



HIV/AIDS

**In Armenia:
Socio-Cultural Approach**

UNESCO 2005

HIV/AIDS

IN ARMENIA:

A SOCIO-CULTURAL APPROACH

UNESCO

2005

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FOREWORD

The Flemish Government and the global fight against HIV/AIDS

On the occasion of the latest World AIDS Day, UNAIDS and WHO released a report stating that the HIV epidemic is spreading fastest in Eastern Europe, Central Asia, Sub-Saharan Africa, and East Asia. Since 2000, the fight against HIV and AIDS has been one of the top priorities of the international community in general, and of the United Nations in particular. A rough global estimate at the end of 2003 was that 40 million people were living with HIV, with 25 million in Sub-Sahara Africa alone.

Children and young adults represent a crucial target group in the fight against HIV and AIDS. Effective prevention of HIV infection requires, among other things, the sensitisation of adolescents. The Flemish Parliament and Flemish government have repeatedly proven their dedication to targeting these groups, and Flemish policy in the fight against HIV and AIDS emphasizes prevention and targets children, adolescents, and women.

In 2002, the Flemish government decided to make the fight against HIV and AIDS a horizontal priority of its development co-operation policy, which is implemented through bilateral and multilateral channels. Flanders finances international programmes, provides indirect support through NGOs, and has signed an agreement with Mozambique to support its health sector.

The Flemish government has included the battle against HIV and AIDS in its list of projects that are eligible for funding under the *UNESCO/Flanders Fund in Trust*. Within the framework of the Fund, special attention is given to educational and cultural HIV-prevention approaches, as well as to the care of those infected and affected by HIV.

In 2001 the Flemish government decided to support the project, 'Culturally appropriate HIV prevention in the Caucasus.' This ambitious pilot project aims to develop and implement culturally-adapted research, capacity-building, and training in order to achieve sustainable change in the behaviour of the people in this deeply affected region.

We wish the UNESCO team much success in their endeavours and look forward to the results of the project and their potential use in other settings and countries.

David Maenaut

*Representative of the Flemish Government
Geneva*

Jos Aelvoet

*Representative of the Flemish Government
Paris*

FOREWORD

Throughout history, humanity has always been confronted by disease and health threats. The greatest challenge of our epoch is HIV and AIDS.

The HIV epidemic today has turned into a global crisis. The statistics show how AIDS can devastate entire countries: it destroys the fruits of human civilizations, takes the lives of millions of people, polarizes societies, and shatters the basis of socio-economic safety. It has also raised serious concerns for the protection of human rights and discrimination against people living with HIV.

The influence of HIV and AIDS on society is not limited to the physical harm it does to people's health. The HIV epidemic affects nearly all the spheres of human activity and indeed hinders the process of human development. This epidemic took humanity by surprise, and has created multiple socio-cultural, legal, traditional, and economic problems, as well as emphasized the difficulty of bringing about sustainable behavioural changes.

The impact of HIV and AIDS can be felt in every country of the world. The Republic of Armenia is no exception, this is indisputable. What is also indisputable is the need to implement relevant activities in a timely and decisive manner that will slow the epidemic's progress and increase the relief and care of those infected and/or affected by HIV. The acknowledgement by society as a whole – and especially by policy makers – that HIV and AIDS is a critical problem is a necessary precondition for any effective response. Only if we realize this simple truth will the HIV epidemic retreat from our country.

It is laudable that the government of Armenia realizes the urgency of the problem, and has made HIV and AIDS the center of its attention. It is taking the necessary steps to prevent the further progression of the epidemic, and developing programmes that will improve the quality of life of people living with HIV. A prime example was the 2002 ratification the “National Programme on HIV/AIDS Prevention,” which established a framework for large-scale HIV prevention activities and programmes that provide treatment and care for HIV-positive people.

The Armenian Ministry of Health considers HIV prevention one of its most urgent responsibilities and since 2000 has given the highest priority to activities implemented in response to HIV and AIDS. However, no governmental decision or document will prevent the epidemic's steady progress if - in addition to the already well-known factors contributing to the spread of HIV - socio-ethnic, cultural, and gender-related influences are not taken into consideration.

The extensive research presented in this publication was carried out with the knowledge that HIV/AIDS is not just a health issue, but also a complex socio-cultural phenomenon. Therefore, the development and implementation of effective activities must take into account the socio-economic, political, and cultural specifications of our country, which remains in a period of transition.

It is my deep conviction that the group of experts who conducted this research successfully uncovered these critically important socio-cultural factors – gender roles and inequalities, traditions and norms, religion, etc. – which not only play a role in the progression trend of the HIV epidemic in Armenia, but also have a place in any effective response to the epidemic. The valuable recommendations of this team should be carefully considered when future HIV prevention strategies are being developed, because in the fight against this global epidemic, information is our greatest weapon.

Samvel Grigoryan

*Director of the National Center for AIDS Prevention
of the Ministry of Health of the Republic of Armenia*

*Adviser to the Minister of Health
on the issues of HIV/AIDS and sexual health*

PREFACE

With a low HIV prevalence yet alarmingly-high observed rate of increase, there is an urgent need to address HIV and AIDS in the region of Southern Caucasus: Armenia, Azerbaijan and Georgia.

Priority must be given to the prevention of new infections. However, the specific needs of those already infected with and affected by HIV and AIDS should also be addressed, and people living with HIV must become key partners in the development of HIV-related activities.

Experience has shown that for any prevention, treatment, or care action to be effective, it has to be culturally appropriate. This means that the target population's characteristics – including lifestyles, traditions, beliefs, gender relations, and family structures – must be taken into consideration during the development of strategies and programmes. This is essential if behaviour patterns are to be changed on a long-term basis, and it is a vital condition for slowing – and hopefully one day stopping – the epidemic's expansion.

It is for this reason that UNESCO and UNAIDS, in order to ensure that culture is always taken into account when HIV and AIDS are addressed, launched the joint project 'A Cultural Approach to HIV/AIDS Prevention and Care.' The project aims at stimulating reflection and encouraging actions that would lead to a better integration of the 'cultural approach' in HIV strategies, policies, programmes, and projects.

Based on the experience and lessons of this project, UNESCO developed a new project, '*Culturally Appropriate Information, Education, Communication (IEC) for HIV Prevention in the Three Caucasus Countries.*' This project has come to day thanks to the generous support of the Flemish government and it has been developed in close collaboration with the national authorities of Armenia, Azerbaijan, and Georgia, with contributions from an international team of experts. Its objective is to contribute to the development of culturally-appropriate responses to HIV and AIDS that will be relevant, effective, and sustainable.

This project was conceived in two phases. The first, research-oriented phase was aimed at the assessment of local socio-cultural specificities affecting the trends of the progression of the HIV epidemic. In this context, culture is not seen as a static obstacle but rather as an evolving resource that has a key role in any effective response to HIV and AIDS.

The second, action-oriented phase is based on the results of research and has three main goals: the development of culturally-appropriate IEC materials, the training of trainers in this field and strengthening of sub-regional cooperation.

Capacity-building is a core component of the project, focusing on strengthening local capacity to integrate socio-cultural factors in responses to HIV and AIDS at all levels, especially the training of social science researchers, decision makers, and HIV/AIDS professionals.

The innovative character of the project required the identification of a team of specialists with a broad spectrum of expertise: an international expert to ensure the overall scientific coordination and three teams on national level. Due to the high level of qualifications and experience required of the research teams, the selection process turned out to be much more difficult and lengthy than foreseen. Cynthia Buckley, Professor of Sociology at the University of Texas at Austin, was appointed as the project's Chief Scientific Consultant, and in consultations with her the national teams were selected, each comprised of three experts from different disciplines: sociology, epidemiology, drug-related treatment and care, psychology, etc.

Despite the challenges faced in the elaboration of the reports presented in this publication, it is our belief that the quality of the reports testifies to the success of the project's first phase.

This publication presents the full-length review of the current situation of the epidemic in Armenia from a socio-cultural perspective. The full-length reviews for Azerbaijan and Georgia, as well as summa-

ry reports for all three countries and a comparative analysis, are available in separate publications.

The second phase of the project will be launched during a sub-regional conference to be held in Tbilisi, Georgia, in June 2005. The meeting will bring together high level representatives of Ministries of Education, Health, Youth, Culture and Social Affairs from all three countries, representatives of UN theme group, IGOs and major international NGOs, with the objective to present the results of the research and assess possibilities of a sub-regional cooperation in the fields of HIV/AIDS, education and culture.

The second phase will continue with a series of national meetings to be held in June 2005 with the participation of key stakeholders working on HIV and AIDS on the national levels. They will be organized in close cooperation with the National AIDS Centers and will bring together representatives of NGOs (youth, women, etc.), networks of people living with HIV, religious organizations, media, IGOs and bilateral organizations. The objective will be to present the national research results and sensitise all key stakeholders on main socio-cultural issues related to HIV and AIDS in each country and on the importance of taking these specificities into account when developing HIV strategies, projects and programs.

The second and last phase of the project should end by April 2006.

UNESCO hopes that this publication will not only demonstrate how culture is at the core of the trends of progress of the HIV epidemic in the Caucasus region, but also make the case that if the international community is to develop an effective response to HIV and AIDS, and help end the stigma and discrimination faced daily by people living with HIV, culture must be taken into account in the design of all strategies, policies, projects, and programmes.

Katrina Stenou

*Director
Division of Cultural Policies
and Intercultural Dialogue*

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UNESCO owes a special debt to all the authors of this publication, and in particular to the national teams of experts that worked on the development of this report: Arshak Papoyan, Noush Arakelyan, and Elmira Bakshinyan. Analysing the HIV epidemic in this region with a socio-cultural approach is an innovative, and thus very challenging, task that the teams have accomplished with remarkable professionalism and competence.

We have the deepest gratitude for Professor Cynthia Buckley and her invaluable work on this project as the chief scientific consultant. Professor Buckley, designed the research methodology for the entire project, provided training to the national teams, and guided them in the development of the national research reports.

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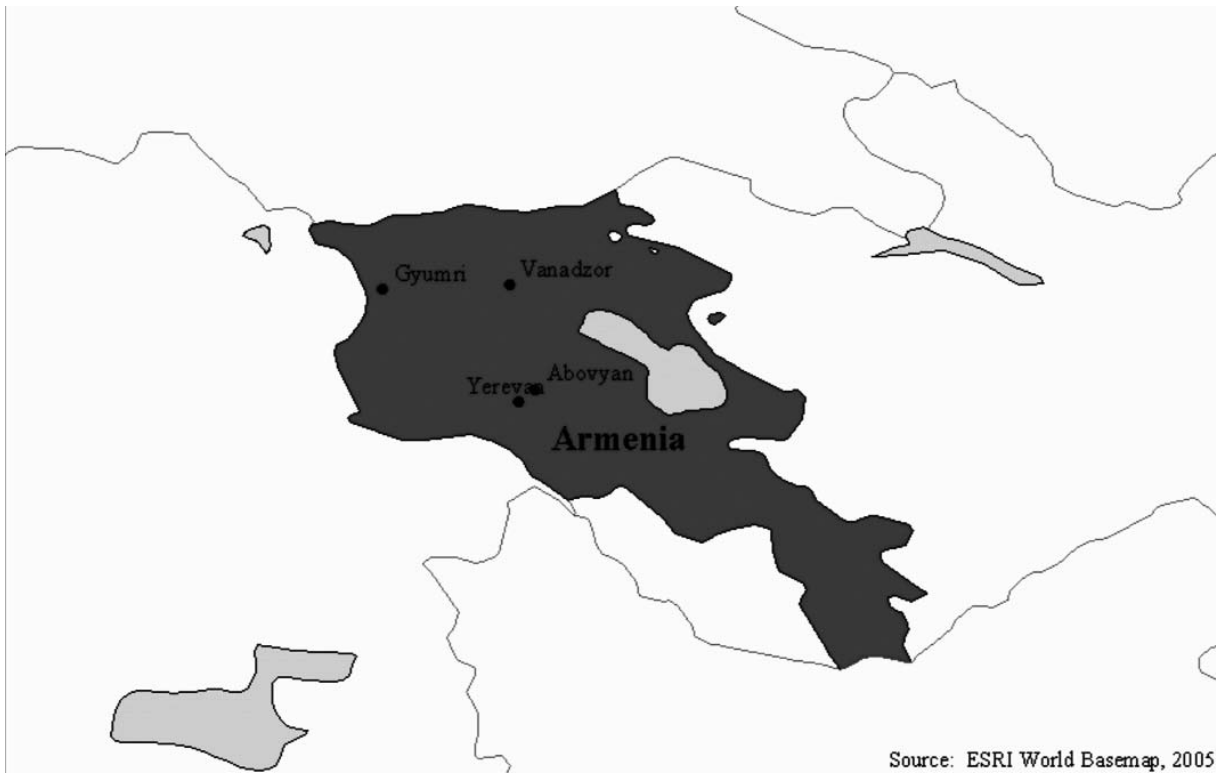
Above all, UNESCO remains indebted to the Flemish government, for without its generous financial support, this project will not have been possible.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
BBP	Basic Benefits Package
CBO	Community-based organisation
CCM	Country Coordinating Mechanism
CDC	Center for Disease Control (USA)
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
FBO	Faith-based organisation
ESPAD	European School Survey Project on Alcohol and other Drugs
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GFC	Georgian Federation of Children
GOC	Georgian Orthodox Church
GIPA	Greater Involvement of People Living with or Affected by HIV and AIDS
HAART	Highly Active Antiretroviral Therapy
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDACIRC	Infectious Diseases, AIDS and Clinical Immunology Research Center
IDU	Injecting Drug User
IDP	Internally Displaced Person/People/Population
IEC	Information Education Communication
IGO	Inter-Governmental Organization
IOM	International Organization for Migration
IRC	International Rescue Committee
MoH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother-To-Child-Transmission
NAC	National AIDS Council/Committee
NAP	National AIDS Plan
NGO	Non-Governmental Organization
PLHIV	People/Persons Living with HIV
RA	Republic of Armenia
SHIP	STI/HIV Prevention
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund

