one third (29.7%) of homosexuals had a single partner, the same percentage was 2.6 (only one case) for bisexuals.

4.5. Condom Use

Table 4.6 shows condom use during the last sexual activity: less than two thirds (60.7%) of the total study population reported use of condoms the last time they had sex, with significant differences among sub-populations. While transgender SWs had the highest rate (76.7%) of condom use, the percentage was the lowest (23.4%) in IV heroin user sub-group.

Figure 4.3 Use of condom reported by survey participants during their last sexual activity, by partner type

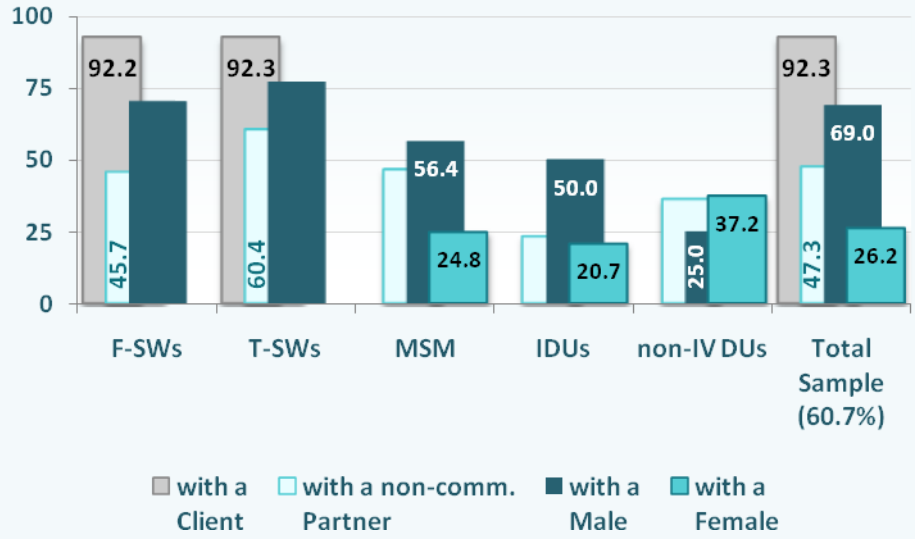


Figure 4.3 summarizes the data regarding the percent distribution of condom use of each sub-population, by partner type (displaying the same data used in the summary table) and indicates the results below:

- Among SWs, while almost all the participants stated use of condom with their most recent clients (92.2 and 92.3% respectively for female and transgender SWs), rate of condom use with their non-commercial partners declined in both sub-groups (45.6 and 60.4%, respectively). The differences in rates of condom use between partner types were statistically significant for both female and transgender SWs (x^2=0.485 p=0.028; and x^2=14.803, p=0.000, respectively).

- Among MSM, almost half (46.6%) of the respondents stated use of condoms with their most recent partners, whether male or female. Again, there was a significant difference in rates of condom use between partner types (x^2=12.589 p=0.000) and MSM were twice more likely to use condoms with a male partner than with a female partner (odds ratio: 2.3).

For heroin users, since there were very few female cases (three in IDUs and only one case in non-IV subgroup), condom use by partner type was not statistically analyzed. Instead, we should once again point out that heroin users had the lowest percentages among all sub-populations: only a quarter of IV heroin users (23.4%) and one third of non-IV users (36.2%) reported use of condom last time they had sex.

Table 4.6 Summary Table: Sexual history and behaviors of the survey participants

	F-SWs		T-SWs		MSM		IDUs		Non-IV DUs		TOTAL	
	n=116	%	n=196	%	n=230	%	n=66	%	n=47	%	N=655	%
Age at sexual debut	**113**		**193**		**227**		**64**		**46**		**643**	
Before age 15	40	35.4	99	51.3	59	26.0	14	21.9	9	19.6	221	34.4
≥ 15	73	64.6	94	48.7	168	74.0	50	78.1	37	80.4	422	65.6
Number of sexual partners (last month)	**110**		**167**		**222**		**64**		**46**		**609**	
1	-	0.0	6	3.6	52	24.8	22	71.0	14	73.7	94	17.6
2-4	4	3.7	18	10.9	86	41.0	8	25.8	5	26.3	121	22.7
5-9	8	7.4	11	6.7	46	21.9	1	3.2	-	0.0	66	12.4
10-29	50	46.3	43	26.1	26	12.4	-	0.0	-	0.0	119	22.3
≥ 30	46	42.6	87	52.7	-	0.0	-	0.0	-	0.0	133	25.0
No sexual activity	2	[1.8]	2	[1.2]	12	[5.4]	33	[51.6]	27	[58.7]	76	[12.5]
Condom use (with the last partner)	**116**	**(C)**	**195**	**(C)**	**227**	**(M)**	**6**	**(M)**	**4**	**(M)**	**649 respond.**	
	105	**(nC)**	**187**	**(nC)**	**101**	**(F)**	**58**	**(F)**	**43**	**(F)**	**1042 sex act.**	
With a client	107	92.2	180	92.3	-		-		-		287	92.3
With a non-commercial part.	48	45.7	113	60.4	153	46.6	15	23.4	17	36.2	346	47.3
With a male	*155*	*70.1*	*293*	*76.7*	*128*	*56.4*	*3*	*50.0*	*1*	*25.0*	*580*	*69.0*
With a female	-		-		*25*	*24.8*	*12*	*20.7*	*16*	*37.2*	*53*	*26.2*
Total condom use	155	70.1	293	76.7	153	46.6	15	23.4	17	36.2	633	60.7

C: Commercial **nC**: non-Commercial **M**: Male **F**: Female

Hakan Boyav

KNOWLEDGE OF HIV/AIDS

5

Awareness of HIV/AIDS, knowledge about modes of transmission, methods of prevention and treatment affect individuals in adopting behaviors that reduce their risk of infection. On the contrary, the fear of stigma when people have little or incomplete knowledge deters people from seeking testing, treatment, and care services. Thus, sound knowledge is an essential prerequisite for preventing the spread of HIV.

In this chapter, the knowledge of sample vulnerable populations on the essential facts about HIV transmission will be evaluated. To assess their knowledge level, the participants were asked to answer the following five questions “right” or “wrong”. The first two questions were related to modes of preventing sexual transmission of HIV, whereas the others were designed to probe misconceptions about HIV transmission.

- The risk of HIV transmission can be reduced by having sex with only one uninfected partner who has no other partners
- A person can reduce the risk of getting HIV by using a condom every time they have sex
- A healthy-looking person may have HIV
- A person can get HIV from mosquito bites
- A person can get HIV by sharing food with someone who is infected

5.1. Basic Knowledge on HIV/AIDS

Tables 5.1-5.5 show the results of the distribution of answers to all questions, including correct/ incorrect and 'don’t know' for each sub-population.

Table 5.1 HIV/AIDS knowledge among female SWs

	Correct answer		Incorrect answer		Don’t know	
	n	%	n	%	n	%
Having only one faithful partner can protect against HIV	74	63.8	22	19.0	20	17.2
Condom can prevent HIV	103	89.6	7	6.1	5	4.3
A healthy looking person can have HIV	76	65.5	23	19.8	17	14.7
Mosquitoes do not transmit HIV	49	42.6	38	33.0	28	24.3
Sharing food does not transmit HIV	64	55.7	35	30.4	16	13.9

The average rate of correct answers was 69.6% for the entire sample. When the percentages for correct answers were counted separately for all sub-populations, MSM group had the highest rates for three questions; while non-IV heroin users had the lowest for four questions.

Elaborating each question separately indicated some interesting results:

1. Although only three fourths (75.2%) of MSM gave correct answer to the first question related to faithful uninfected partner, they, as a sub-group, accounted for having the highest rates among all sub-populations; whereas non-IV heroin users had the lowest rate.
2. In regard to condom use question, the two sub-groups of heroin users shared the highest and lowest rates of correct answers: 95.5 percent among IV users and 87.2 percent among non-IV users.

Table 5.2 HIV/AIDS knowledge among transgender SWs

	Correct answer		Incorrect answer		Don't know	
	n	%	n	%	n	%
Having only one faithful partner can protect against HIV	130	66.7	39	20.0	26	13.3
Condom can prevent HIV	185	94.4	4	2.0	7	3.6
A healthy looking person can have HIV	144	73.6	25	12.7	27	13.7
Mosquitoes do not transmit HIV	104	53.6	53	27.3	37	19.1
Sharing food does not transmit HIV	136	70.1	23	11.9	35	18.0

Table 5.3 HIV/AIDS knowledge among MSM

	Correct answer		Incorrect answer		Don't know	
	n	%	n	%	n	%
Having only one faithful partner can protect against HIV	173	75.2	29	12.6	28	12.2
Condom can prevent HIV	215	93.5	5	2.2	10	4.3
A healthy looking person can have HIV	193	83.9	9	3.9	28	12.2
Mosquitoes do not transmit HIV	108	47.0	40	17.4	82	35.6
Sharing food does not transmit HIV	188	81.7	13	5.7	29	12.6

Table 5.4 HIV/AIDS knowledge among IV heroin users

	Correct answer		Incorrect answer		Don't know	
	n	%	n	%	n	%
Having only one faithful partner can protect against HIV	43	65.2	11	16.7	12	18.2
Condom can prevent HIV	63	95.5	1	1.5	2	3.0
A healthy looking person can have HIV	51	77.3	5	7.6	10	15.2
Mosquitoes do not transmit HIV	18	27.3	20	30.3	28	42.4
Sharing food does not transmit HIV	28	42.4	16	25.8	18	31.8

3. The belief that a healthy looking person cannot be infected with HIV is a common misconception. Female SWs who got the lowest rate of correct answers (65.5%) for this particular question might easily be inclined to have unprotected sexual intercourse with infected partners.
4. The question about mosquito bites had the lowest correct answer rates among all questions and two thirds of the total sample (66.0%) was unable to correct such false belief which could weaken their motivation to adopt safer sexual behavior. The lowest rates of correct answers were shared by two heroin user subgroups: 17.0 and 27.3 percent for non-IV heroin users and IV heroin users, respectively.

Table 5.5 HIV/AIDS knowledge among non-IV heroin users

	Correct answer		Incorrect answer		Don't know	
	n	%	n	%	n	%
Having only one faithful partner can protect against HIV	28	59.6	8	17.0	11	23.4
Condom can prevent HIV	41	87.2	1	2.1	5	10.6
A healthy looking person can have HIV	35	74.5	3	6.4	9	19.1
Mosquitoes do not transmit HIV	8	17.0	19	40.4	20	42.6
Sharing food does not transmit HIV	14	29.8	14	29.8	19	40.4

5. The belief that HIV can be transmitted through sharing food could reinforce the stigma faced by people living with AIDS. Once again, non-IV heroin users had the lowest rate (29.0%) of giving correct answers, followed by IV heroin users (42.4%).

5.2. Total Knowledge Score

When the correct answers were scored as '1' and all incorrect ones including 'don't know' answers were scored as '0'; total knowledge score for the sample was calculated and is shown in **Table 5.6**. Only 26.5% of the total respondents gave the correct answer to all five questions. This result clearly indicates that only a quarter of the total sample both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.

When the percentages of getting full knowledge score were elaborated among sub-populations, the rates for the sub-categories were very similar. For example, while around a quarter of SWs had the full knowledge score (22.8 and 27.0%, respectively for female and transgender SWs), the rate was only one tenth for drug users (6.4 and 13.6%, respectively for non-IV and IV users) and MSM got the highest rate with one third (35.2%).

Table 5.6 Number and percent distribution of survey participants who gave correct answers to HIV/AIDS related questions

	SWs				MSM		DUs				TOTAL	
	F-SWs		T-SWs				IDUs		Non-IV DUs			
	n	%	n	%	n	%	n	%	n	%	n	%
5 (full score)	26	22.8	53	27.7	81	35.2	9	13.6	3	6.4	172	26.5
4	29	25.4	63	33.0	80	34.8	15	22.7	9	19.1	196	30.2
3	24	21.1	33	17.3	36	15.7	21	31.8	15	31.9	129	19.9
2	17	14.9	27	14.1	19	8.3	15	22.7	12	25.5	90	13.9
1	11	9.6	13	6.8	6	2.6	5	7.6	6	12.8	41	6.3
0	7	6.1	2	1.0	8	3.5	1	1.5	2	4.3	20	3.1
Total	**114**	**100.0**	**191**	**100.0**	**230**	**100.0**	**66**	**100.0**	**47**	**100.0**	**648**	**100.0**

Table 5.7 Number and percent distribution of survey participants aged 15-24 who gave correct answers to HIV/AIDS related questions

	SWs				MSM		DUs				TOTAL	
	F-SWs		T-SWs				IDUs		Non-IV DUs			
	n	%	n	%	n	%	n	%	n	%	n	%
5 (full score)	2	14.3	13	26.5	26	32.9	2	10.5	-	0.0	43	24.0
4	2	14.3	11	22.4	32	40.5	3	15.8	2	11.1	50	27.9
3	6	42.9	10	20.4	10	12.7	9	47.4	6	33.3	41	22.9
2	2	14.3	8	16.3	8	10.1	3	15.8	4	22.2	25	14.0
1	2	14.3	6	12.2	-	0.0	1	5.3	5	27.8	14	7.8
0	-	0.0	1	2.0	3	3.8	1	5.3	1	5.6	6	3.4
Total	**14**	**100.0**	**49**	**100.0**	**79**	**100.0**	**19**	**100.0**	**18**	**100.0**	**179**	**100.0**

When the knowledge scores were further analyzed for age categories, getting full score rates of the young respondents aged 15-24 were even lower for each sub-population (**Table 5.7**).

Table 5.8 Summary Table: HIV/AIDS knowledge of the survey participants

	F-SWs		T-SWs		MSM		IDUs		Non-IV DUs		TOTAL	
	n=116	%	n=196	%	n=230	%	n=66	%	n=47	%	N=655	%
Correct answers	**116**		**196**		**230**		**66**		**47**		**655**	
Having only one faithful partner can protect against HIV	74	63.8	130	66.7	173	75.2	43	65.2	28	59.6	448	68.5
Condom can prevent HIV	103	89.6	185	94.4	215	93.5	63	95.5	41	87.2	607	92.8
A healthy looking person can have HIV	76	65.5	144	73.6	193	83.9	51	77.3	35	74.5	499	76.2
Mosquitoes do not transmit HIV	49	42.6	104	53.6	108	47.0	18	27.3	8	17.0	287	44.0
Sharing food does not transmit HIV	64	55.7	136	70.1	188	81.7	28	42.4	14	29.8	430	66.4
Full knowledge score	**114**		**191**		**230**		**66**		**47**		**648**	
	14	**(Y)**	**49**	**(Y)**	**79**	**(Y)**	**19**	**(Y)**	**18**	**(Y)**	**179**	**(Y)**
Total sample	26	22.8	53	27.7	81	35.2	9	13.6	3	6.4	172	26.5
Youngsters (aged 15-24)	2	14.3	13	26.5	26	32.9	2	10.5	-	0.0	346	24.0

Y: Young

HIV TESTING PRACTICES AND TEST RESULTS 6

Voluntary counseling and HIV testing is a cornerstone of the fight against HIV/AIDS and actually an entry point to prevention and care services. However, the coverage of VCT services has always been inadequate in most parts of the world, in both high-income and resource-constrained settings. On the other hand, use of VCT services has been hampered by many factors including stigma and discrimination, limited access to treatment, care and health services in general, as well as gender issues.

It is estimated that less than 10 percent are aware they are infected, mainly because of the limited availability, access, and use of VCT for HIV. The result of low coverage and limited use of VCT services and low levels of knowledge of HIV status is that the majority of people living with HIV access HIV testing and counseling only when they already have advanced clinical disease.

As a way of expanding the supply of HIV diagnosis to populations, Turkey established 14 VCT Centers in four provinces in 1996. Those VCT Centers were planned to be easily accessible sites to offer serological testing for the entire population, particularly to vulnerable groups. Since the services were limited to counseling in conjunction with diagnosis, with no community involvement, the majority of the VCT Centers faced low service utilization rates. Despite the huge need in the field, the lack of active prevention activities targeting special populations played a major role in low utilization of services provided by these centers, among many other aspects.

The present chapter analyzes the previous HIV testing behaviors of the sample populations and provides the results of the tests performed during the course of the bio-behavioral survey.

6.1. HIV Testing Practices

HIV testing history of the study sample was determined including their lifetime experiences and practices within the most recent 12 months, and whether they know the results or not. All the results of HIV testing behaviors are shown in **Table 6.1**.

First, the results revealed that almost two thirds of the study population (66.3%) have had tested for HIV before. The lifetime prevalence varied extensively across sub-groups: as anticipated, SWs had the highest rates (83.6% for female and 86.2% for transgender SWs), followed by MSM (61.3%). On the contrary, the vast majority of the drug users (68.2% IV users, 83.0% non-IV users) stated that they had never been tested.

The respondents were then asked whether they were tested during the last 12 months preceding the survey.

Table 6.1 Number and percent distribution of HIV testing practices among survey participants, by lifetime prevalence and within last 12 months

	SWs				MSM		DUs				TOTAL	
	F-SWs		T-SWs				IDUs		Non-IV DUs			
	n=116	%	n=196	%	n=230	%	n=66	%	n=47	%	N=655	%
HIV testing practices	**116**		**195**		**230**		**66**		**47**		**654**	
Never tested	19	16.4	27	13.8	89	38.7	45	68.2	39	83.0	219	33.4
Ever tested	97	83.6	168	86.2	141	61.3	21	31.8	8	17.0	435	66.3
▸ Tested within a year	71	61.2	139	71.3	59	25.7	11	16.7	4	8.5	284	43.4
▸▸ Know the result	42	36.2	75	38.5	56	24.3	8	12.1	1	2.1	182	27.8

The percentages of those who were tested within a year was as low as around two thirds in the SWs sub-group (61.2 and 71.3% for female and transgender SWs, respectively), and only a quarter (25.7%) in MSM. For drug users, the situation was even worse in this case, as almost 90 percent of them had not been tested in the last year. These results indicate low utilization of testing services by vulnerable populations which points out the urgent need of increasing the provision of HIV testing through a wider range of effective options.

Finally, an additional question on HIV testing practices were asked to determine whether they knew the result or not. The results revealed that only one third of SWs, a quarter of MSM and only one tenth (or even less) of drug users had been tested and knew their results during one year preceding the survey.

6.2. Test Results

As an important component of the survey, the participants who wanted to be tested were referred to VCT services. As discussed in methodology, SWs and MSM were reached primarily through outreach and at WD, thus referred to Şişli VCT Center; whereas drug user inpatients benefited from provider initiated counseling and testing during their hospitalization.

The vast majority (81.2%) of all SWs and MSM respondents agreed to have HIV testing and were referred to VCT Center. Among the referred cases, 139 of them did not show up and a total 301 HIV tests were performed. The total uptake for VCT services was 56.8 percent for SWs and MSM. Similarly, 77.9 percent of drug user inpatients who have participated in the survey were tested not only for HIV but also for hepatitis B and C during the course of their hospitalization.