UNICEF	United Nations International Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VC(C)T	Voluntary (and Confidential) Counselling and Testing
WB	World Bank
WHO	World Health Organization
WV(I)	World Vision (International)

MAP OF ARMENIA



HIV and AIDS in Armenia: a socio-cultural approach

Arshak Papoyan, Anoush Arakelyan, Elmira Bakshinyan

INTRODUCTION

Evaluating and effectively responding to the global challenge of the HIV epidemic requires an in-depth understanding of the strong correlation between health and social, cultural and economic conditions, and how these shape behaviour at both individual and societal levels.

While the number of people living with HIV (PLHIV) in Armenia is comparatively low, the rate is growing rapidly. Current prevalence among officially registered cases is 0.02%. The actual rate of prevalence is estimated to be approximately ten times higher, with a greater prevalence among distinct key population groups. Among the factors driving the HIV epidemic in the country – which faces profound socio-economic, political and cultural changes – are: a particular negative and fearful attitude towards the disease; discrimination against people living with HIV; low level of HIV and AIDS awareness among the population; and an increase in injecting drug use and commercial sex work.

In Armenia, HIV-positive people are primarily associated with three key populations that are socially marginalized: commercial sex workers (CSWs), injecting drug users (IDUs) and men who have sex with men (MSM). For many years an individual's positive HIV status has been equated with immoral behaviour. As a result, PLHIV face aggression. Moreover, it is taboo to openly discuss HIV and AIDS, resulting in the further isolation of PLHIV. Currently many programmes have been implemented in Armenia to surmount stigmatization. However, this process demands numerous long-term activities and commitments from the state.

The collapse of the Soviet Union led to a prolonged period of transition in Armenia, bringing serious consequences in the demographic structure and ethno-cultural sphere of the population. The immigration typical of Soviet Armenia (repatriation) was replaced by emigration mainly to the Russian Federation and Ukraine, resulting from various socio-economic, ideological, moral, and psychological factors that arose during the late 1980s and early 1990s. Seasonal migration was one of the most typical patterns, but in the beginning of the 1990s a large amount of people emigrated from Armenia either permanently or for long periods of time. According to the director of the Armenian National Center for AIDS Prevention (NCAP), the perception that HIV and AIDS is not a significant issue in Armenia, taking into account the country's national particularities, is groundless and inconsistent with reality. The epidemic has spread (at different levels) into all countries of the world, irrespective of their national, cultural, religious, other contexts. In Armenia, poor conditions, and the rise of sex work, injecting drug use, and other high-risk behaviour – especially among youth – exposes the general population to HIV. This is a context in which the HIV epidemic may readily spread.¹

The socio-cultural background that exists in Armenian society because of fifteen years of transformations – cultural anomic²; rejection of traditional values in the absence of new ones; the system of social values not being formed, particularly freedom of expression of sexuality; absence of health care culture (both on institutional and individual level) – all contribute to different displays of behaviour being looked upon as divergence from group 'norms.' This divergence from norms may lead to isolation, treatment, correction and punishment of injecting drug user, criminality, commercial sex work, etc. In several social spheres, including education and public health, previous norms and expectations are no longer adhered to, but new forms of behaviours and interactions have yet to be institutionalised. This lack of stable and sustainable infrastructure is manifested by an inaccessibility of medical services by different groups of the population, a general distrust towards health care officials and the system connected with it, and the grave financial condition of educational and medical institutions. All of these reasons create fertile soil for the spread of HIV in the country.

¹ In regards to other STIs, according to the available statistical data, syphilis rates have not increased significantly the last four years, following a steady increase in syphilis numbers until 2000. On the contrary, there is an observed tendency in growing cases of trichomoniasis and chlamidia, in particular.

² An absence, breakdown, confusion, or conflict in the norms of a society.

PART I. EPIDEMIOLOGICAL AND SOCIO-CULTURAL REVIEW

The review of existing literature on HIV and AIDS in Armenia shows that the phenomenon has been deeply examined from the epidemiological viewpoint, but only among certain key population groups. Little focus has been devoted to the examination of the phenomenon from a socio-cultural viewpoint.

I.1. Existing information on prevalence and trends of the disease

Information on HIV prevalence and particular epidemiological trends in Armenia are based on the ongoing epidemiological surveillance conducted by NCAP since 1988. According to this surveillance, the first case of human immunodeficiency virus (HIV) infection was registered in 1988, with an annual progression of the epidemic as follows:

- 1988** - registration of the first HIV carrier infected through heterosexual practice;
- 1988** - registration of the first AIDS patient;
- 1989** - registration of the first death from AIDS;
- 1990** - registration of the first case of HIV infection in injecting drug users;
- 1996** - registration of the first HIV carrier woman;
- 2000** - registration of the first case of HIV transmission through homosexual practice;
- 2001** - registration of the first case of HIV-infection and AIDS among children;
- 2001** - registration of the first case of child death from AIDS;
- 2002** - HIV prevalence among IDUs is in the range of 15%;
- 2004** - 13 cases of HIV infection have been registered among women, which exceeds the number of cases of HIV infection registered among women in any of the previous years;
- 2004** - the number of HIV and AIDS cases as well as number of cases of death of patients with HIV/AIDS registered this year is the highest.

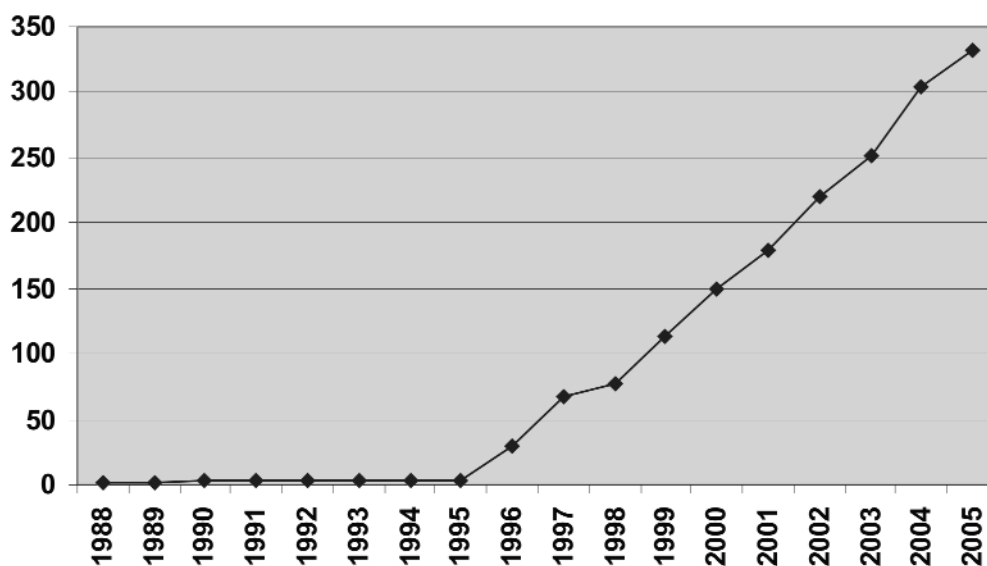
In order for an HIV infection in Armenia to be officially diagnosed and registered, the final diagnosis must be confirmed by the Reference Laboratory of the NCAP. HIV infection is diagnosed when double positive results obtained by the ELISA test are confirmed by a Western Blot test. Blood samples of individuals who registered as seropositive in laboratories – including those of the Marzes³ of the country and in Yerevan city – other than the NCAP, are re-tested in the NCAP. The final diagnosis by a Western Blot test is made directly at the Center. When the NCAP is notified of an HIV-positive diagnosis of a citizen of Armenia who lives abroad, the necessary procedures are carried out to perform a confirming testing in the NCAP. Individuals are registered as PLHIV solely on the basis of the testing results performed in the NCAP. An AIDS diagnosis is made according to the U.S.A Center for Disease Control (CDC) recommendations (1993). These recommendations are based on either the immunological status of an HIV-positive individual (CD4+ count <200/p1) or at least one of a series of AIDS-defining illnesses (such as Kaposi Sarcoma, lymphadenopathy, etc.).⁴

From 1988, the year the first HIV infection case was registered in Armenia, to 1 June 2005, 332 new HIV infection cases were registered. Among these, 315 were citizens of Armenia. Men constituted 77.4% of all people living with HIV (244 cases) and women represented 22.6% (71 cases); there were sex cases of infection among children, with the first such case registered in January 2001 (National Center for AIDS Prevention).

³"Marz" refers to country region and "Marzes" refers to different country regions.

⁴Please consult <http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm> for more details on the CDC's recommendations.

Figure 1. A simple line graph indicating the cumulative number of HIV/AIDS cases from 1988 to 2005.



The majority of PLHIV (76.2%) are between 20-39 years of age, 76.6% of whom are men and 76.1% of whom are women. The 6 registered cases of HIV infection among children include cases of mother to child transmissions (MTCT). The exact number of children infected from MTCT is not known, as the HIV status of a child born to HIV-positive parent(s) is not known, as some parents refuse testing of their child, while in other cases the children haven't reached the age of 18 months (the infant's age after which an HIV antibody test can be used for a definitive diagnosis).

In the Republic of Armenia the main modes of HIV transmission are through injecting drug use (54.0%) and unprotected heterosexual practices (37.8%). At a lesser rate of transmission there are registered cases of MTCT, medically-acquired HIV infection (through blood transfusions and through workplace exposure by health professionals) and unprotected sexual relationships among MSM.

Since 1988 two cases of medically acquired transmissions have been registered: one through blood transfusion and the other through workplace exposure. Blood safety is one of the priorities for the country. To meet these needs, in 2004 the state created a laboratory infrastructure in all the regions of the country. Specialists from all regions have been trained to conducting HIV testing using the high-quality test-kits with which they are provided.

Table 1. Modes of HIV transmission in Armenia (among HIV-positive citizens of the RA) June 2005 (NCAP).

Mode of transmission	Total	Women	Men
Injecting drug usage	54.0%	-	100%
Heterosexual practices	37.8%	54.6%	45.4%
Mother-to-child transmission	1.6%	83.4%	16.6%
Medically-acquired transmission	0.6%	50.0%	50.0%
MSM	0.6%	-	100%
Unknown	5.4%	5.9%	94.1%

Figure 2. Main modes of HIV transmission

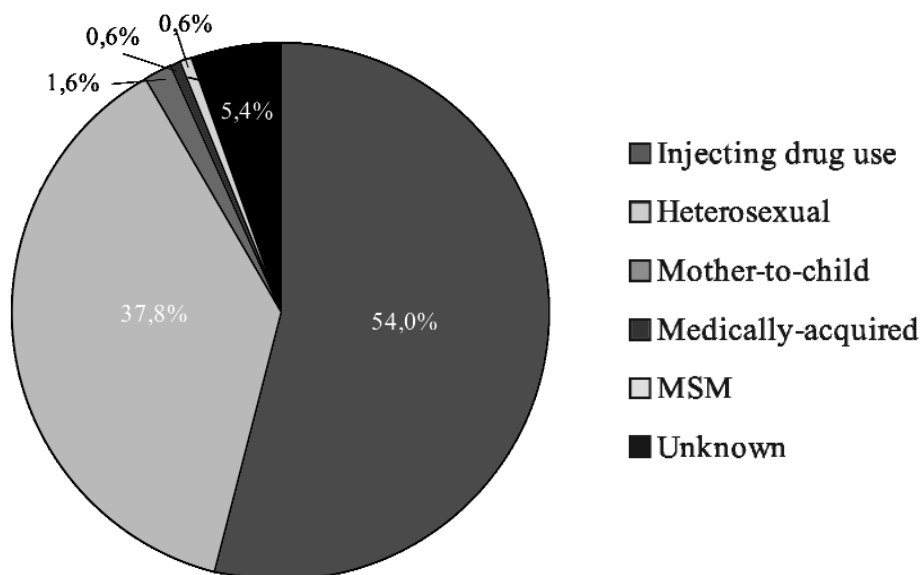
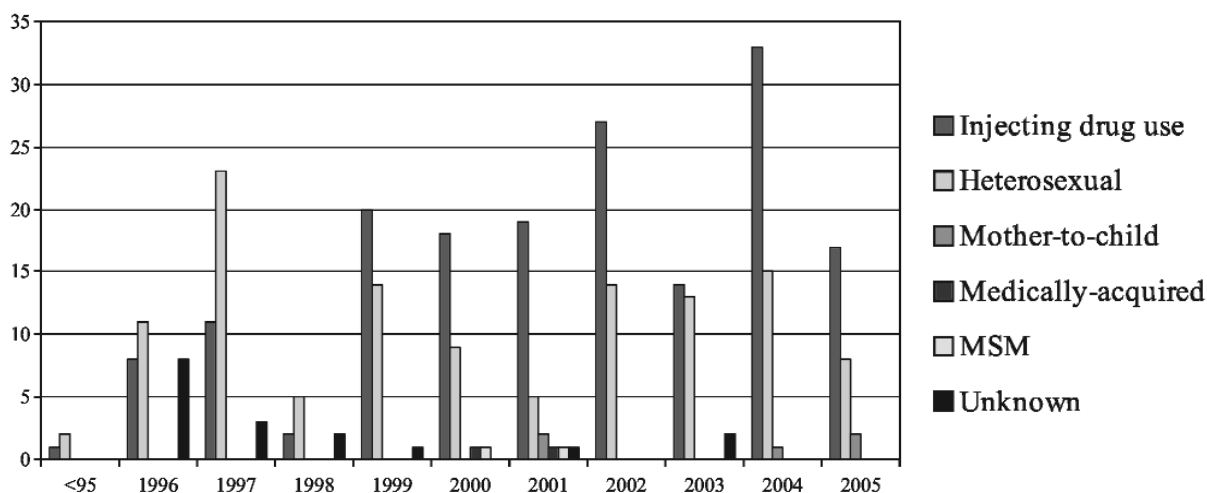


Figure 3. Modes of HIV transmission in Armenia⁵ by year (among HIV-positive citizens of RA) (NCAP)



In recent years, a considerable increase in HIV cases through injecting drug use has been observed. The majority of all HIV-positive men (69.9%) are individuals who practice injecting drug usage, whereas the main transmission mode for women is unprotected heterosexual contact (91.5%). Until 1 January 1999, sexual transmission accounted for nearly twice the number of cases transmitted by injecting drug use. Comparatively, these rates were reversed between 1 January 1999 and 1 June 2005, when twice as many cases were attributed to intravenous drug use rather than sexual contact. From the beginning of the epidemic, in 1988, until 1 January 1999 (eleven years), forty-one cases of HIV transmission via heterosexual contact have been registered. For the period of 1 January 1999-1 June 2005 (fifteen years) this figure rose to sixty-eight (or twenty-seven new cases). Since the beginning of the epidemic until 1 June 2005, 170 cases of HIV infection via injecting drug use have been registered. Eighty five HIV-infected individuals have been diagnosed with AIDS (of whom 17 are women and 4 are children), at that the

⁵Please note that the above figure (Figure 3) does not represent the linear progression of HIV cases with time, but rather the comparative rates per mode of transmission for one year at a time, depending on the number of individuals tested from each group during that year. In other words, the numbers do not necessarily reflect the total rates. For example, the decrease shown from 2002 to 2003 among IDUs is not real as it reflects the number of people tested for HIV in these two years; 212 IDUS were tested in 2002 in the framework of the epidemiological surveillance, as opposed to only 46 IDUS tested in 2003.

majority - during the last three years. From the beginning of the epidemic 61 cases of death from HIV/AIDS have been registered (the cases include 8 women and 1 child). Nearly one third of these cases were registered last year. The number of cases of HIV infection (53), AIDS (21) and death from AIDS-related illnesses (20) registered in 2004 is the highest in comparison with the number of the cases registered in any of the previous years. All the individuals infected via injecting drug use were men. Some of these IDUs (labour migrants, students, some who were visiting their relatives, and so on) had temporarily lived in the Russian Federation (Moscow, St. Petersburg, Irkutsk, Rostov, and Surgut) and Ukraine (Odessa, Kiev and Mareupol) and may have been infected with HIV there⁶.

There is a correlation between the regional spread of the epidemic and development trends. Regionally, registered cases are concentrated in the capital city of Yerevan, where nearly half (154 cases, or 48.9%) of all individuals living with HIV reside. The number of the registered HIV cases in Ararat, Shirak and Lori Marzes is the second-highest in Armenia - 26 cases, which constitute 8.3% of all the registered cases. Then comes Gegharkunik Marz, with 7%; and Kotayk Marz, with 3.5%. This situation is accounted for by the high level of migration in Gegharkunik, Shirak, and Lori Marzes, while drug usage has its traditional roots in Yerevan, Ararat, and Armavir Marzes (NCAP). Currently, 64.2% of the total population resides in urban settings and 35.8% resides in rural settings (National Statistical Service of the Republic of Armenia).

However, these statistics on HIV prevalence in Armenia do not reflect the actual picture of the epidemic. HIV and AIDS situation assessment has shown that the estimated data of people living with HIV in Armenia is approximately 2800-3000 (NCAP) – about ten times the number of officially registered cases.⁷

In 2002, with the support of a WHO consultant, the NCAP developed a national strategy of updated HIV surveillance systems (second generation surveillance systems). That same year, according to the national strategy, Biological HIV Surveillance and Behavioural HIV Surveillance were conducted among key population groups (biological surveillance among IDUs, CSWs, MSM, prisoners, pregnant women, and behavioural surveillance among IDUs, CSWs, MSM, pregnant women, and youth).

The national strategy set guidelines for defining sentinel populations and sites, sample size, methods for data collection, processing and analysis, sample collection and registration, and laboratory testing and quality monitoring. Laboratory HIV testing was voluntarily conducted as either confidential or anonymous. Mandatory testing, solely for the purpose of the survey, was conducted within penitentiary institutions.⁸ A coupon system was introduced to ensure confidentiality. Each coupon contained coded information about an individual's gender, age, relation to the group under survey, and residence. Those who wanted to know test results could do so by presenting their coupon.

Behavioural surveillance was conducted through voluntary and anonymous interviews and questionnaires. The questionnaires contained questions on gender, age, family status, education, occupation, and residence, as well as questions on HIV methods of prevention, sexual behaviour, and drug use.

According to the data of Second Generation HIV Surveillance conducted in 2002, HIV prevalence among IDUs is roughly 15% (the study was conducted among 201 IDUs, target sample). Among CSWs it is less than 3% (250 CSWs, all women, were observed, staged cluster sample) (Grigoryan, Mkrtchyan and Davidyants 2002). Until now antiretroviral (ARV) therapy in Armenia has not been available. Presently, 'National HIV/AIDS Treatment and Care Protocols' and 'National Guidelines on Antiretroviral Treatment'

⁶ It is important to note that the highest number of HIV-positive people in the region is in the Russian Federation - which has 860,000 cases, and where 1-2% of the general population are IDUs. The number of registered HIV-positive people in Ukraine is 68,000 (UNAIDS/WHO 2004).

⁷ Estimated data are received according to "An Estimation and Projection Package for Multiple Groups and Epidemics" programme provided by UNAIDS and WHO, which serves as methodology for estimating and projecting the HIV/AIDS epidemic at a state level. The essence of the method is that HIV prevalence is determined in different key populations who might be more vulnerable to HIV; the size of these groups are determined, and the estimated number of people infected with HIV is calculated.

⁸ According to the law, "Prevention of the disease caused by human immunodeficiency virus," there are some other mandatory testing groups, but within the framework of this survey mentioned above, prisoners were the only mandatory testing group. Currently, amendments to the given law are to be discussed in the National Assembly. According to this law, all groups should be excluded from mandatory testing groups.

have been designed and ratified by the Minister of Health of Armenia. These standards were intended to provide twenty PLHIV with antiretroviral treatment by the end of 2004 within the framework of the National Programme on HIV/AIDS Prevention. However, that deadline was moved to February 2005, upon which twenty individuals living with AIDS were to be provided with ARV treatment. Following a meeting, the CCC decided to provide ARV treatment medication to the first 20 people with AIDS applying for treatment.

S. Grigoryan, the director of the National Center for AIDS Prevention, thinks that 'Armenia is in a comparatively better condition [in regards to injecting drug use and HIV prevalence than in Russia and the Ukraine] – which is explained by the 'national mentality' of an absence of traditional roots in injecting drug use and the negative attitudes of society towards IDUs – in general. However, migration to Russia and Ukraine must not be forgotten. Our compatriots being temporarily in these countries can practise risky behaviour and on their return serve as a source of infection for their families. [HIV/]AIDS is mostly a behavioural disease.' ('AIDS is attacking,' Hayots Ashkharh daily, 6 June 2002).

I.2. Demographics of registered PLHIV

The main mode of HIV transmission (for both men and women) is injecting drug usage, followed by heterosexual relations. According to the research completed by the NCAP of the Ministry of Health, the vast majority of people living with HIV in Armenia are in the age group of 20-39, the majority of whom are married men who have a secondary education, and most of whom live in Yerevan. However, 43.3% of HIV positive men are unemployed, 29.9% are migrants, 14.2% were incarcerated (at the time of registration of HIV status) and the main mode of transmission is through injecting drug use (Armenian National AIDS Center; Grigoryan et al. 2002). Armenian women living with HIV are mainly housewives (48.7%) or unemployed (28.6%). Among this group, the main mode of transmission was reported as being through heterosexual sex. It is also important to note that all registered PLHIV who used drugs before diagnosis have since stopped. As stated earlier, men constitute 77.5% of all people living with HIV (217 cases) while women represent 22.5% (sixty-three cases). The estimated number, however, of women living with HIV (ages 15-49) in Armenia by the end of 2001 was 700 (UNAIDS 2004).

Table 2. Distribution of PLHIV according to sex, age, marital status, education and residence, based on a target sample survey among 50 PLHIV in 2002 (Grigoryan et al, 2002).

PLHIV demographics, based on a target sample survey	Absolute number	%
Sex		
Male	41	82
Female	9	18
Age groups		
20-24	5	10
25-29	15	30
30-34	12	24
35-39	11	22
40-44	5	10
45 and older	2	4
Marital status		
Married	26	52
Single	17	34
Divorced	4	8
Widowed	3	6
Education		
Secondary	34	68
Specialised secondary	7	14
Higher education	7	14
Eight-year	2	4
Residence		
Yerevan	34	68
Other towns	8	16
Rural areas	8	16
Total	50	100

Studies investigating the needs of PLHIV through self-reports find that medical and financial support are more often cited than psychological or legal assistance (Grigoryan et al., 2002).

What is of particular interest is the opinion expressed by the doctors themselves: 'There is an opinion in Armenia that people living with [HIV] are the 'low layer' of the society and the state is not obliged to spend money on them.' (*Aravot* daily, 24 March 2001).

I.3. Socio-Cultural context of HIV-related risk behaviour

'[HIV/AIDS is a global problem, as when resisting the [reality of the] epidemic it is difficult to make changes in socio-ethnic, cultural, and gender criteria, discussions on sexual relations, issues on insuring women's rights and the importance of men's role. Any governmental order or document cannot overcome these difficulties. National efforts are required for this, including community, women's organizations, churches, and other organizations.'

Mark Meloc Braun, UNDP administrator, UN news, 2001.

I.3.1. Overview

This section describes the socio-cultural overview of Armenia, which is important for having a general notion of the trends of the HIV epidemic in the country. The overview attempts to describe the situation in different spheres of social life, which of course, reflects on HIV, and AIDS issues.

Armenia is an ethnically homogeneous country. The majority of the population (97%) is ethnically Armenian. Christianity is the main observed religion in Armenia, led by the Armenian Apostolic Church. The situation in the religious field abruptly changed when the law on 'liberty of conscience and religious organizations' was changed in 1997, allowing different religious and religious-charitable organizations to be officially registered. After passing the law, fifty such organizations have been registered, representing thirteen religious orientations. Armenian Apostolic, Armenian Catholic Church and Armenian Evangelical Churches implement Christian and charitable programmes (UNDP 2001). National minorities (making up 3% of total population) are comprised mainly of Yezidis, Kurds, Russians, Ukrainians, and Jews⁹. 66.7% of the total population resides in urban environment and 33% live in rural areas.