Table 6.2 Number and percent distribution of tests performed during the survey and test results

	SWs				MSM		DUs				TOTAL	
	F-SWs		T-SWs				IDUs		Non-IV DUs			
	n=116	%	n=196	%	n=230	%	n=66	%	n=47	%	N=655	%
Tests performed												
HIV	88	75.9	114	58.2	99	43.8	48	72.7	40	85.1	389	59.4
Hepatitis B	NA		NA		NA		47	71.2	41	87.5	88	[77.9]
Hepatitis C	NA		NA		NA		47	71.2	41	87.5	88	[77.9]
Test results												
Positive HIV antibody	-	0.0	4	3.5	5	5.1	-	0.0	-	0.0	9	2.3
Positive HBsAg	NA		NA		NA		1	2.1	4	9.8	5	[22.4]
Positive HCV antibody	NA		NA		NA		23	48.9	1	2.4	24	[20.4]

The HIV prevalence rates were 3.5 percent (95%CI 0.96-8.74) for transgender SWs and 5.1 percent (95%CI 1.66-11.39) for MSM sub-populations. Anti-HIV tests revealed negative results in all cases of female SWs and heroin user sub-groups. The test results for hepatitis B and C among drug users revealed prevalence rates of 2.1 and 9.8 percent for hepatitis B; and 48.9 and 2.4 percent for hepatitis C, in IV and non-IV heroin user subgroups, respectively (refer to **Table 6.2** for the number of tested cases and positive results).

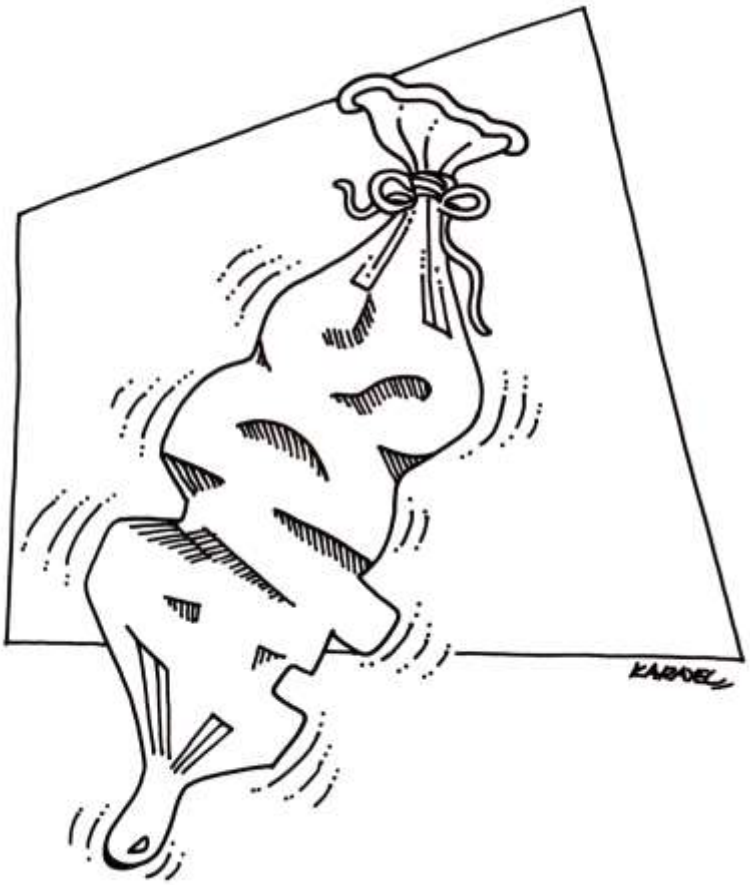
Selected characteristics and risk behaviors of the survey respondents with positive HIV and HCV antibody results were summarized below and presented in **Table 6.3**.

Table 6.3 Selected characteristics and risk behaviors of the survey respondents with positive HIV and HCV antibody results

	HIV (+)		HCV (+)	
	T-SWs	MSM	IDUs	
	n=4 *	n=5 *	n=23	%
Age	**Mean: 28.5**	**Mean: 36.2**	**Mean: 34.3**	
15-24	2	-	4	17.4
≥ 25	2	5	19	82.6
Education				
High school (11 years) or less	4	4	20	87.0
University student or graduate	-	1	3	13.0
Marital status				
Single	4	5	13	56.5
Ever married	-	-	10	43.5
Alcohol use - Frequency (last month)				
None or not frequent (< once a week)	1	1	16	69.6
Frequent	3	4	7	30.4
Drug use (ever)				
Ever used (IV)	-	-	23	100.0
Ever used (any except IV)	2	4	23	100.0
Syringe share				
Shared	NA	NA	9	39.1
Age at first sexual experience	**Mean: 16.3**	**Mean: 17.6**	**Mean: 16.7**	
Before age 15	2	-	4	17.4
≥ 15	2	5	19	82.6
Number of sexual partners (last month)	**Mean: 88.8**	**Mean: 6.2**	**[12]**	**Mean: 1.2**
1	-	1	10	[83.3]
2-9	-	3	2	[16.7]
≥ 10	4	1	-	[0.0]
Condom use (with the last partner)			**[22]**	
With a client	4	NA	NA	
With a non-commercial partner (*male for MSM*)	2	3	4	18.2
Knowledge				
Full knowledge score	1	1	4	17.4
HIV testing practices				
Ever tested	3	4	11	47.8
▸ Tested within a year and know the result	1	1	4	17.4

* Since the numbers are too small, percentages were not provided for positive anti-HIV results

- Anti-HIV positive cases in the transgender group were more likely to be younger (mean age: 28.5 vs 32.5), less educated, used alcohol more often, had more sexual partners (mean: 88.8 vs 46.5); and less likely to be tested for HIV compared to the total sub-population.
- Again when compared to the total MSM sub-population, the anti-HIV positive MSM were more likely to be less educated, used alcohol more often, ever used illicit drugs, had more sexual partners (mean: 6.2 vs 4.4) and less likely to be tested within a year.
- Anti-HCV positive cases were less likely to use condom with their last partner and be tested for HIV.



Erdoğan Karayel

SUMMARY RESULTS AND PROGRAM IMPLICATIONS

7

This chapter presents the main findings and program implications of the survey results. In addition, it highlights the key results in relation to UNGASS indicators to inform country progress on monitoring the implementation of the Declaration of Commitment on HIV/AIDS.

7.1. Main Findings

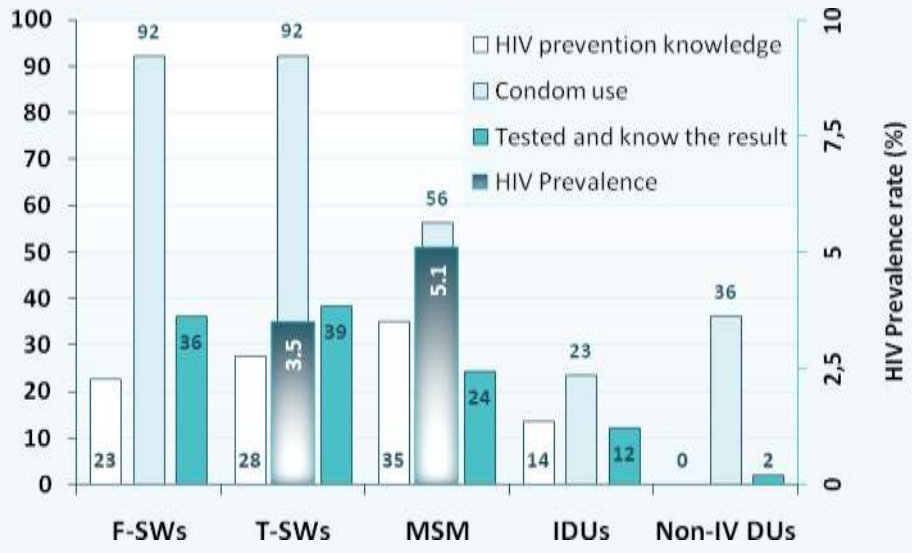
HIV BBSs aim to assess the sexual risk taking behaviors and the prevalence rates among particular sub-populations and monitor the trends in time. But interpreting the results with the data obtained has always been challenging, particularly for complex behaviors and other contributing factors with too many parameters. On the other hand, using a common research language -using same indicators with similar methodologies- is a prerequisite in order to compare the results with other surveys targeting same sub-populations and among repeated surveys to monitor the trends. The real challenge in Turkey is that almost all HIV bio-behavioral surveys use different methodologies. Because of all these factors, this report will content with presenting core behavioral findings (**Figure 7.1**) and interpret the prevalence rates for each sub-population below.

Risk Behaviors

The highest percentage of condom use with the most recent partner was reported by SWs (92% with the last client), whilst the lowest percentage was reported by IDUs (23%). It was 56 percent for MSM (with the last male partner) which was similar to the overall rate of condom use (61%) in total survey participants. In addition, although SWs had a high percentage of condom use with their clients, rate of condom use declined to almost half with their non-commercial partners (see **Table 4.6**). As a summary, we may conclude that our survey documented high-risk sexual behavior for all sub-populations.

In regard to HIV testing behaviors, although only one third of SWs reported that they were tested within a year and know the result (36 and 32% for transgender SWs and female SWs, respectively) they had the highest percentages among all sub-populations. Testing practices were even worse in MSM and IDUs (24 and 12%, respectively). Thus, all groups had very low frequency of HIV test seeking behavior, most probably due to limited availability of VCT services.

Figure 7.1 Selected UNGASS Indicators: HIV/AIDS knowledge, condom use and HIV testing behaviors, and HIV prevalence rates among sub-populations



Finally, low level of HIV prevention knowledge (with a range of 0-35 percent of full score) might be one of the main reasons that hamper sexual and test seeking behavior.

Prevalence Rates

Men having sex with men: The published reports in the past few years concerning the increase in HIV incidence rates among MSM in various regions generated a great deal of global interest (*see* **Box 7.1** for details). Our result of 5.1 percent HIV prevalence among MSM also indicates a rapid increase when compared with the previously reported rate of 1.8 percent (ICON, 2007; n=166). More importantly, this is the highest rate ever reported in Turkey for any sub-population, calling for immediate action for active prevention initiatives.

Our results concerning MSM are also comparable with the results of a multi-centre bio-behavioral survey (Mirandola et al, 2009) conducted in six European countries namely Czech Republic, Italy, Romania, Slovakia, Slovenia and Spain. **Table 7.1** summarizes the selected UNGASS indicators by city, comparing sexual and test seeking behaviors, and HIV rates among MSM. Results clearly show the high-risk sexual behavior (on average more than half of MSM had unprotected sex with their last partner), and low frequency of HIV testing behavior (on average less than half of MSM were tested within a year and know the result; Turkey had the lowest percentage). In regard to HIV prevalence rates among MSM, while Spain and Italy had the highest percentages, Check Republic had the lowest rate, followed by Turkey and Slovenia.

Box 7.1 Global facts and figures: HIV & MSM

In USA, MSM account for more than half of all new HIV infections each year (57% for 2006) and is the only risk group in which new HIV infections have been increasing steadily since the early 1990s.

Hall et al, 2008

In 23 European Union/ European Economic Area (EU/EEA) countries with data available, the number of new HIV diagnoses in MSM increased 96% during 2000-2007.

Likatavičius et al, 2009

Sex between men is the predominant mode of transmission in European region accounting for 35% of the HIV diagnoses in 2009.

ECDC & WHO, 2010

Sex workers: For transgender SWs, 3.5 percent HIV prevalence rate indicates the vulnerability of the particular sub-population. When evaluated together with the recently reported rate of 5.0 percent (Pink Life, 2009), our result confirms the increased HIV risk among transgender SWs.

Table 7.1 UNGASS indicators by city: Results of BBSs among MSM conducted in six European Countries, 2008-2009 and in İstanbul, 2010

	HIV testing UNGASS 8		Condom use UNGASS 19		HIV prevalence UNGASS 23	
	n=2356	95%CI	n=1925	95%CI	n=2243	95%CI
Barcelona, ES	56.2	±4.9	57.2	±5.1	17.0	±3.7
Bratislava, SK	32.1	±4.9	30.8	±5.3	6.1	±2.5
Bucharest, RO	43.2	±4.9	42.7	±5.3	4.6	±2.2
Ljubljana, SI	38.2	±4.8	43.0	±5.6	5.1	±2.2
Prague, CZ	41.5	±4.8	29.8	±5.2	2.6	±1.6
Verona, IT	53.0	±4.9	45.6	±5.2	11.8	±3.2
	n=230	95%CI	n=227	95%CI	n=99	95%CI
İstanbul, TR	24.3	±5.7	56.4	±6.6	5.1	±4.9

Box 7.2 Global facts and figures: HIV & transgender women

A growing body of data has documented exceptionally high transmission rates among transgender population:

Meta-analytic findings of 25 studies conducted in 14 countries indicating an overall crude HIV prevalence rate of 27.3% among transgender SWs and 4.5% among female SWs, revealed a 4-fold risk for HIV in transgender SWs.

Operario et al, 2008

Box 7.3 Global facts and figures: HIV & SWs

HIV infection among sex workers and their clients has long played an important role in HIV transmission worldwide and continue to be at the center of the epidemic:

For sub-Saharan Africa as a whole, median reported HIV prevalence among sex workers was 19 percent ranging from zero to 49.4. More than 30% of SWs were living with HIV in seven African countries.

The common overlap between sex work and injecting drug use further facilitates the spread of HIV particularly in both Eastern Europe and Asia. Studies indicated that in the Russian Federation more than 30% of sex workers have injected drugs and in a province of China more than 40% of female IDUs were also engaged in sex work. In Ukraine, available evidence indicated that HIV prevalence among SWs ranged from 13.6 to 31.0 percent.

UNAIDS & WHO, 2009

In regard to female SWs, or SWs in general, the national surveys have some uncertainties that make interpretation difficult. Early surveys had reported 0.5-0.7 percent prevalence rates (in 2003 and 2002, respectively) among female SWs, which also had included foreigners coming from Eastern European countries (WHO Europe, 2006). More recent two surveys targeting SWs (ICON, 2007; KLIMIK, 2007) used the terminology 'unregistered SWs' but not defined whether the participants were female or transgender. Thus, although providing valuable inputs, the HIV prevalence rates reported by these two surveys (0.8 and 2.3, respectively) also cannot be attributable for a particular sub-population.

Our result with zero seropositive case among female SWs was identical with the result of the survey implemented in Ankara (Pink Life, 2009). Yet, since our initiative failed to reach different sub-groups among SWs, but instead was limited to the members of small networks who had continuously benefited from the services of WD (including information and education on HIV/AIDS, promoting their life skills to adopt safe sex behaviors and provision of free condoms), the result may not be representative of all female SWs.

As a matter of fact, since sex workers are at high risk for contracting and transmitting HIV, all countries included this vulnerable group in their prevention efforts. According to an earlier report of Ankara Chamber of Commerce (ATO, *in Turkish acronym*) there were around one hundred thousand SWs in Turkey (ATO, 2004). So there is always room for preventive initiatives for such big numbers of female SWs, particularly for the ones targeting different sub-groups, i.e. street-based, independent home-based, unregistered brothel-based or foreign SWs.

Box 7.4 Global facts and figures: HIV & IDUs

The largest numbers of IDUs live in China, the USA, and Russia, where mid-estimates of HIV prevalence among injectors are 12%, 16%, and 37%, respectively.

About 3·0 million (range 0·8-6·6 million) people who inject drugs might be HIV positive worldwide.

Mathers et al, 2008

Needle and syringe programs (NSPs) had been implemented in 82 countries and opioid substitution therapy (OST) in 70 countries; both interventions were available in 66 countries by 2009. Worldwide, an estimated two needle-syringes (range 1-4) were distributed per IDU per month and there were eight recipients (6-12) of OST per 100 IDUs.

Mathers et al, 2010

According to UNODC estimations for 2008 there were 25.000 heroin users in Turkey.

UNODC, 2010, p. 40

Intravenous drug users: Drug users are the most neglected group among vulnerable populations in HIV prevention efforts in Turkey. With a result of zero positive case, our survey might eventually be underestimating the reality, in that the previous survey results reported 4.3 (Mırsal et al, 2003) and 1.8 (ICON, 2007). Although the first survey with a higher prevalence rate had involved almost 50 percent foreigners (as country of origin or Turkish citizens living abroad), hence methodological limitations, the latter with a percentage of 1.8 seems more acceptable as being representative. On the other hand, there is a potential for HIV outbreaks among IDUs. For example, in Bulgaria BBS results indicated that HIV prevalence among IDUs increased from 0.6 in 2004 to 6.8 percent in 2008 (CPR, Bulgaria, 2010). The lack of targeted HIV prevention

initiatives and particularly the lack of harm-reduction measures including syringe exchange programs in Turkey may also pose a rapid increase in HIV rates among IDUs. Therefore, all these facts call for a continuous bio-behavioral monitoring with careful strategic interventions targeting IDUs.

In regard to HCV prevalence among IDUs, our result (48.9 percent) has a similar rate with 44.9 percent reported by Mırsal et al (2003). It is also consistent with the literature, since a review (Aceijas & Rhodes 2007) found HCV prevalence of at least 50% among IDUs in 49 countries worldwide and another review (Roy et al, 2002) examining 98 studies across Europe reported overall 71 percent prevalence with a range of 30 to 98. Compared to anti-HCV prevalence estimation of 1.5 percent in the general population for Turkey (ECDC, 2010), our result with much higher HCV rate also clearly demonstrates the burden of the most important infectious disease affecting those who inject drugs. High hepatitis C prevalence rate also implies widespread needle and syringe sharing practices among IDUs, which reflects the increased risk for HIV transmission for the group.

7.2. Informing Country Progress

Since our survey questionnaire was designed to be concordant with UNGASS indicators (UNAIDS, 2009), the results enabled us to inform country progress for the implementation of the Declaration of Commitment on HIV/AIDS. **Table 7.2** summarizes the main results of our survey and compares them with the previously reported national results (CPR, Turkey, 2008 and 2010).

Call for collaboration

The strategy utilized by this survey -monitoring the special populations- is the most epidemiologically sound method for identifying emerging epidemics and responding to behavioral risks among the most vulnerable groups. This strategy, which is more commonly known as the second generation surveillance strategy can easily be integrated to all national/ local level prevention initiatives and must remain at the forefront of the country's HIV response. The implementing agencies are eager to collaborate with the academic institutions to foster HIV related bio-behavioral research and with the civil society organizations who wish to integrate a bio-behavioral monitoring perspective into their prevention initiatives, and are ready to share lessons learned and provide any possible assistance.