Special research into the particular risk to HIV of national minorities has not been conducted. Among the the registered PLHIV Armenian citizens, three are not Armenians. Similarly, research concerning particular risks for HIV infection faced by religious minorities is also lacking. Importantly, the emergence of 'sects' has been observed. The liberalisation processes in Armenia now allows different religious and religious-charitable organizations to become influential and popular. Among different groups of the general population, norms and values are shifting according to these emergent organizations and religious affiliations. For example, some religious groups demand obligatory abstinence for both men and women.

In the health care sphere, according to the 2001 National Human Development Report, life expectancy in Armenia is 70.5 years for men, and 74.5 years for women. The unavailability of medical care, especially for more socially vulnerable layers of population, is a serious problem. The health care system works at 50% capacity because people rarely visit polyclinics; reasons include high costs, poor quality of medical services, and an inability to pay (UNDP 2001).

There are private and public clinics in the health care system that receive certificates for providing services. Currently, universal health care insurance does not exist as a separate, coordinated structure. Improvements implemented in the country are intended to develop a preventive health care system that will provide high-quality medical services based on a primary health care/family doctor-oriented system.

The Armenian government ensures free secondary school education and covers 20% of post-graduate education. In Armenia, education has always been considered a 'national value.' During the Soviet period, illiteracy in Armenia was overcome and a high-quality education system was established to continuously train specialists of middle and high qualification. Sexual education (and in some cases issues of reproductive health) are provided in schools and in institutes of higher education.

⁹ According to the Armenian Legal Act, Jews are considered an ethnic minority.

Table 3. The distribution of population in Armenia by educational level (according to the survey conducted in the framework of the situational analysis report 'Education, poverty and economic activity,' UNDP 2002).

No elementary education	Elementary education	Not full secondary	Secondary	Not full Secondary Special	Secondary Special	Not full high education	Higher education	Postgraduate high education	Scientific degree	Total
0.7%	2.4%	20.7%	31.1%	1.8%	18.9%	4.6%	18.9%	0.3%	0.6%	100%

According to statistical data, even though Armenia has a literacy rate approaching 99%, as much as 55% of the population is living in poverty.¹⁰ According to official data 30% of those unemployed are under the age of 30, and around 33.7% have secondary or higher education.

Economic changes implemented by the state over the past ten years have been aimed at developing a regulatory system typical of a market-based economy. As a result, rather effective solutions have been found, but in general, the approaches have not been completed or coordinated, and very often, face significant delays in implementation. The analysis of the labour market between 1994-2001 shows that a discrepancy between demand and supply continued to deepen. Recent increases in the gap between rates of hidden unemployment and employment has been observed in labour market. According to official data, the level of unemployment in 2000 was 11.7%. However, according to independent evaluation, a more correct estimate is about three times that, or 34.4%(UNDP 2001). Health issues faced by the population outweigh the infrastructural improvements that have been introduced.

During 1988-1999, almost the entire Armenian population was in some way affected by external migration. From 1991-2000 approximately 900,000 (23.7% of the population) people migrated from Armenia, the majority of whom (more than 60%) were men in the active and reproductive age range (20-44 years) (UNDP 2001). The majority migrate for purposes of short-term work that they seek in high-prevalence regions such as Ukraine and Russia. These circular migration patterns not only potentially expose them and their families to HIV, but also impact family structure and stability.

When evaluating cultural development of the last ten years it is important to emphasize the abrupt decrease in production of scientific publications, a crisis in film production, and the loss of a large number of libraries, culture clubs, museums, cinemas, theatres, ensembles, and creative collectives. These changes are related to the 'brain drain,' the low economy, and a lack of state-allocated funds. The main concept and direction/orientation of a national cultural policy in response to this crisis was formed and ratified by the government only in October 2000. The official main objective of the national cultural policy is to protect cultural heritage and support the necessary institutions and social networks for their dissemination to younger generations, and to generally promote cultural values. Three manifestations are typical of socio-cultural changes of the last decade, which dominated in different stages: substitution of ideologization (Soviet) by absence of ideology, the efforts to preserve cultural institutions by any means, and striving for direct cooperation with foreign countries.

¹⁰ The indicators describing the absolute poverty in Armenia were first defined in 1996, based on the results of the survey on types of housekeeping the following distinctions of population are made- extremely poor, poor, not poor. Poor: Households are considered to be poor when consumer expenditure of one person is less than the minimal basket of goods of 11735 drams cost (22 USD), in 1998-1999. This is considered absolute line of poverty.

Some Specifications of 'Armenian Identity'

In contemporary Armenia, the strategies intended to solve social problems should take into account the great significance of social networks in national public life. Over the course of long-term historical development, religious and cultural traditions have played an important role in the protection of Armenian identity (Margaryan 2003). The importance of *family ties* is one of the values that has a stable role in the Armenian mentality. It is characteristic that the concept of family includes not only direct relatives, but also distant relatives. Surveys confirm that family and children are key components of 'success' for the majority of Armenians, even more important than employment. Correspondingly, the cultural specification of society accentuates the significance of ties to relatives and the protection of family. The family remains the key agent of protection and reproduction of Armenian ethnic identity. Furthermore, the leadership of elder women and men, traditionalism in distribution of work, strict control of sexual behaviour and education norms of children are typical of family life (ACNIS 2002).

Another value underlying the importance of social ties is cooperation between family members, as well as between friends and acquaintances. Cooperation in Armenia has historically been a means of survival in conflict situations and complicated conditions (including difficult terrain and natural disasters). The data of the World Value Survey conducted in Eastern Europe and Germany (1995–1998) support these claims about the meaning of kinship and family for Armenians. For example, in Armenia only 32% of a survey group mentioned 'independence' as a necessary quality for a child. However, 30.6% of those surveyed placed importance on the necessity of such qualities as 'sincerity,' in contrast to Germany, where these indicators have correspondingly been 58% and 4.6% (Margaryan 2003).

Collectivism and group orientation were important aspects of the Soviet value system, and the *expectations* of friends and parents are still an important factor in Armenian public life. The traditional value of family ties and relations grows with the growth of economic support from relatives (Margaryan 2003).

Group orientation was typical of Armenian society even in the Soviet period. Both the Armenian family and the community have traditionally viewed the individual as a factor that can preserve the structure (ACNIS 2002) Armenians have strong family ties and work together to preserve that unity, they respect elders, and they try to learn from their experiences by passing on knowledge from one generation to another. In this way, they ensure the continuity and preservation of a cumulative intelligence (Semerjian 2002).

The following quotation by Grigoryan and Papoyan (2004) notes that the role of the 'courtyard' (i.e. people living in the neighborhood) as a social network is also important for Armenian people: 'In Armenia the smallest unit of administrative and territorial division can be considered not the community or the Marz, but the 'court' with its specific laws and unwritten rules, secrets known to everybody and hackneyed rumours which are [an] indispensable part of the 'court.' The path leading from the family to the society necessarily goes through this court for an Armenian teenager. The first contact with peers, the first attempts at self-assertion and self-affirmation, the first friend, the first love – all this is included in that small world' (*Charagajt* journal, 2005.).

I.3.2. Gender issues, HIV and AIDS

In Armenian society the influence of women's roles and status with regards to HIV and AIDS is broader than the existing health care system accounts for. This issue is connected to women's rights and benefits, particularly given the existing gender stereotypes. In Armenia, women form 22.6 % of PLHIV, the majority of whom have been infected through heterosexual practice (NCAP, 2005). In any society, gender relations are displayed in the family and accordingly in the public sphere. In traditional Armenian society female and male gender roles were conditioned by a family community, in which the role of women was rather limited and unequal. This was especially true of young women, and visible in prohibitions on their behaviour and their overall subordinate position. In 'Domestic violence in Armenia,' the authors argue that in Armenian traditional society, prohibitive attitudes towards, and pressures placed on, women by the community and elder family members was theoretically constructed as a 'positive function' regarding family, which creates a double position for a woman (Akunk center for ethno-sociological studies, 2002). In traditional Armenian society, women are perceived both positively and negatively. On the positive side, she is regarded as a man's half and a mother – as an embodiment of 'right, kindness, light, life, and fertility.' At the same time a woman is also perceived as an embodiment of 'evil and

misfortune.’ This was especially true of single girls and women, and widows who bore great pressure from the community. Violence against women, particularly verbal and moral abuse, and sometimes beating, is considered to be an exhibition of ‘manly courage’ for husbands. People say, ‘If a woman is not beaten she’ll be known to be a widow.’ It is not surprising that even today many women connect torture and sexual pleasure; some women consider being beaten a natural part of marriage, and a manifestation of their husband’s prerogative, or love.

Based on a survey of 6,430 women ages 15-49, the Armenian Demographic and Health Survey 2000 (DHS) provided actual data concerning cultural tolerance towards wife-beating. When asked about five scenarios of wife beating, 35% of respondents agreed to at least one situation in which a husband was justified in beating their wife (example scenarios included neglecting children, refusing sex, burning food, arguing, or going out without a husband’s permission).

In the Soviet period, the state attempted to improve and alter the social image and role of women in the family. But women continued to bear the burden of home affairs, children’s upbringing and care. Though legislatively, women and men were equal, in families and society, traditional roles were still unequal. These traditional values and positions regarding gender remain prominent in Armenian cultural life. At the same time, it is noteworthy that today the economic role of women and girls (18-35) has become more important. In some cases they are the primary wage-earners within a family. This phenomenon is contradictory to traditional gender roles, according to which women’s economic and social role became more important with age.

Yet at the same time the majority of women consider that their primary concern is the family, their place is in the kitchen, and their role is to deliver babies and bring them up and to care for their husbands, demonstrating further the contradicted gender perceptions in regards to both traditional and individualistic culture elements in the society.

According to the traditional Armenian stereotype, marriage and producing babies are the two activities that define a woman’s sexual behaviour, and are the ways in which she corresponds to the image of femininity in society’s collective mind. Contemporary ethnographic research and sociological surveys conducted in Gyumri testify to this, and argue that of all possible roles – mother, wife, daughter - the primary and most critical role for the majority of women is as a mother. Yet, at the same time, the average age at marriage and divorce rates are increasing (Consolidation of democracy. The civil society in the perspective of globalization. 2003).

The unequal social status of men and women in society attests to the fact that many women are in so-called ‘dependent status’ in sexual relations, where men wield considerably more power and control than women do. In particular, women are not empowered to refuse to have a sexual relation and/or are not in a position to negotiate the use of condoms with their sexual partner or husband. This is true for both married couples and CSWs. This issue might be linked to issues of domestic violence, as it is the threat of violence that often makes both female HIV status risky to disclose and condom use very difficult to negotiate.

In these cases, a woman’s health and safety are largely dependent upon her sexual partner’s will. The facts show that the majority of HIV-positive women in the world (including Armenia) were infected not through casual sexual intercourse or drug usage, but through sexual relations with their regular sexual partners. Experts attribute this recent ‘feminization’ of the epidemic to the specific vulnerability of HIV as a global phenomenon (UNAIDS 2004). To halt these trends and reduce their general subordination and vulnerability to HIV, men’s and women’s socio-cultural behavioural models must be changed. Whether or not a woman becomes infected does not just depend on her lifestyle, her number of sexual partners, or her ‘moral principles.’ Her level of exposure to HIV is also determined by her limited rights negotiating with her sexual partner to use a condom. Given the current low education levels, there is a need for gender-responsive educational responses regarding gender issues.

Marriage or a long lasting monogamous relationship does not necessarily protect women. The results of DHS 2000 show that only 7% of married couples used condoms during their last sexual intercourse. It is noteworthy that condoms are used primarily for preventing undesirable pregnancy (DHS). Combined with the high level of migration (usually, seasonal labour migrants are married men), married couples are also at risk for HIV. According to the same source, if the husband or sexual partner has a sexually-transmitted infection – which increases vulnerability to HIV – more than 21% of women and 27% of men do not think that a woman is justified in refusing to have sexual intercourse with her husband (DHS 2000,

pp. 48-49).

Widespread perceptions of domestic violence are also interesting in this context. According to the report, 'Domestic violence in the Republic of Armenia,' Armenian women and men have different perceptions of sexual violence and negotiating powers during sexual contacts (Akunk center for ethno-sociological studies, 2002). In response to the question of whether they have had sexual intercourse against their will, the vast majority of women (regardless of education level or age) answered that it is their duty and must be fulfilled. Only fifteen out of 1,626 people surveyed (fourteen women and one man) acknowledged the existence of sexual violence in their families. (In fact, very often women are violated by their husbands and such violations are not usually reported; see survey 'Domestic violence in the Republic of Armenia').