Table 7.2 Informing Country Progress: Related core indicators for the implementation of the Declaration of Commitment on HIV/AIDS

	CPR 2008	CPR 2010	BBS-İstanbul 2010		
			SWs	MSM	IDUs
National Programmes					
UNGASS Indicator # 8: Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	NH	NR	**F**: 36.2 (n=116) **T**: 38.5 (n=195)	24.3 (n=230)	12.1 (n=66)
Knowledge and Behavior					
UNGASS Indicator # 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	NH	NR	**F**: 22.8 (n=114) **T**: 27.7 (n=191)	35.2 (n=230)	13.6 (n=66)
UNGASS Indicator # 15: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	**SWs**: 37.0	NR	**F**: 38.5 (n=13) **T**: 63.5 (n=52)	24.4 (n=78)	29.4 (n=17)
UNGASS Indicator # 18: Percentage of female and male sex workers reporting the use of a condom the last time they had sex with their most recent client	**F**: 35.8	NR	**F**: 92.2 (n=116) **T**: 92.3 (n=195)	NA	NA
UNGASS Indicator # 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	36.7	NR	NA	56.4 (n=227)	NA
UNGASS Indicator # 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	10.0	NR	NA	NA	23.4 (n=64)
UNGASS Indicator # 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	NR	NR	NA	NA	32.8 (n=64)
Impact					
UNGASS Indicator # 23: Percentage of most-at-risk populations who are HIV infected	**SWs**: 1.6 **MSM**: 1.8 **IDUs**: 1.5	NR	**F**: 0.0 (n=88) **T**: 3.5 (n=114)	5.1 (n=99)	0.0 (n=48)

CPR: Country Progress Reports. *References:* CPR, Turkey 2008 and 2010 **NA:** Not applicable

NR: Not reported **NH:** Not harmonized with UNGASS guidelines *Reference:* UNAIDS (2010)

Cemalettin Güzeloğlu

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HIV Behavioral Survey Questionnaire for Sex Workers

Annex I

Code: _____ **Date of survey conducted:** ___ / ___ / _____

DD / MM / YYYY

Example: DGT-2511-03

Interviewer's initials -- Date of the interview: DD-MM -- # of the same-day interviews

Line code: | | | |

Informed consent obtained: ☐ Verbal ☐ Written

INSTRUCTION: **Circle the appropriate option/ write the answer under each question. If none of the answer choices is appropriate fill in the blanks at "Other" option using the respondent's own expression.**

Background Information

1. Date of birth (year): _____

2. Education:

1) Literate
2) Primary school (5 year) graduate
3) Secondary school (8 year) graduate
4) High school (11 year) graduate
5) University/ academy graduate
6) Student School: _____ Grade: _____

3. Marital status:

1) Single
2) Married
3) Divorced
4) Other (*Write*): _____ (*cohabit etc*)

Alcohol and Drug Use

4. During the past **4 weeks** (one month) have you used alcohol?

1) No
2) Yes, less than once a week
3) Yes, at least once a week but not everyday
4) Yes, everyday
5) Don't know/ remember

5. If the answer is **YES** how do you define yourself in regard to alcohol use during the past **4 weeks** (one month)?

1) Social drinker: never lost control
2) Drunk too much at least once till I lost my self-control
3) Don't know/ remember

6. Have you ever used illicit drugs/ substances causing dependence/ addiction? (**Except the drugs prescribed for health reasons or for treatment**)

1) No
2) Yes, but don't know/ remember the name of the drug
3) Yes (Circle the appropriate option(s) below. Fill in the blanks at "Other" option using the respondent's own expression)

a. Hashish, marijuana b. Heroin
c. Cocaine d. Stimulants
e. Tranquilizers
f. Other (*Write*): _____ , _____ , _____

7. Have you ever used intravenous (injection) drugs?

( ) Yes ( ) No ( ) Don't remember

8. During the last time you injected drugs, have you shared needle/ syringe with someone else?

( ) Yes ( ) No ( ) Don't remember

Sexual History

9. How old were you the first time you had sexual experience (vaginal/ anal/ oral)?

_____ years old

10. For how many years are you working as a sex worker?

_____ years _____ months (*if less than a year*)

11. During last **4 weeks** (one month), how many **different people** have you had sex (vaginal/ anal/ oral) with, including your spouse/ partner and clients?

Spouse/ partner: _____ different people Clients: _____ different people

Condom use

12. The last time you had sex with a client, did you or your partner use a condom?

( ) Yes ( ) No ( ) Don't remember

13. The last time you had sex with your spouse/ partner, did you or your partner use a condom?

( ) Yes ( ) No ( ) Don't remember

14. Dou you have a condom with you?

( ) Yes ( ) No

HIV/AIDS Knowledge

15. Have you heard about Human Immunodeficiency Virus (HIV) or acquired immunodeficiency syndrome (AIDS)?

( ) Yes ( ) No ( ) Don't remember

If the answer is YES answer the questions below (*Circle the appropriate option*).

16. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?

( ) Yes ( ) No ( ) Don't know

17. Can a person reduce the risk of getting HIV by using a condom every time they have sex?

( ) Yes ( ) No ( ) Don't know

18. Can a healthy-looking person have HIV?

( ) Yes ( ) No ( ) Don't know

19. Can a person get HIV from mosquito bites?

( ) Yes ( ) No ( ) Don't know

20. Can a person get HIV by sharing food with someone who is infected?

( ) Yes ( ) No ( ) Don't know

HIV Testing

21. Have you ever been tested for HIV?

( ) Yes ( ) No ( ) Don't remember

22. If the answer is **YES** was it in the last 12 months (one year)?

( ) Yes ( ) No ( ) Don't remember

23. If the answer is **YES** is there a test that you don't know the result?

( ) Yes ( ) No ( ) Don't remember

Referral for VCT

Do you want to have a voluntary counseling and free HIV testing?

( ) Yes ( ) No

Referral Code: _____ **Date of Testing: _____**

(**IMPORTANT**: Should be identical with the questionnaire code)

Interviewed at

a. Women's Door

b. Mobile counseling unit

c. Voluntary counseling and testing center

d. Residence/ office

e. Night club/ cafe etc.

f. Other (*Write*): _____

In addition to receiving information, condoms, lubricants and brochures about HIV/AIDS, what kinds of activities you or other sex workers may want to see? Would you be willing to volunteer and be involved in planning or contribute to such activities/events in future?

HIV Behavioral Survey Questionnaire for Men Having Sex with Men

Annex II

Code: _____ **Date of survey conducted:** ___ / ___ / _____

DD / MM / YYYY

Example: DGT-2511-03

Interviewer's initials -- Date of the interview: DD-MM -- # of the same-day interviews

Line code: | | | |

Informed consent obtained: ☐ Verbal ☐ Written

INSTRUCTION: **Circle the appropriate option/ write the answer under each question. If none of the answer choices is appropriate fill in the blanks at "Other" option using the respondent's own expression.**

Background Information

1. Date of birth (year): _____

2. Education:

1) Literate
2) Primary school (5 year) graduate
3) Secondary school (8 year) graduate
4) High school (11 year) graduate
5) University/ academy graduate
6) Student School: _____ Grade: _____

3. Marital status:

1) Single
2) Married
3) Divorced
4) Other (*Write*): _____ (*cohabit etc*)

Alcohol and Drug Use

4. During the past **4 weeks** (one month) have you used alcohol?

1) No
2) Yes, less than once a week
3) Yes, at least once a week but not everyday
4) Yes, everyday
5) Don't know/ remember

5. If the answer is **YES** how do you define yourself in regard to alcohol use during the past **4 weeks** (one month)?

1) Social drinker: never lost control
2) Drunk too much at least once till I lost my self-control
3) Don't know/ remember

6. Have you ever used illicit drugs/ substances causing dependence/ addiction? (**Except the drugs prescribed for health reasons or for treatment**)

1) No
2) Yes, but don't know/ remember the name of the drug
3) Yes (Circle the appropriate option(s) below. Fill in the blanks at "Other" option using the respondent's own expression)

a. Hashish, marijuana b. Heroin
c. Cocaine d. Stimulants
e. Tranquilizers
f. Other (*Write*): _____ , _____ , _____

7. Have you ever used intravenous (injection) drugs?

( ) Yes ( ) No ( ) Don't remember

8. During the last time you injected drugs, have you shared needle/ syringe with someone else?

( ) Yes ( ) No ( ) Don't remember

Sexual History

9. How old were you the first time you had sexual experience (vaginal/ anal/ oral)?

_____ years old

10. During last **4 weeks** (one month), how many **different people** have you had sex (vaginal/ anal/ oral) with, including your spouse/ partner and friends?

Male: _____ different people
Female: _____ different people

Condom use

11. The last time you had sex with a man; did you and/ or your partner use a condom?

( ) Yes ( ) No ( ) Don't remember

12. The last time you had sex with a woman, did you use a condom?

( ) Yes ( ) No ( ) Don't remember

13. Dou you have a condom with you?

( ) Yes ( ) No

HIV/AIDS Knowledge

14. Have you heard about Human Immunodeficiency Virus (HIV) or acquired immunodeficiency syndrome (AIDS)?

( ) Yes ( ) No ( ) Don't remember

If the answer is YES answer the questions below (*Circle the appropriate option*).

15. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?

( ) Yes ( ) No ( ) Don't know

16. Can a person reduce the risk of getting HIV by using a condom every time they have sex?

( ) Yes ( ) No ( ) Don't know

17. Can a healthy-looking person have HIV?

( ) Yes ( ) No ( ) Don't know

18. Can a person get HIV from mosquito bites?

( ) Yes ( ) No ( ) Don't know

19. Can a person get HIV by sharing food with someone who is infected?

( ) Yes ( ) No ( ) Don't know

HIV Testing

20. Have you ever been tested for HIV?

( ) Yes ( ) No ( ) Don't remember

21. If the answer is **YES** was it in the last 12 months (one year)?

( ) Yes ( ) No ( ) Don't remember

22. If the answer is **YES** is there a test that you don't know the result?

( ) Yes ( ) No ( ) Don't remember

Referral for VCT

Do you want to have a voluntary counseling and free HIV testing?

( ) Yes ( ) No

Referral Code: _____ **Date of Testing: _____**

(**IMPORTANT**: Should be identical with the questionnaire code)

Interviewed at

a. Women's Door
b. Mobile counseling unit
c. Voluntary counseling and testing center
d. Residence/ office
e. Night club/ cafe etc.
f. Other (*Write*): _____

In addition to receiving information, condoms, lubricants and brochures about HIV/AIDS, what kinds of activities you or other gay groups may want to see? Would you be willing to volunteer and be involved in planning or contribute to such activities/events in future?