According to data from research conducted by the NCAP in 2002, the reason for commercial sex workers' not using condoms in 68% of cases was their client's disagreement; in 31.5% of cases those surveyed mentioned that they were sure that the client was healthy (as a rule, these were repeat customers). Such behaviour can be identified with the accepted model of sexual relations of married couples, when spouses who 'trust each other' do not use condoms. At the same time, experts mention that although from the viewpoint of gender relations and models of sexual behaviour, society still preserves the patriarchal conservative model, the results of the research show that 67% of men and 14% of women had another sexual partner besides their regular one during last year (Grigoryan, Mkrtchyan and Davidyants 2002).

Patterns of premarital sexual relations in Armenia are shaped by cultural norms and assumptions concerning gender and HIV risk in interesting ways. In-depth interviews conducted among young girls and boys in Yerevan and Marzes at the beginning 2004, in the context of research on sexuality, showed that in Armenia, boys usually have their first sexual intercourse with a CSW. According to traditional social norms, when women engage in pre-marital sex, this behaviour casts them as 'immoral,' whereas the boys surveyed consider it normal and socially acceptable to have sexual relations with CSWs before marriage. In fact, this is one of the main forms of sexual behaviour among young boys, who rarely use a condom. In the words of one boy, 'If ten HIV positive CSWs are imported to Armenia, then a great number of people will become infected in a short period of time. Unfortunately it is so.'¹¹

In the expert survey conducted as part of the same research, it is argued that discussions about HIV and AIDS among women have become more frequent as they have realized that HIV and AIDS is not a narrow national problem. According to one expert, in contrast to other STIs, discussions about HIV and AIDS take place among women, especially among those whose husbands go abroad. According to the same source, cases of women becoming infected with HIV are connected with their husbands' migration; the man leaves, occasionally returns to the family, infects his wife, who in turn often remains silent, and rarely seeks medical attention. Activities organized by women's clinics and other institutions working on reproductive health issues are addressing these issues.

It's impossible to make progress without women's participation in designing responses to HIV and AIDS (UNAIDS 2004). Because gender stereotypes in Armenia are deeply entrenched, promoting awareness about HIV and AIDS is not enough. Even though HIV and AIDS is a problem in Armenian society, there are just a few women (compared to the number of men) working professionally on the issue. Moreover, there are no women leaders in the national response to HIV and AIDS. The cause of HIV and AIDS education and treatment has not garnered widespread support of popular female social, cultural, political, or sports figures in Armenia. This is particularly important, especially when taking into consideration that women are usually the ones who break gender stereotypes and initiate, or ask for, safer sex. In the opinion of experts', women accept their passive role (Expert interviews¹²).

¹¹ Citation from an in-depth interview conducted among young girls and boys in Yerevan and Marzes at the beginning of 2004, in the framework of the above-mentioned research on sexuality (not yet published, but documental information, particularly interviews with boys and girls, and one expert discussion was used for the current report).

¹² Citation from an in-depth interview conducted among young girls and boys in Yerevan and Marzes at the beginning of 2004, in the framework of the above-mentioned research on sexuality (not yet published, but documental information, particularly interviews with boys and girls, and one expert discussion was used for the current report).

I.3.3. Key populations

Situational analysis conducted in 2000 within the framework of ‘The National Strategic Planning of National Response to HIV/AIDS’ epidemic programme and epidemiological surveillance periodically conducted by the NCAP suggest that Armenia is in the second, or ‘concentrated,’ stage of an HIV epidemic, when the infection is concentrated in certain distinct key population groups (such as IDUs, CSWs, etc). The situational analyses provided an opportunity to clarify the vulnerability of all key populations to HIV and the main type of action that needs to be taken. The key populations are IDUs, CSWs, prisoners, migrants, and youth, and the main efforts are focused on ensuring donor blood safety and convincing people to adopt safer sexual behaviour (Grigoryan, Mkrtchyan and Davidyants 2002).

I.3.3.1. Injecting Drug Users

Contextual evaluation

Factors contributing to injecting drug use are: geopolitical and socio-economic factors, easy access to illicit drug trafficking and drug availability due to geographical position. The climate in the country is also favourable for cultivating narcotic plants such as wild hemp and opium poppy. Armenia has well-developed transportation routes and interstate borders with Iran, which contributes to the intensification of drug trafficking. Iran has more than 2000 kilometres of borders with the countries of the ‘Golden Crescent’ – Pakistan and Afghanistan, from where criminal drug groups transport drugs. An unstable economic situation in the countries of the Southern Caucasus provides the basis for the formation of a ‘Golden’ passage, which is the main means of producing (making and preparing) and transporting heroin.

Recently, a growth in the volume of heavy drugs (heroin and opium) has been observed on the black market. According to data from the Ministry of Interior Affairs, the main countries that import drugs to Armenia are Iran, Turkey, ‘Middle Asian’ countries, Ukraine, and Russia. Armenia is increasingly a transit country for illicit drug trafficking originating in Iran and headed to Russia. The extended frontiers with Iran make heroin readily available in the drug market. The cost of heroin varies according to quality, but generally ranges from 150-250 USD per gram. The high cost of heroin leads users to consume the substance by injecting it into their bloodstream, which requires a smaller quantity of heroin than by other means.

Several factors further expose IDUs to health risks and increase their vulnerability to HIV. These include: IDUs’ inaccessibility as a group, a lack of understanding by health professionals about the severity of the situation, the absence of a unified information system, and limited options for receiving anonymous treatment and counselling/education services. The only current harm reduction programmes are in Yerevan, with regional expansion scheduled (see section 5.5). The absence of rehabilitation services in the drug treatment structure (e.g. a ‘narcology center,’ the regional term for health care institutions providing treatment and care related to drug use) reduces the efficiency and effectiveness of treatment. Existing repressive policy against IDUs (criminalisation of injecting drug use and fear of arrest) hinders the implementation of preventive activities. In one study, nearly half of those surveyed had hostile attitudes towards IDUs and said they thought that drug users must be isolated and treated forcibly. It is worth noting that only 8.1% of respondents thought that injecting drug use is not a widespread phenomenon (Grigoryan, Busel and Papoyan, 2002).

In Armenia injecting drug use is experiencing a growth trend, encouraged by the accessibility of drugs and socio-economic factors. Estimates¹³ show that there are 4,000-5,000 injecting drug users in the country. IDUs are at high risk of HIV infection because of needle sharing and a low level of awareness. According to data from an epidemiological survey, HIV prevalence among IDUs is in the range of 15% (the study was conducted among 201 IDUs, target sample) (Grigoryan, Mkrtchyan and Davidyants 2002). According to the data of the Second Generation Surveillance (2002), only 68.5% of IDUs use disposable syringes – the rest use unsterilized needles or share them with other drug users. Currently, there are needle exchange programmes in Yerevan city, in Gyumri city of Shirak Marz, in Kapan city of Syunik Marz, and in one of the country’s thirteen penitentiary institutions.

¹³ Made by the multiplier and nomination techniques.

Until 2002, medical institutions in Armenia – including the Narcology Center, STI Center, AIDS Center, and other clinics and hospitals – did not offer treatment for the majority of IDUs. Moreover, IDUs were not counselled on behaviour change, which contributed to spread of HIV and other infections transmitted through blood. The previous system of control and monitoring of IDUs created distrust between IDUs and specialists conducting preventive activities. On the one hand, mandatory testing of IDUs provided an opportunity to register separate cases of HIV infection. On the other hand, the existing practice of registration in medical institutions (as well as by law enforcement authorities) and mandatory treatment of IDUs isolated this group and made them inaccessible (due to their lack of confidence in specialists at health care institutions). Implementing preventive activities became difficult because of this. In turn, the absence of rehabilitation centres reduces the effectiveness of drug treatment (Grigoryan, Mkrtychyan and Davidyants 2002; Grigoryan, Busel and Papoyan 2002; Papoyan, Grigoryan and Sargsyan 2004).

Currently 3,500-4,000 drug users are registered in the Department of Internal Affairs (60-70% reside in Yerevan) (Grigoryan, Mkrtychyan and Davidyants 2002). Of those registered, 287 use opiates (90% through injecting). However, according to the operational data from the Ministry of Internal Affairs, in 2000 there were approximately 20,000 drug users in Armenia, nearly 2,000 of whom were injecting drug users. Today, the sale of prepared heroin solution for syringe use is widespread in Ukraine and Russia, but in Armenia no such cases have been registered.

In Armenia, behavioural patterns that increase exposure to HIV include a particular culture of syringe usage and sexual behaviour. Shared drug usage indicates closeness and trust among IDUs and sharing the same syringes and needles within the same circle is considered normal. Caution is only used with strangers. Drug usage in small groups (three to five people) in private locations is also typical. According to the results of the 2002 Second Generation HIV Surveillance, nearly 66% of those surveyed use drugs together with friends and acquaintances. Almost 69% of those surveyed mentioned usage of disposable syringes. In response to the question of whether they had ever used another person's syringe or needle, almost 44% of those surveyed answered that they had engaged in this practice sometimes or very often. Finally, 47% mentioned that he/she was infected with hepatitis B or C, and 60% were infected with STIs (Grigoryan and Papoyan 2004).

The implications for transmission are minimal, as the networks are small, provided that no member of the network is HIV-positive, and that needle-sharing remains within the network. However, transmission outside of the network can take place if sexual contacts for IDUs do not follow these small, highly trusted use groups.

In regards to the sexual behaviour patterns of IDUs, the following is typical:

- the initial stage – episodic drug usage characterized by a large number of incidental unprotected sexual contacts outside of their drug-using circles;
- the second stage – systematic drug usage leads to loss of libido and potency, sexual activity of drug users is characterized by a variety of sexual partners practicing 'non-traditional' forms of contact (oral sex, anal sex) without using means of protection (Grigoryan, Mkrtychyan and Davidyants 2002).

According to the results of 2002 Second Generation HIV Surveillance, 64% of those IDUs who have history of STIs are married and 74% do not use condoms; 55% have had more than one sexual partner in the past year. Nearly 14% have reported having sexual partners who are also IDUs. It is worth noting that only one-fourth of those who had a history of STIs reported condom use, and 60.5% of those married had a history of hepatitis B or hepatitis C. Ninety-one percent (91%) of those surveyed were sexually active; 64.5% have more than one sexual partner during a year and only 28% use condoms. Fifty-four percent (54%) of those married reported having more than one sexual partner in the past year. These results imply a significant possibility for overlapping modes of transmission.

The findings of behavioural surveillance revealed that two thirds of the surveyed IDUs are young people under the age of 34, the majority of whom (81.5%) started to use drugs between the ages of 15-29. Sixty percent (60%) of those surveyed started with injecting drugs. Roughly 70% of the respondents started drug using with opiates, 27% with heroin. According to that study, individuals are trying injection drugs at younger ages. Thus, while five years ago the majority of injecting drug users (50%) started injecting drug use at the age of 30 and older, in 2001-2002 almost half of injecting drug users (49%) started injecting drug use at the age of 20-24.

According to the results of epidemiological surveillance conducted within the 2002 Second Generation HIV Surveillance, HIV prevalence among IDUs is in the range of 11-20%, which constitutes the average of 15% (Grigoryan, Mkrtychyan and Davidyants 2002).

I.3.3.2. Sex Workers

Research conducted in 2000 within the framework the Sentinel Epidemiological Surveillance show that CSWs represent the group that is most vulnerable to HIV (Grigoryan, Mkrtychyan and Davidyants 2002). As in many other countries, CSWs in Armenia are conditionally classified into several groups:

- street CSWs (CSWs wait for their clients in a specified places of the town);
- mobile CSWs (CSWs leave for foreign countries for the purpose of prostitution, whereas they are not engaged in the same activity in Armenia);
- elite CSWs (CSWs contact their clients directly, without intermediaries, mainly by cellular phones, and they travel with their own cars);
- middle-rank CSWs (contacts with clients are mainly established through pimps or by calls to houses, without going onto the street).

Commercial sex workers who emigrate go abroad for sexual work consciously with the aim of earning more money.

According to surveys conducted among CSWs (all women):

- only 71% use condoms;
- one out of three married CSWs does not use a condom;
- almost half of the CSWs have contracted, at some point in time, an STI or had inflammations of genital organs;
- clients of every third CSW are married men;
- 46% of inquired CSWs have permanent clients;
- 23% are married;¹⁴
- 93% of inquired CSWs live in urban areas;
- 44% of the CSWs and the 59% of the general population are in favour of brothels;
- 34% of the CSWs prefer to be left alone, that nobody shows interest in them.