HIV Behavioral Survey Questionnaire for Drug Users

Annex III

Code: _____ **Date of survey conducted:** ___ / ___ / _____

DD / MM / YYYY

Example: DGT-2511-03

Interviewer's initials -- Date of the interview: DD-MM -- # of the same-day interviews

Line code: | | | |

Informed consent obtained: ☐ Verbal ☐ Written

INSTRUCTION: **Circle the appropriate option/ write the answer under each question. If none of the answer choices is appropriate fill in the blanks at "Other" option using the respondent's own expression.**

Background Information

1. Gender:

1) Female 2) Male

2. Date of birth (year): _____

3. Education:

1) Literate 2) Primary school (5 year) 3) Secondary school (8 year)

4) High school (11 year) 5) University/ academy graduate

6) Student School: _____ Grade: _____

4. Marital status:

1) Single 2) Married 3) Divorced

4) Other (*Write*): _____ (*cohabit etc*)

5. Do you have a job (or self employed)?

1) Yes 2) No

6. What is your average monthly income?

1) None 2) Not constant

3) < 500 TL 4) Between 500-1,500 TL 5) >1.500 TL

Alcohol and Drug Use

7. During the past **4 weeks** (one month) have you used alcohol?

1) No 4) Yes, everyday

2) Yes, less than once a week 5) Don't know/ remember

3) Yes, at least once a week but not everyday

8. If the answer is **YES** how do you define yourself in regard to alcohol use during the past **4 weeks** (one month)?

1) Social drinker: never lost control
2) Drunk too much at least once till I lost my self-control
3) Don't know/ remember

9. Which illicit drugs/ substances causing dependence/ addiction have you used during your lifetime? (**Except the drugs prescribed for health reasons or for treatment**). Circle the appropriate option(s) below. For 4-6 circle **and** fill in the blanks using the respondent's own expression.

1) Hashish, marijuana 2) Heroin 3) Cocaine
4) Stimulants: _____ , _____ , _____
5) Tranquilizers: _____ , _____ , _____
6) Other (*Write*): _____ , _____ , _____

IV drug use

10. Have you ever used intravenous (injection) drugs?

( ) Yes ( ) No ( ) Don't remember

11. During the last time you injected drugs, have you shared needle/ syringe with someone else?

( ) Yes ( ) No ( ) Don't remember

12. If you ever shared needle/ syringe why do you or people in general share needles?

1) Price 2) Barriers to access
3) Not caring 4) Don't know
5) Other (*Write*): _____

13. Can sharing needles/ syringes cause health problems?

( ) Yes ( ) No ( ) Don't remember

14. Can hepatitis virus and HIV/AIDS be transmitted by sharing needles/ syringes?

( ) Yes ( ) No ( ) Don't remember

15. If you were aware of risk of virus transmission would you take precautions?

( ) Yes ( ) No

16. Other than needle/ syringe, do you share drugs or injection equipment i.e. filters, water and cookers with someone else?

( ) Yes ( ) No ( ) Don't remember

17. In average how many people do you share this equipment with?

_____ people

18. Do you know what to do in case of health problems related to overdose?

( ) Yes ( ) No ( ) Don't remember

19. In case of emergency/ overdose which special precautions can you practice? (*Circle all answers*)

1) Cardiac massage 2) Mouth-to-mouth resuscitation 3) Clear the airway

4) Injecting salty water 5) Other (*Write*): _____

Sexual history

20. How old were you the first time you had sexual experience?

_____ years old

21. During last **4 weeks** (one month), how many **different people** have you had sex with, including your spouse/ partner?

Male: _____ different people

Female: _____ different people

22. The last time you had sex did you or your partner use a condom?

( ) Yes ( ) No ( ) Don't remember

HIV/AIDS Knowledge

23. Have you heard about Human Immunodeficiency Virus (HIV) or acquired immunodeficiency syndrome (AIDS)?

( ) Yes ( ) No ( ) Don't remember

If the answer is YES answer the questions below (*Circle the appropriate option*).

24. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?

( ) Yes ( ) No ( ) Don't know

25. Can a person reduce the risk of getting HIV by using a condom every time they have sex?

( ) Yes ( ) No ( ) Don't know

26. Can a healthy-looking person have HIV?

( ) Yes ( ) No ( ) Don't know

27. Can a person get HIV from mosquito bites?

( ) Yes ( ) No ( ) Don't know

28. Can a person get HIV by sharing food with someone who is infected?

( ) Yes ( ) No ( ) Don't know

HIV testing

29. Have you ever been tested for HIV?

( ) Yes ( ) No ( ) Don't remember

30. If the answer is **YES** was it in the last 12 months (one year)?

( ) Yes ( ) No ( ) Don't remember

31. If the answer is **YES** is there a test that you don't know the result?

( ) Yes ( ) No ( ) Don't remember

In addition to receiving information and brochures about HIV/AIDS, what kinds of activities you or other drug users may want to see? Would you be willing to volunteer and be involved in planning or contribute to such activities/events in future?

SAFER SEX & UNREGISTERED FEMALE SWs: A FOCUS GROUP REPORT

Location: Project Office (Women's Door), Beyoğlu - İstanbul

Date: 12 May 2010

Duration: 60 min.

I - Introduction and Socio-Demographic Characteristics

The focus group discussion (FGD) conducted with fourteen participants included only female sex workers, a moderator and two observers at the meeting room of the Project Office. Initially, the moderator and observers introduced themselves and mentioned the ground rules, i.e. respect, privacy and confidentiality principles. Basic demographic features were identified during the participants' introduction.

All of the fourteen female sex workers who participated in FGD were unregistered, thirteen worked at Taksim Square or Tarlabaşı Avenue and one worked as a callgirl. Age: The youngest was 28, the oldest was 58. Education: One university student, five primary school graduates, four literate and four illiterate. Four participants started working as a B-girl at night clubs or were registered SW at brothels and are now working independently. Basic demographic features of the participants are summarized below (*see* **Table A-IV.1**).

Table A-IV.1 Socio-demographic characteristics of FGD participants (F-SWs)

Name	Se	Di	Sev	Giz	Den	Ayş	Fat	Ley	Ay	De	Ka	Yü	Ya	Ar
Age	50	54	47	30	31	53	49	57	28	31	58	53	40	38
Working area/ place	TS	TS	B/H	CG	TS	TA	TS	TS	TS	TS	TS	TA	TS	TS
Duration of SW (year)	20	20	34	2	1	20	10	5-6	10	10	25	20	22	8-10
Education	Il-L	Il-L	PS	Us	Il-L	Il-L	PS	Il-L	PS	L	L	PS	PS	L

TS: Taksim Square **B/H:** Beer house and a hotel **CG:** Callgirl **TA:** Tarlabaşı Avenue

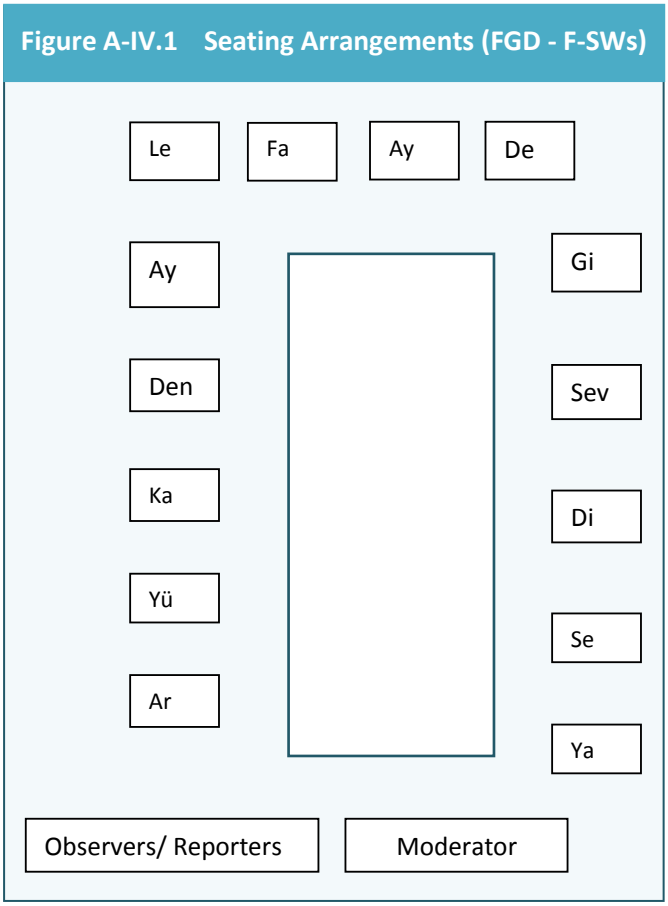
Il-L: Illiterate **L**: Literate **PS**: Primary school graduate **Us**: University student

The seating arrangement of FGD is shown in **Figure A-IV.1**, coded by the first two/ three letters of the participants' first names.

II - Living and Working Conditions

The participants said that they worked independently without procurers, stating "initially you have to work with pimps, as time goes by you can work on your own". They said that they found clients through telephone or at Taksim Square, bargained with them, and went together to their own houses or to a shared residence. Two participants stated that they used hotel rooms, and one of them lived there, as well. In regard to the working conditions, they expressed their feelings as "… we use a residence and pay for that. This is not a regular working place, one of our friend's house…", "there are no residents in the house we use. We pay the rent… around 500-1000 TL monthly. An old lady comes for cleaning and then leaves", "there is no residence

Figure A-IV.1 Seating Arrangements (FGD - F-SWs)



that we own and use", "houses vary a lot but they are all really dirty places", "people who owned the unregistered brothels do not work any longer. Clean houses were shut down because of the regulations. Some houses even don't have clean water, almost an empty building. With two beds, lucky if we have a wet tissue. No hygiene at all, we light a cigarette afterwards", and "you have to use a shared bed with 15 people if you work in the streets".

In addition to mentioning residences having mostly bad conditions and with no water, some of the participants stated that they used hotel rooms where the expenses were paid by the clients. Almost all of the participants defined their working conditions as "totally in the streets".

A group of participants mentioned their previous working experiences at Karaköy brothel, but following the death of the brothel owners they were closed. With no retirement, they had to continue working in the streets.

Having no clients some days, but on average maximum 2-3 clients per day. Some stated that they worked from 09:00 to 18 hours during day time, some till 3 AM midnight. They stated that they had more clients 4-5 years ago.

The rate per client varied from 20-35 TL, younger SWs could get 30-70 TL depending on the bargain. As they put it, "easy for young ones, you may accept even 15 TL if you are hungry". The duration differed, could be as short as 5 minutes, without even taking off the clothes. The youngest one who was working as a callgirl said that "it is around one hour, and I get 100 TL, I get more if they want all night".

III - Health

After having sex with the clients they had vaginal douche with soup as self care. But it was not the case for everyone. Particularly, if there was no water where they had sex, they used wet tissues and no hygienic practice. They continued the discussion as they had to work during their menstrual periods also, and stated that "with jellies or wet tissues we cannot go anywhere". They stated that most of the time they cleaned themselves with tissue paper, got rid of the used condom and had a shower at home 5-6 hours later.

They said that they always used a condom in every sexual act. One stated that "… previously I used to agree to have sex without condom. After getting gonorrhea 'I do not accept anyone without condom anymore". Some said that they learned to put on condoms with their mouth, stating "I put it on while I say I'm not", "some use some not, if we use condoms with the clients we may not use them with our lovers, zero hygiene", "we cheat the clients saying that we will practice sax -oral sex- in order to put on condom".

They stated that they didn't use condoms with their spouse/ partner, except one participant. Also, most of them stated that they currently didn't have a spouse/ partner. They expressed this situation as "Lover? You wish!" But they also declared that their spouses often had other partners. Mostly they bought condoms from grocery stores. Since those condoms were torn easily, they preferred to get condoms from Women's Door.

While vaginal intercourse was defined as “normal” sexual act, they stated that they also engaged in oral sex but abstained from anal intercourse. They expressed as “In general we have vaginal sex, also sax. But if paid properly, may have anal sex with condom”.

Some participants (the ones who have worked at brothels) stated that due to legal arrangements they could no longer benefit from STD Hospital services, also that the hospital was moved to Bakırköy. Some others shared the information within the group, as similar health checks were provided by Şişli Etfal (Hospital).

IV - Knowledge on HIV/AIDS-STIs

They all heard and were knowledgeable about STIs-HIV/AIDS. When caught gonorrhea, they went to docs or bought the medicines they knew. Previously they were reactive to and keeping themselves away from people with AIDS, but they now accepted the situation and no longer discriminated against the PLHA. A participant stated that “I know all the stages, I had a friend who had AIDS and I looked after her until she died”. They added that “for prevention only condoms work”.

V - Moderator’s/ Observers’ Additional Notes

The most interesting information about the group is related to their working location. It seems that although they initiated some attempts to set up a system similar to brothels, because of the fines for running such unregistered bawdyhouses, all of them were closed and they ended up working in the street, in ruined houses or tried to share a residence with a couple of SWs. In addition, they faced difficulty reaching health care services and could not continue using “Cancan” (STD Hospital) as one of their old habit. Not having regular health checks was particularly stated as a problem.

They shared positive opinions about Women’s Door (WD), with no negative aspects. Old or young, all adopted condom use. Some women, after having or personally experiencing STIs started using condoms. Although their fear about HIV/AIDS still continued, they no longer discriminated against the positive cases.

Since the majority of them stated that their families or children were not aware of their job, they definitely didn’t want to be publicly known. For this reason, meeting each other, having a chat or participating in the discussions at WD was defined as an appropriate approach respecting their privacy. On the other hand, the approach, attitude and behavior of security forces were the most common complaint and they wanted the Project to address this issue as well.

SAFER SEX & TRANSGENDER SWs: A FOCUS GROUP REPORT

Location: Project Office (Women's Door), Beyoğlu - İstanbul

Date: 12 May 2010

Duration: 65 min.

I - Introduction and Socio-Demographic Characteristics

The focus group discussion (FGD) was conducted with eleven participants included only transgender sex workers, a moderator and an observer at the meeting room of the Project Office. Initially, the moderator and observer introduced themselves and mentioned about the ground rules i.e. respect, privacy and confidentiality principles. During the participants' introduction basic demographic features were identified.

Among participants, nine were unregistered SWs, one former SW who quitted the job recently and started working as customer representative, and one was working as hairdresser during work days and as a SW during weekends. Their workplaces/ working areas were night clubs, Taksim Square, İstiklal Street, Feriye Street, Şişli, Harbiye and Tarlabaşı; whereas one stated that she was finding clients through the internet. Age: The youngest was 22, the oldest was 60. Education: Three university graduates, three high school (11 years) graduates, two primary school graduates, one illiterate and the remaining two quitted their schools (secondary school and high school). Basic demographic features of the participants are summarized below (*see* **Table A-V.1**).

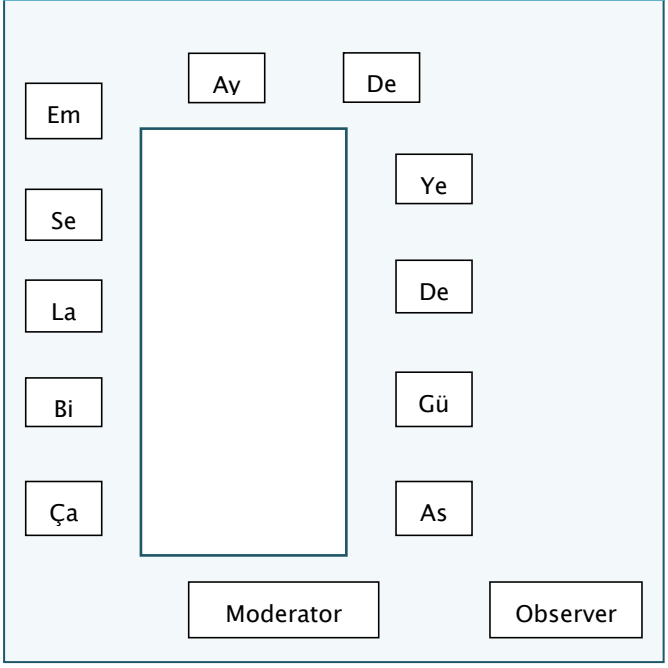
Table A-V.1 Socio-demographic characteristics of FGD participants (T-SWs)

Name	Ça	Bi	La	Se	Em	Ne	De	Ye	De	Gü	As
Age	60	35	35	31	38	32	35	22	37	50	25
Working area/ place	TS	H	Cr	Hd	TS	İS	Ş	FS	Int.	TS	NC
Duration of SW (year)	20-30	22	22	16	17	9	7	4 mos	5	30	5
Education	Il-L	HS-i	HS	HS	PS	HS	U	U	SS-i	PS	U

TS: Taksim Square **İS**: İstiklal Street **TS**: Tarlabaşı Street **Fs**: Feriye Street **H**: Harbiye
Ş: Şişli **HD**: Hairdresser **Cr**: Customer rep. **NC**: Night club **Int**: Internet
Il-L: Illiterate **PS**: Primary School **SS-i**: Secondary School incomplete
HS: High School **HS-i**: High School incomplete **U**: University

The seating arrangement of FGD is shown in **Figure A-V.1**, coded by the first two letters of the participants' first names.

Figure A-V.1 Seating Arrangements (FGD - T-SWs)



II - Life and Working Conditions

The participants said that they were mostly working independently but rarely with procurers, stating "transvestites are independent", "the ones with procurers are new transvestites…, transvestites never share/ grease the palm, we all work independently", "procurers rarely obtain/ acquire customers, once I worked with some, and was paying them once in every month or bimonthly". They stated that they found the clients through the telephone or at Harbiye, Nişantaşı, Tarlabaşı areas; haggled over the price, and went together to their own residences, to a shared residence or to a hotel. In case of a shared house, they paid their share for the "bed". They quoted as "there are some houses, we pay for the bed", "we work with some hotels under an agreement, and we pay 40 TL to them".

They stated that they had around 1-2 clients per day, quoting: "previously, regarding the number of clients there were 5-6 parcel (work), but nowadays only 1-2 parcel". They attributed this situation to the economic crisis and to being bothered by the police. They argued about the issue of police fines for a while. In regard to these fines one stated that "I was dressing traditionally, wearing a long, full skirt etc, still be fined for exhibitionism", and others continued "our girls are used to displaying certain parts of their body, I personally never wear revealing clothes, and I have never been fined. The families come with their children, for sure they may feel disturbed", "normal woman may wear nasty, but you are still a he essentially", "we are not discussing our origin/ core, we were all fined undeservedly", "they want to completely wipe us out".

They stated that their working hours varied since they were independent. Some stated that they worked from 14:00 to 20:00, some from 23:00 midnight till 5 AM.

In regard to the rate per client, they stated that it varied from 10-40TL, with a maximum of 150TL depending on the working area. They said that the mean and maximum rate ranges were 30TL and 50 TL for Tarlabaşı, whereas the maximum 50 TL for Harbiye, and 150 for Nişantaşı; adding that "depending on the treatment they might pay an additional 30TL or more".

III - Health

They stated that they had anal or oral sex, or both with their clients. They said that they randomly tried a position as they defined as 'intercrural sex' since the customers didn't allow when they noticed.

In regard to self care, they stated that they had shower, performed anal lavage with water using elastic pipe before every client. While one participant stated that he had never experienced, the others shared their experiences with irrigation as: "a couple of my friends just prop the hose", "it should be performed with warm water" and described making anal lavage to each other as "cut the finger tips of a plastic glove, wear it to the head of a hose, give the water slowly". Some stated that they bought enemator from the pharmacy and used it, others said that "the doctor told us to use jellies instead of using a hose".