The main reasons for being engaged in sex work are economic: unemployment, unavailability or incompleteness of social services. Forty-two percent (42%) of CSWs list sex work as their main source of income.

According to reports from the Department on Combat against Illegal Drug Trafficking, there are nearly 1,800 (female) commercial sex workers in Armenia, half of whom are in Yerevan. However, research shows that a more realistic estimate is nearly 7,000-8,000 (Grigoryan, Mkrtychyan and Davidyan 2002).

Eleven percent (11%) of the CSWs¹⁵ have drug usage experience, and 4.4% of them have experience in injecting drug usage. During sexual contacts, CSWs regularly use alcoholic beverages (73%), psychotropic medicines (14.3%), and/or drugs (7.2%).

Most street CSWs are under strict control (including registration) of the relevant bodies from the Ministry of Internal Affairs and Ministry of Health. Commercial sex work is largely concentrated in saunas, hotels, motels, and similar places, which are practically used by all of the above-specified groups of CSWs (less control is observed over mobile, elite, and middle-rank CSWs). The attitude of various sectors of society towards CSWs is mainly one of tolerance. The overwhelming majority does not create obstacles for this key population to receive assistance, treatment or free information, which implies that society is more tolerant of sex workers than it is of other key populations such as IDUs and MSM.

Within the framework of 2002 Second Generation HIV Surveillance, research was conducted in this group as well. In general, HIV laboratory testing was conducted among 250 CSWs aged 15-49 (staged cluster sample), only three of whom tested seropositive. Behavioural surveillance was conducted among 268 CSWs with an average age of 26.5.

¹⁴ Please note, that this a different survey from the 2002 Second Generation HIV Surveillance, whose results are discussed in section 4.1, where the suggested figure is 7%.

¹⁵ Please note, that this a different survey from the 2002 Second Generation HIV Surveillance, whose results are discussed in section 4.1.

The absolute majority of CSWs (98%) indicated that using male condoms during sexual contacts can prevent HIV transmission, though only 48% of them always use condoms; 74% of those who do not use condoms have had STIs in the past year. Fifty-five percent (55.5%) of CSWs residing in Yerevan and 45.5% of CSWs residing outside of Yerevan (of whom 16% reside in rural areas) consistently use condoms when providing their services. Their knowledge of safer sexual behaviour and HIV transmission and prevention is higher than among other surveyed key populations considered to be at high risk.

According to the same survey (2002 Second Generation HIV Surveillance) 17% of the surveyed CSWs have used drugs. During sexual contacts, 5.5% of CSWs use drugs and 97% of CSWs use alcohol, which further increases their risk. Seven percent (7%) of those CSWs surveyed are married, and among those who are married only 63% use condoms consistently. This behaviour increases both their and their spouse's risk for HIV (Grigoryan, Mkrtychyan and Davidyants 2002; Manukyan, Grigoryan and Hakobyan 2004; Grigoryan, Manukyan and Hakobyan 2004).

Although the statistics mentioned in this section on CSWs were taken from surveys conducted among female sex workers, some MSMs also engage in sex work (please see section below). No information, other than the one mentioned below, is available regarding male sex workers.

I.3.3.3. Men who have sex with men

Voluntary and anonymous HIV testing was conducted in 2002 among fifty MSM, none of whom tested seropositive (the individuals were identified by the method of 'snowball') (Grigoryan, Mkrtychyan and Davidyants 2002). It is noteworthy that public opinions on homosexuality are rather tough: traditional Armenian society rejects displays of non-heterosexual relations. It is also important to note that until a new criminal code was adopted (on 18 April 2003), same-sex sexual contacts between men was a criminal offence, punishable by imprisonment for up to five years.

Until 2003, when the given article was excluded from the Criminal Code of the Republic of Armenia, homosexuals were registered with the state, and according to data provided by the Ministry of Internal Affairs (also referred to as 'the Police of the RA'), there were 21 'registered' male homosexuals. It is thus not surprising that information related to MSM is rather limited, reflecting the traditionally negative attitude of society towards homosexuality, and the criminalisation of MSM.

In response to surveys about sexual behaviour conducted among students attending higher educational institutions in Yerevan, 5% of them answered that they have casual or permanent homosexual contacts (further indicating that the number of 'registered cases' does not reflect the actual situation).

Of those surveyed within the Second Generation HIV Surveillance study in 2002, 76% of the MSM surveyed had their first homosexual contact between the ages of 7-15 (with probably no sufficient knowledge on HIV and AIDS). Among those, 12% were forced to have their first homosexual contact. The survey found that 92% of respondents have more than one sexual partner during a year, and 26.5% have a history of STIs. It is worth noting that only 18% of the MSM use condoms consistently. Twenty-four percent (24%) of the surveyed MSM reported that they provide payable sex services to males, and 46% of them had had more than one client in the month prior to the survey; 18% of those surveyed reported that they had experience with drug use.

The majority of the surveyed MSM (86%) started their regular sexual life (not necessarily sexual debut) at the age of 10-20, i.e. at the age of becoming more vulnerable to HIV infection (among women age 25-49, the median age of first intercourse was 20.5 years, Armenia DHS 2000). No comparative information exists on the relative age for heterosexual men in Armenia DHS or in other sources.

Not all men who have sex with men identify themselves as homosexual, like some of the students surveyed above for example.

Even after decriminalisation of sexual relationships between men, there still no 'gay' bars in Armenia. According to a survey performed by the NGO 'Education in the name of health,' due to the lack of acceptance of same-sex relationships by society, MSM tend to create closely knit groups in which they feel free to express their sexuality. Outside of these groups, however, MSM very rarely express their sexuality; some are married, some do not identify themselves as homosexuals, and many have not confided their sexual orientation to their families. A consequence of these close contact groups is that sexual relationships are kept within the groups, which increases the risk to HIV of the group if one member of the group becomes HIV positive. Currently, the HIV prevalence among MSM is considerably lower than

other key populations (IDUs, CSWs, etc.).

Marginalization of this key population also makes them unavailable for medical and social services, and makes it difficult for them to receive information or to increase their awareness, which puts them at high risk for HIV and other STIs.

I.3.3.4. Prisoners

In Armenia, mandatory testing of persons in penitentiary institutions was initiated in 1989. The first case of HIV infection among prisoners was registered in 1996. In general, from 1996 to 1 May 2000, approximately 1,800 persons in penitentiary institutions were tested, and fifty-eight individuals were HIV-positive (only fifteen of whom already knew of their HIV status) Due to the lack of Western Blot test, it was not possible to do provide a definitive diagnosis for the majority of those tested (Grigoryan, Mkrtychyan and Davidyants 2002).

In 2000 within the framework of the Sentinel Epidemiological Surveillance project, 182 persons in penitentiary institutions who are members of key populations (MSM, IDUs, individuals with STIs and clinical symptoms typical of AIDS, e.g. tuberculosis) were tested. In the result of the testing HIV prevalence was reported in the range of 8.8%, with the highest rate registered among MSM (they identified themselves, 10.1%) and the lowest rate among the injecting drug users (5.8%) (Grigoryan, Mkrtychyan and Davidyants 2002; Ohanyan, Grigoryan and Hakobyan 2004; Grigoryan 2004).

According to data from the biological surveillance conducted in 2002, within the framework of the Second Generation HIV Surveillance in the Republic of Armenia by the NCA, with the support of UNDP and UNAIDS, twenty-four out of 438 individuals tested for HIV in penitentiary institutions were seropositive (staged cluster sample). Therefore, the data estimated with 90% confidence that HIV prevalence among prisoners is in the range of 5.6%.

Although behavioural surveillance hasn't been conducted among prisoners, it is noteworthy that 7.5% of all seropositive cases had worked abroad and 10% were former IDUs. Furthermore, the majority of seropositive individuals who had worked abroad had lived temporarily, and probably become infected with HIV, in the Russian Federation or Ukraine (the main destination countries of migration). It must be taken into account that without appropriate HIV-prevention education and/or sufficient HIV and AIDS knowledge, HIV-positive prisoners returning from penitentiary institutions to their regular places of residence may further facilitate the spread of HIV through their sexual partners (Grigoryan, Mkrtychyan and Davidyants 2002).

Despite the fact that TB is currently one of the most urgent problems in penitentiary institutions throughout the former Soviet Union, there are no publications concerning TB prevalence studies in penitentiary institutions in Armenia.

I.3.3.5. Youth

Youth are one of the key populations most vulnerable to HIV (according to the UN standards, 'youth' are defined as people between 15-24 years-old). The period of transition during the last fifteen years opened borders, and introduced new values and opportunities. However, these changes have been accompanied by stress and abrupt changes of accepted morals; youth are the most active carriers of these changes. As a result, many young people begin to use drugs 'out of interest' (UNICEF 2002). Behavioural HIV Surveillance conducted in 2000 revealed that 53% of IDUs began using drugs between the ages of 15 and 24 (Grigoryan, Mkrtychyan and Davidyants 2002).

The vulnerability of youth to HIV is particularly evident from the perspective of their overall lifestyle choices regarding health, and how they internalise information about risky behaviour in general. As a rule, risky habits such as smoking and experimental or ongoing alcohol and drug use constitute a real danger to one's health and are more typical of young people in Armenia than of representatives of other social groups here. The results of surveys conducted in 1999 by Yerevan State University, Department of Sociology, show that today following a healthy lifestyle is less of a priority for youth. These trends are attributed to social and institutional crises in the public health and mass media sector, and how that has impacted the process of socialisation among this generation.

According to the same survey, young Armenian female graduates prioritise a healthy lifestyle in discourse, but not in practice. Their behaviour in relation to exercise, nutrition, stress, and how they spend

their free time does not guarantee a healthy lifestyle (Arakelyan, 1999). The fact that female students have a negative attitude toward cigarettes, alcohol, and drugs may be attributed to the strong influence of cultural norms and traditions. At the same time, the findings of another study conducted in 2003 among the students (men and women; sample size 500) of higher educational institutions in Armenia, showed that 87.6% of those surveyed young people used alcohol during the last year and 70.8% used alcohol during the last month (UNDP/DMS 2004). (No information is available specifically for male students).

According to another survey that was designed to assess both the extent and pattern of consumption of different drugs in students, as well as the characteristics and behaviours of users, the frequency with which youth use different substances varies according to substance. Unfortunately, this data was not analysed from the perspective of gender differences.

Table 4. Frequency of drug use by youth

Drugs	LTP*	LYP*	LMP*
Hashish or marijuana	19.4%	71.9%	45.8%
Ecstasy	3.6%	94.4%	33.3%
Amphetamines	2.8%	78.6%	57.1%
Cocaine	3.2%	68.8%	25%
Heroin	1.4%	85.7%	57.1%
LSD	1%	60%	40%
Sedatives or tranquillizer	-	33.5%	21.2%

- * LTP - lifetime prevalence
- LYP - last year prevalence
- LMP - last month prevalence

Unfortunately, the information on the issues differences between men and women, drug use stigmatisation, is not included in the report we have used as a source.

According to the same survey among students:

Those who perceive drug users as criminals	5.6 %
Those who perceive drug users as individuals in need of medical attention	49.2 %
'People should be permitted to take hashish or marijuana'	8.2% fully agree
	48.5% fully disagree
'People should be permitted to take heroin'	3.8% fully agree
	65.7% fully disagree
Attitudes towards those who try ecstasy once or twice	25.5% disapprove
	59.4% do not disapprove
Attitudes towards those who try heroin once or twice	30.7% disapprove
	46.6% do not disapprove
Attitudes towards those who occasionally smoke marijuana or hashish	31.9% disapprove
	43.9% do not disapprove
Considered risk in smoking marijuana or hashish regularly	2.6% no risk
	74.5% great risk
Considered risk in trying cocaine or crack once or twice	4.6% no risk
	65% great risk

Among those surveyed, 47.4% are aged under 19, 49.1% are aged 20-24. Approximately 70.9% of those surveyed reside in Yerevan, 22% reside in other cities and 5.9% reside in villages (UNDP/DMS 2004). The level knowledge of these students on HIV modes of transmission and prevention, and thus how their extend of drug use puts them at risk has not been studies.

According to Buckley (2004):

‘A recent Demographic and Health Survey in Armenia (2000) enables the exploration of information channels used by young Armenian women (15 to 19) for reproductive and sexual health issues. The Armenian DHS employed a large-scale nationally representative sample of women between the ages of 15 and 49, who were sampled within households across the country. I examine the self reports from women 15 to 19 in Armenia regarding exposure to family planning in the media (newspapers, radio, and television), discussions of family planning with their peers, discussions with family members, or information gained from medical personnel to answer three questions. First, have previous public health programs expanded the available channels of health information for young women? Second, can individual characteristics help predict patterns of information access and reliance among young women? Lastly, is there a relationship between the sources of information relied upon and levels of reproductive and sexual health knowledge? Examining these issues in Armenia can test the relevance of previous studies pointing to the high reliance and low accuracy of peer networks among young adults and clarify the extent to which other channels (the media, family, medical personal) are being effectively employed.