They said that they always used condoms during sexual intercourse, but that others did accept clients without condoms. They defined the process as "earlier we would be out of condoms", "there were no

condoms in our time", "I have a lover for the last one and a half year, and I don't use condoms with him". Some said that they didn't use condoms for oral sex, but one said that "I know how to put on a condom on the quiet; the client allows it when I do it secretly". Except two of them the participants stated that they didn't use lubricants. While sharing information on where to obtain it, they said that the best was saliva, and that it was also a microbicide.

IV - Knowledge on HIV/AIDS-STIs

They had considerable knowledge about STIs; they named them as gonorrhea, syphilis, hepatitis A, B, C, AIDS and fungal infection. They could count almost all of the contamination routes. They mentioned about all stages of AIDS in detail saying "I know it all, how it is spread, and its treatment". They said that they no longer stay away from people with AIDS, and that they took care of their infected friends. They added that "for prevention only condoms work".

V - Moderator's/ Observer's Additional Notes

In the meeting which took place in a crowded participatory environment, compared to the previous FGD's with transgender population their dressing were different. It was noticeable that their way of dressing and their appearances were more masculine. The AIDS patients they had as close friends and coworkers enabled them to learn all stages of the illness and led them to accept their situation. They were aware that the only way for protection was condom. But, their anal lavage practices were continuing with the same frequency.

SAFER SEX & HOMOSEXUAL AND BISEXUAL MEN: A FOCUS GROUP REPORT

Location: Project Office (Women's Door), Beyoğlu - İstanbul

Date: 26 May 2010

Duration: 75 min.

I - Introduction and Socio-Demographic Characteristics

The focus group discussion (FGD) was conducted with nine participants included only self-identified gay male volunteers, a moderator and two observers at the meeting room of the Project Office. Initially, the moderator and the observers introduced themselves and mentioned about the ground rules i.e. respect, privacy and confidentiality principles. During the participants' introduction the following basic demographic features were identified (*see* **Table A-VI.1**):

Table A-VI.1 Socio-demographic characteristics of FGD participants (MSM)

Name	Bo	Ta	Ka	Se	Re	Yi	Ge	Ka	Hi
Age	24	38	23	41	28	30	29	35	21
Education	Univ	High School	Univ	Univ	High School	Univ	Univ	Univ	Univ
Marital status	Single	Single	Single	Single	Single	Single	Single	Single	Single

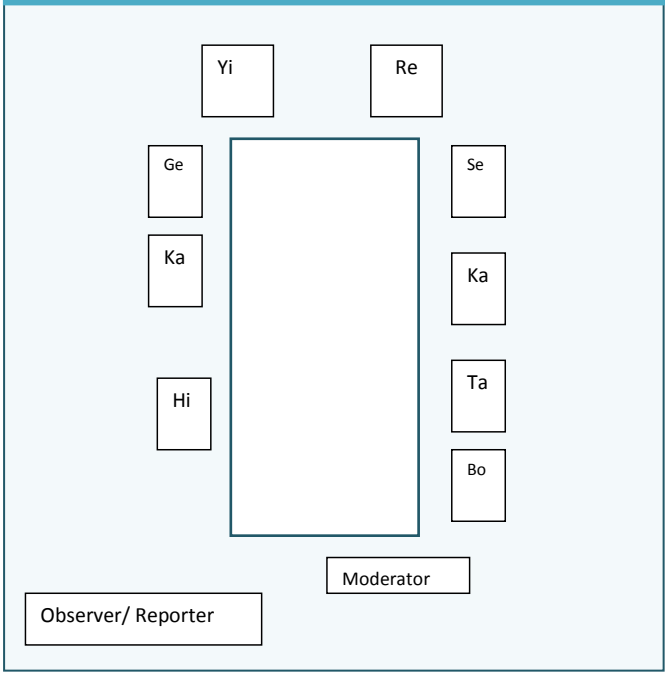
Age: The youngest was 21, the oldest was 41. Education: Two were high school (11 years) graduates; three were university students, and the remaining four were university graduates. Marital status: all were single.

The seating arrangement of FGD is shown in **Figure A-III.1**, coded by the first two letters of the participants' first names.

II - Sexual Life

When asked to share their first sexual experiences, the oldest participant initiated the discussion "A bit blindly. It starts among friends. Later sex becomes anonymous/ incorporated: at parks, bars, theaters, etc. and then via internet." A 35-year-old participant stated that "it happens as you say let it happen. I cannot say that it is a natural process." A 30-year-old participant expressed it as "totally instinctive" and referred to his first sexual experience as "hardly accepted the idea, but found myself having sex with my closest friend when I was 15-16." He also added the effects of some impulsive factors such as "arousing men in blue jeans".

Figure A-VI.1 Seating Arrangements (FGD - MSM)



A 38-year-old participant stated "I've been molested when I was young. But I would have been (gay) anyway. I think it's genetic". A 23-year-old participant, on the other hand, said that "these things were settled in my time" and continued "with preknowledge I entered the circle. I was gay before my first sexual experience, and then I met a guy over the internet". A 24 year-old participant said that his first experience was with a woman when he was 17, with a "transgender" at age 20 and with a "homosexual" at age 21. A 21-year old participant, claiming he was bisexual, said that his first sexual experience was with a man, but he had difficulty "getting out of the closet" because of his environment. A 41-year-old participant said that he felt desire for a man for the first time and he understood what he actually wanted as he intermingled with people. Later, he added that there were men who were with men after their 30s, who were married with children, after their 60s and even after the Hajj. Performing the Hajj was interpreted as "for recovery" by another participant.

The bisexual participant said that his first experience was within a religious community. Another participant said that it was difficult to get closer to girls in such societies, and that since they were with men all the time they "inevitably" became closer. Another participant also said that it (being with men) was common in religious societies.

A participant said that he thought that it was in every man, referring to Freud. The participants agreed on the view that being interested in men was not the same in everyone, and that it had a scale. A participant stated that this situation (being gay) might not be life-long; another participant explained it as a "sexo-flexible" process. Another participant described the process as "Like a cigarette. Even if you quit, when a friend smokes, you might also smoke".

A participant made a description of monogamy as "wanting to claw someone with your nails in fear of loneliness". Another participant said that he was "passionate" until he was 30, and then he adopted monogamy. Another one said that it was just the opposite for him. The bisexual participant stated that, although not defending monogamy, he disapproved anonymous relationships.

It was learned that alcohol and drug use was common before sexual activity. A participant used the phrase "social lubricant" for alcohol. There were ones who couldn't get into a sexual intercourse without alcohol use, preferring spirits (with high level alcohols). A participant said that "ones who have money use cocaine, ones who have more money use poppers" about drugs.

A participant said that paying money for sex was unethical. Most of the other participants did not agree with this. And one participant further explained this as "there are people who can't go from chat to sex, and people need sex, and if money is necessary for it, I don't find this weird". Moreover, a participant said that paying money was a "fetish" for some. It was learned that some male SWs received laptops or suits instead of money. The participants added the following issues as problems related to paying money for sex: destroying sensuality, disliking being asked for money after sex without mentioning beforehand and causing uncertainty about how the relationship would continue afterwards. A participant stated that some people

who engaged in homosexual relationships “they don’t identify themselves as gay; instead they say ‘I do it for money”.

It was learned that they performed both anal and oral sex. The group also regarded “kissing and making sex is a little more romantic”. A participant explained this as “kissing is more private. I would make anal sex with somebody from the street but I wouldn’t kiss”. The group named this situation as “Pretty Woman Syndrome”. A participant continued as “by not kissing, these people think that they are protecting themselves mentally”.

III - Sexual Health

The majority of the FGD participants were knowledgeable about sexually transmitted diseases. The most annoying illness was HPV, they thought. Nearly all of them had pubic lice, even if they did not get into sexual contact they could acquire it from their housemates.

HIV/AIDS was viewed similarly among the participants. The oldest participant said that in the past, he thought he had AIDS when he had the flu; he continued as “but recently there are people living very long with HIV, so if they ask me ‘HIV or cancer’, I would say cancer is more scary”. A participant said that he had attended a seminar and was informed after his close friend’s being infected with HIV. He continued that hepatitis C scared him more and that the situation in Europe was better, “HIV thing is going a bit stiff in Turkey”. A participant said that they were knowledgeable and a somewhat “elite” group, but even if it happened to them no one would “continue seeing” them. They shared the example of a small student who had to be taken out of his primary school in İzmir, last year.

Various views were expressed about condom use. A participant said that he didn’t know how sex without a condom is. Different participants stated that “using condom is a habit” and that “sometimes people don’t use it simply because they don’t have it with them”, “sex with or without condom is different, so people may prefer sex without condom”, “it is primitive”, “condoms are expensive” etc. The price of condoms was compared with cigarettes, and paying for cigarettes but not for condoms was criticized. However, they wanted condoms to be cheaper, and stated that it should be promoted in various ways, such as “free condom for a pack of cigarette”. In addition, they said that people used water-based jelly, hair cream and mostly saliva as lubricants.

IV - Recommendations by the Participants

The group suggested initiatives such as attracting MSMs by forming “fake profiles” at gay sites, reaching married MSMs, reaching “homosexuals not gays”, and working with truck drivers in order to expand the reach.

V - Moderator’s/ Observers’ Additional Notes

The group was open to talk and to share throughout the interview. Despite the number of participants’ being relatively small, their heterogeneity and high level of education accelerated the information flow. The discussion atmosphere enabled frequent intellectual debates with each other. Common acceptance of unprotected and casual sex by the group (except two participants) was an interesting finding that should draw attention.