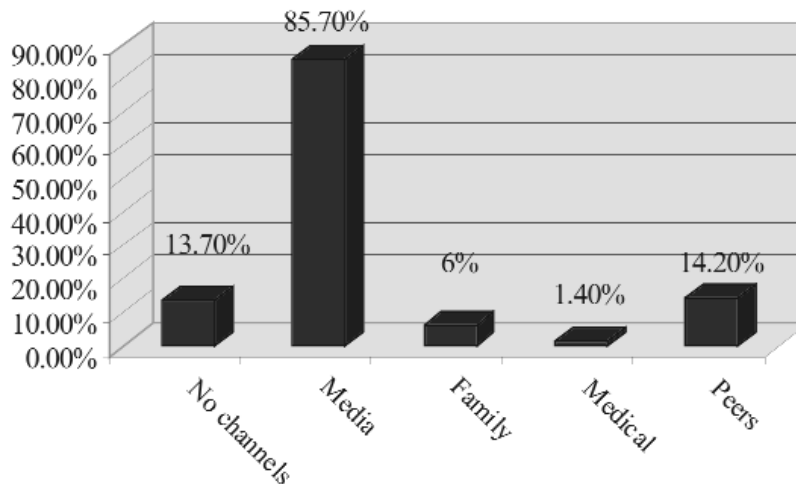
Access to information channels are measured using the answers to questions regarding whether respondents recall seeing, hearing or reading information regarding family planning programs in the media (television, radio, or newspapers respectively), discussing family planning with family members (sisters, mothers, mother in laws, fathers, brothers, other family members), obtaining family planning related information from medical personnel (including special school courses), or from peers (friends and neighbors). While the focus on family planning alone is imperfect for assessing all information channels regarding sexual health, it does serve as a reliable indicator of communication networks related to reproductive and sexual health. Since the Cairo conference in 1994, sexual health issues have been viewed as a major component of overall reproductive health programs. Tracing communication patterns regarding family planning should provide reliable indicators of overall reproductive and sexual health communication channels.

More than one of ten young women between the ages of 15 and 19 in the 2000 Armenian DHS reported they had not heard of family planning programs in the media or discussed the topic of family planning with peers, medical personnel, or family (160 of a total of 1168). Over 86% reported accessing family planning information from one or more of the channels measured. As seen in Figure [Four], among young females reporting some contact with family planning issues, the vast majority reported hearing, seeing, or reading something about the campaigns in the media. Media campaigns reached over 85% of all females respondent between the ages of 15 and 19, although no information regarding the extent or depth of their media exposure was gathered. Actively discussing family planning issues was reported by far fewer young adults. Only 6% of all young women reported discussing family planning with any family member and less than 2% had engaged in any formal training or discussions with medical personnel. As found in other countries, conversations concerning family planning occur most often within peer networks, with nearly 15% of women between 15 and 19 reporting such conversations. Peer networks provide the most significant active information channel for information regarding reproductive and sexual health in Armenia.’

The author indicates that the patterns of information reliance and efficacy found in other nations are similar to those found in Armenia. Discussions of sexual and reproductive health issues are more likely to take place among peers than with parents or medical personnel, even though young women employing these information channels appear better informed than their peer-based counterparts. In Armenia specifically, a sizable proportion of young women aged 15 to 19 are not accessing existing channels of information, or are exposed to them only in passing via media programs. Expanding the focus of present programs to reach young women not yet exposed to reproductive and sexual health information channels is vital, and should consider a focus on young working women. Building on relatively high rates of media access to include ethnic minorities is also justified. As reliance upon peer networks for information is found across social groups, efforts to expand peer discussions while improving the accuracy of the information shared is critical. As of yet, family and medical networks appear woefully under-utilized and careful consideration of their possible expansion, particularly to young women who are not yet sexually active, is clearly justified. Lastly, young women can only benefit from expanded choices in information channels if overall efforts concentrate on raising knowledge in the areas of reproductive and sexual health. The observed levels in Armenia are cause for immediate concern.

Figure 4 (Borrowed from Buckley 2004)

Percent of Young Women (15-19) Employing Channels of Reproductive Health Information, Armenia 2000



Increasing access to existing information channels, emphasising and expanding those channels that appear most effective, and improving the efficiency of information provided through peer networks can significantly improve program efficacy in Armenia. Further evaluations focusing on the patterns of information access and the persistence of peer reliance in Armenia and the Caucasus is important as it assists in identifying groups excluded from the benefits of reproductive health campaigns.

According to a counsellor during a radio interview: 'The reason for high vulnerability to HIV is the students' lack of awareness about HIV and AIDS, knowledge about prevention, and the risky sexual behaviour they practise. In general it is evident that the youth need accurate information, as the information provided is either not concrete, or it is not spoken on these issues in families and in schools at all,' (Hotline counsellor from the programmes of the Ardzagank radio station, 2000).

According to the results of the 2002 Second Generation HIV Surveillance in Armenia (500 young people between the age of 15-29 were surveyed, 40% of whom were sexually active), only 32.5% always use condoms, 15.5% have experience in drug use, and 60% have more than one sexual partner during a year (Grigoryan, Mkrtychyan and Davidyants 2002). It is noteworthy that in comparison with results from the 2000 survey, the number of those using condoms has not changed significantly (32%), while the number of those using drugs has grown by 4%. The number of youth within key populations at a particular risk to HIV is significant: they form the majority of IDUs and CSWs. In particular, 70.5% of CSWs are under the age of 29, and two-thirds of IDUs are under the age of 34. According to the results of the same survey two-thirds of youth have more than one sexual partner, only one-third always use condoms, and approximately 5% sometimes or always engage in homosexual relations. According to cultural and familial norms regarding virginity, young girls are prohibited from engaging in pre-marital sexual relationships. For this reason, having a regular partner is not accepted behaviour among single youth, a factor that can increase the risk of HIV (Grigoryan, Mkrtychyan and Davidyants 2002).

The delay of the first sexual contact until marriage, and correspondingly to an older age (in Armenia that age is 22.5 for women) (Armenia DHS 2000) may reduce the possibility of an HIV infection as it increases the probability that at this later age girls are better informed about means of prevention. As in other key populations the majority of Armenian youth think that they cannot be infected by HIV (Grigoryan, Mkrtychyan and Davidyants 2002).

At the same time, youth most often mentioned the existence of the danger of infection (49%) (Grigoryan, Mkrtychyan and Davidyants 2002).

Summing up we can say that raising the level of awareness on STIs, HIV, and AIDS and safer sexual behaviour among youth is one of the primary issues for HIV prevention.

I.3.4. Sexual Education

Sexual education is central to promoting safer sexual behaviour among teenagers. Sexual education programmes should include not only distribution of condoms and provision of knowledge, but also information on abstinence, modes of prevention and transmission of HIV and other STIs, as well as cultural moral norms concerning fidelity.

While this section focuses on teenagers, they are not the only group of the population in need of sex education. However, as discussed above, they carry a high vulnerability to HIV.

According to the NCAP director: 'Nowadays, sexual education is limited to the promotion of condom use, which is also very important, but [...nothing is said] about the existence and necessity of feelings, starting sexual life in [due] time, the danger of STIs, their prevention, and so on. Sexual education is one of the main issues of our society. Sexual life is a constituent part of culture of the society, the reflection of its social and moral condition. It's not difficult to imagine the condition of that culture in the state of existing psychological, social, and financial pressure, when [an] individual's physical and mental health undergoes serious trials, which influence sexual behaviour. In a number of European countries sexual education is started at the age of seven. To my opinion, sexual education must be [a] constituent part of the school programme in our country. Some teenagers have their first sexual intercourse at school age. That's why it is necessary [to be aware of...] sexually transmitted infections and undesirable pregnancy. Unfortunately, today our youth remains vulnerable to HIV.'

S. Grigoryan

Interview, 'Sexual education is an inseparable part of sexual health, Eros journal, 2000

Since 1999, a 'Life skill' course has been introduced for grades one through seven (pupil ages 6-13) in 282 secondary schools in Armenia. In 2004, the number of courses offered increased by seventy. The course is directed at an individual's socio-psychological education and toward promoting awareness of their social responsibilities. This is the first programme that clarifies the significance of cultural values regarding all spheres of life aside from subject knowledge, and which tries to form a system of values. The sexual education content is addressed to sexual hygiene, delaying sexual activity, preventing unwanted pregnancy, etc.

Within the framework of the National Programme on HIV/AIDS Prevention, the 'HIV/AIDS prevention and formation of safer behaviour' course has been developed for pupils in grades eight and nine (ages 14-15) of secondary schools. There is no information for a nation-wide adoption of this course.

Such a course is needed to educate youth about the current health risks they face from alcohol use, smoking, drug use, violence, HIV infection, and STIs. Unplanned pregnancy with its undesirable consequences (such as illegal abortions, in most cases not in proper clinics, which leads to many infections) has become more frequent (manual, 'HIV prevention and formation of safer behaviour,' by S. Grigoryan, A. Topuzyan, A. Muradyan). Arming the young generation with the appropriate knowledge to pursue a healthy lifestyle, and the skills to withstand peer pressure and make informed decisions, can reduce unwanted pregnancies and other health risks. Teenagers must be able to negotiate and to orient themselves correctly (in relation to social norms) in different situations in favour of sexual and reproductive health protection. An individual's viewpoint is formed on the basis of information he/she possesses.

For a long time discussing sexual life with teenagers was viewed as taboo, in part due to concerns that such discussions could drive teenagers into engaging in sexual activity at an early age. Estimates from the Ministry of Education have shown, to the contrary, that following accurate sexual education, youth begin their sexual relations later and practise safer sexual behaviour. Contrary to the aforementioned concerns, informing teenagers about safe sex and the benefits of abstinence does not necessarily lead to experimenting. In many cases, it protects in dangerous situations. Openly discussing matters of sexual health helps teenagers conclude that sexual relations require maturity and mutual desire, and cannot be forced by environmental or peer pressure. Such sexual education is particularly important nowadays, when the spread of STIs and HIV infection is rampant. When sexual partners are unaware and inexperienced, risks and vulnerability to HIV and other STIs, and pregnancy rise. The educational system must actively develop different coping mechanisms regarding various issues of sex and sexuality for students from an early age.

Including healthy lifestyle and sexual education components in the curriculum is a universal vaccina-

tion against life-threatening infectious diseases. Such guidance can protect teenagers and adults from practising risky behaviour, as well as from harbouring prejudices and misconceptions concerning individuals living with STIs.

The objectives of the course are:

- to contribute to prevention of HIV, STIs as well as spread of drug use;
- to arm youth with necessary knowledge on preventive methods of HIV and STIs, and with the skills necessary to apply such knowledge in the face of social pressure;
- to form responsible behaviour directed to protection of health;
- to form tolerable non-discriminative attitude toward people living with HIV.

The course has been envisaged by the National Programme on HIV/AIDS Prevention, and developed by the specialists of the Ministry of Health and Ministry of Education of the RA. Its introduction is currently implemented by the NGO 'SAMSA.' As the course is still in the introduction stage, it is difficult to speak about the groups that do or may oppose it, or about the role of mass media and the attitude of families toward it.

I.3.5. Migration and AIDS

The last decade of demographic movements caused serious problems for Armenia. Since 1998 migration in Armenia has primarily consisted of emigration, mainly to other countries of the former Soviet Union. The main reason for migration is the socio-economic condition of the population: poverty.

According to official statistical data (National Statistical Service) nearly 700,000 people migrated from Armenia in 1991-1997 (nearly 18% of the total population), 59.5% of whom were men and 40.5% of whom were women. Many Armenian families have chosen migration as means of adaptation to the new socio-economic conditions, to support themselves and their families. Estimates show that one out of four families has a migrant member. As a rule, they are men who return to the family from time to time, and leave again to continue earning money. Living for many years abroad and having irregular sexual contacts, they and their wives become vulnerable to HIV and AIDS. According to another source migration is mainly directed to the CIS countries, especially Russia (75% of emigration) and Ukraine (12% of emigration) where it is believed that migrants' vulnerability to HIV is preconditioned by their work conditions in the host country, by the attitude of the population in that country towards migrants, and by the obstacles they face living and working illegally there (Grigoryan, Sargsyan and Harutyunyan, 2002).

Table 5. Inter-country migration (thousand people) (National Statistical Service)

	Emigrants	Immigrants	Net population Migration (+, -)
1998			
<i>Total</i>	8.8	1.6	-7.2
<i>Including CIS</i>	8.1	1.6	-6.5
1999			
<i>Total</i>	8.6	1.7	-6.9
<i>Including CIS</i>	6.9	1.4	-5.5
2000			
<i>Total</i>	12.0	1.6	-10.4
<i>Including CIS</i>	11.1	1.2	-9.9
2001			
<i>Total</i>	11.9	1.6	-10.3
<i>Including CIS</i>	10.7	1.5	-9.2
2002			
<i>Total</i>	10.9	1.7	-9.2
<i>Including CIS</i>	8.5	1.1	-7.4

The state does not have any official data on migration. However, it is worth noting that people (students, businessmen, young families, and so on) move from villages to cities, and mainly to the capital.

Diaspora is an important factor in the Armenian migratory process, which is expressed in the growth of the tourist industry during recent years, which includes Armenians living abroad who return as tourists (especially during the summer season). 'One of the main negative consequences of development of

tourism is the fear of HIV spread. Such fear mainly prevails in people [aged] 55 and more (35%), then come young people [between] the age of 18-24 (21.6%).’ (Periodical journal, *Rating*, November 2001).

To cope with the conditions of hardship in which emigrants live and work, they often engage in behaviour that may put them at risk to HIV, such as seeking the services of CSWs or using drugs. Research shows that 43% of surveyed drug users began using drugs abroad, 64% of whom while in the Russian Federation (Grigoryan, Mkrtchyan and Davidyants 2002). Additional vulnerability to HIV arises for individuals who are undocumented, and, as a result, do not have access to medical services. Even among those who are legally registered immigrants, these services are often difficult to access or are too expensive. Without sufficient knowledge about HIV and AIDS, many migrants have the misconception that having unprotected sexual relations with someone who is not a CSW will not potentially expose them to STIs or HIV (Grigoryan, Sargsyan and Harutyunyan, 2002).

According to 2000 Sentinel Epidemiological Surveillance conducted in Armenia, with regards to the migrant population:

- 31% of migrants always use condoms.
- 38.3% report having more than one sexual partner in the past year.
- 11.5% have experience in drug usage, 2.6% in injecting drug use.
- 24.7% suffered from sexually transmitted diseases during their lifetime (Grigoryan, 2004a).

High rates of migration have also had a serious impact not only on the demographic condition of Armenia, but also on rates of marriage, which are less than half (UNDP 2001). It also weakens the basis of family relations.

1.3.6. Poverty and HIV/AIDS

Poverty influences the possibility of being infected with HIV, and can increase the individual’s vulnerability and risk for HIV infection. Very often poverty supposes a lower level of education, poor access to, and awareness of, effective means of HIV prevention, lack of health care treatment, and negative coping behaviours (drugs, alcohol). It is generally accepted to call HIV and AIDS ‘disease of the poor’ (Grigoryan, Sargsyan, Harutyunyan, 2002).

One method for measuring poverty is with indicators that describe *absolute poverty*. In Armenia these indicators were first defined in 1996, based on the results of a survey about types of housekeeping. The following distinctions are made about the population according to three main subgroups – extremely poor, poor, not poor.

Poor: Households are considered to be poor when consumer expenditure of one person is less than the minimal ‘basket of goods’ of 11,735 drams cost (22 USD), in 1998-1999. This is considered the *absolute line of poverty*.

Extremely poor: Households are considered to be extremely poor when consumer expenditure of one person is less than the minimal food basket of 7,194 drams cost (13 USD). This is considered *food line of poverty*.

Table 6. Dynamics of main indications of poverty of general population in Armenia (National Statistical Service)

	1996	1999	2001
	%	%	%
Number of poor population	54.73	55.05	50.9
Number of very poor population	27.67	22.91	16.0
Depth of poverty	21.5	19.0	6.1
Severity of poverty	11.1	9.0	6.1
JINI coefficient according to the profit	0.65	0.57	0.53
JINI coefficient according to expenses	0.44	0.37	0.34

Besides absolute poverty, **relative poverty** is also a criterion for evaluation of poverty in Armenia. JINI coefficient is the indicator of the relative poverty and it describes the degree of inequality and polarization of profits and expenses within society. It is between 0-1, in the lowest level of which we deal with

the total equality of profits and expenses of all the population groups, and in the highest, total inequality.

The data of 1996, 1998-1999 is taken from the National Statistical Service of the RA, and the data of 2001 is based on the survey on education, poverty, and economic activity conducted within the framework of the programme implemented in cooperation of the UNDP and the government.

In comparison with the CIS countries, Armenia bears the highest level of poverty. The economic situation is worse in the Shirak and Lori Marzes disaster area (areas where earthquake occurred in 1988), and where the specific gravity of population under the poverty line is 60%. The social tension is especially high in Shirak Marz, where the poor constitute 73% of the population, and in Lori Marz, where the poor constitute 64% of the population. It is noteworthy that HIV prevalence is the highest in these Marzes.

Furthermore, HIV antiretroviral treatment is not yet available in Armenia due to the high cost involved. As mentioned earlier, the situation is expected to change in 2005 during which 20 people with AIDS will be provided with ARV treatment medication through the programme supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In spite of rather stable economic indicators in recent years, Armenia has failed to direct economic growth to wider layers of the population. In reality, such growth has not contributed to poverty reduction. Levels of unemployment and poverty remain high, especially among women – especially among women with children - although no references are available to support this claim.

Trafficking of women

Women's poverty and unemployment are the main factors driving behaviour that puts them at risk, especially commercial sex work, sometimes as a result of forced trafficking. During the Soviet era, Armenian citizens mainly knew about trafficking and slave labour only through history textbooks. Following independence, however, a growing number of citizens were directly drawn into illegal trafficking of humans, and trafficking continues to grow to significant proportions. As defined by the UN, trafficking refers to instances when someone is taken across international borders for the purposes of exploitation. While such exploitation is not limited to sex work, for the purposes of this report we emphasize the HIV risks associated with trafficking, which are closely linked with sex work. Armenia is mainly a transit point and a source of trafficking of women. The following countries are the main receiving areas of trafficked women: United Arab Emirates, Turkey, western European countries, former socialist nations, Transcaucasian countries, Germany, Greece, Russia, Ukraine, and the United States of America. The causes of trafficking include: the opening of the borders and poor border regulation, economic crises and poverty, and government corruption. Men, women, and children can fall victim to trafficking. However, women are more at risk in this process and are more unprotected and vulnerable.

According to research conducted by the International Organisation for Migration in Armenia and the NGO 'Business Woman', women migrate mainly because of their grave economic situation, with the aim of finding a well-paid job abroad and solving their economic problems. Some go abroad knowing that they are going to earn their living by entering commercial sex work (IOM 2001). The same research also shows that the rates of trafficking children is on the rise. Among those surveyed by the IOM were teenagers who had been exposed to trafficking (Petrosyan, 2003). One respondent to the survey, who was a victim of trafficking, testified that fourteen girls between the ages of 13-23 went to Dubai with her, and that there were twenty-seven girls with the woman in charge, who had come from orphan's homes and the streets.

Teenagers are a big source of profit in the trafficking business, as the demand for virgin girls – a demand connected with fears to HIV infection – has greatly increased in receiving countries (Petrosyan, 2003). There is no concrete data on the volume of this problem, as statistical data does not exist. Neither the police, judicial bodies, nor Armenia's embassies collect official data about this issue. During a three-day visit to six nightclubs in Dubai, participants in an IOM research team found sixty Armenian women and children. Conversations with them revealed that the problem is even bigger – there are many more trafficked Armenian women and children in Dubai than the sixty who were found. It is estimated that each year 2,000-3,000 women become victims of trafficking. When a woman is trafficked, she often has serious reproductive health problems and is put at high risk for HIV (and thus possible further transmis-

sion). According to some sources, women are often forced to have sexual contacts with as many as twenty clients every day, all without condoms. Those who control trafficking prohibit these women from using condoms, which thus explains the higher rates of HIV and other STIs prevalence among this population. Moreover, they are prevented from seeking medical attention, and often undergo unsafe abortions. According to the report, '10 years of transition,' one-third to one-fourth of deaths among women were the result of abortion-related complications (UNICEF 2001).

Poverty, Trafficking and Sex Work

The issues of trafficking, sex work, and poverty are interrelated. Even though one of the causes of sex work is trafficking, it is not accurate to say that rates of commercial sex work grow only because of trafficking. The majority of victims of trafficking join commercial sex workers upon their return to Armenia (Petrosyan, 2003). (Although this fact deserves further investigation, no further information is available as to why this phenomenon is observed.) As in the case of trafficking, there are no statistics on the real rates of commercial sex work in Armenia.

According to the results of research conducted by the 'Hope and Help' NGO, factors contributing to the spread of commercial sex work are: grave economic conditions, poverty of the general population, development of the sex industry, migration by male members of society, homelessness, a lack of family and religious education, and liberation from traditionalism. A survey conducted among 175 'street' and 'home-based' CSWs in Yerevan, Gyumri, Vanadzor, and Kapan showed that the main reason for commercial work is to secure income. [The 'record of service' of those surveyed showed that only 15% had been in this sphere of work for more than ten years, and 85% had been for eight years (correlating with the hardest economic crisis in Armenia, which occurred in the last ten years). Only 12% of respondents said commercial sex work was their preferred choice of occupation. According to the results of the same survey the level of safer sex practices (i.e. condom use) is rather low among CSWs.

Public opinion towards commercial sex is rather severe and negative. Armenian society, as in the case of other problems, reveals a classical duplicity to this question as well: a pseudo-liberal attitude directed outside (i.e., the 'external,' liberal world, outside Armenia) and patriarchal-punishing attitude directed inside (Armenian society). By 'outside' we mean the external liberal world, and by 'inside' we mean the Armenian society (Consolidation of democracy. The civil society in the perspective of globalization. Yerevan, 2003). One of the CSWs who participated in the aforementioned survey reported that when she became a commercial sex worker, a year later her mother decided to be her 'pimp' so that they would not have to share the income with others. The attitude of family members towards her is positive; she is respected and appreciated as an income-earner (Petrosyan, 2003). She is regularly tested in the STIs diagnosis center of 'Mnecins Sans Frontiers' and she receives a regular supply of condoms. According to another CSW, all her neighbours know about her occupation, but 'as she behaves well, does not drink or curse, does not bring men with her,' they treat her well. She said she had been infected with syphilis, as some of her clients persuaded or forced her to have sexual relations without condoms. After that incident she vowed to use condoms consistently.

So there is little stigma against domestic sex workers and there exists a double standard towards them. On the one hand there exist very restrictive and conservative sexual attitudes, and on the other hand it is justified by the fact that young boys are taken to them like a rite of adult passage.

I.3.7. HIV, AIDS and religion

The role of the church in HIV prevention is very important, as the church can promote safer behaviour concerning HIV and create a supportive environment for PLHIV. Similarly, as a respected and increasingly influential social institution, the Armenian Church wields significant power in social and political spheres. Currently, activities are implemented for including the church in HIV prevention. The 'HIV and AIDS and Church Involvement' seminar-training was initiated and conducted by World Vision (WV) Armenia in partnership with the Armenian Apostolic and Armenian Evangelical Churches as an introductory training-seminar for representatives of Armenia Apostolic Church (Yerevan) and Armenian Evangelic Church (Yerevan), theological gymnasiums (Echmiadzin, Sevan). The aim of seminar-training was to provide up-to-date information and increase awareness of church representatives about HIV and AIDS-related issues, and to demonstrate how religious leaders can play a role in responding to HIV and

AIDS by promoting HIV prevention. In particular, religious leaders are well positioned to carry out the following: promote abstinence before marriage and family fidelity and monogamy, advocate the fight against stigma and discrimination towards those affected by HIV and AIDS, and conduct peer education among other church members/priests. The main purpose of the four day training was to introduce the situation of HIV and AIDS in Armenia, and World Vision Armenia's response, in the framework of the 'Hope Initiative' project. (No information is available as to the relationships between the Armenian church and other Christian organizations such as World Vision and/or other NGOs)

The training left a valuable impact in preparing church representatives for future involvement in HIV and AIDS activities. The main achievement of the training was that church representatives became actively interested in the HIV and AIDS issue and recognized their key role in responding to HIV and AIDS. Training focused on key issues and points, especially those that intersect those regularly handled by church representatives in their work. However, the content primarily focused on abstinence.

Based on this training experience and evaluation, several recommendations have been made:

- provide follow-up training with more detailed focus on the principles of abstinence, family fidelity and monogamy as key strategies for HIV prevention;
- integrate churches from other regions of Armenia in HIV and AIDS training;
- conduct special training for preparing church activists as individuals who can provide necessary psychosocial support and counselling, and listen to confessions from an HIV- positive person, drug user or a CSW;
- prepare church representatives for public speaking about the dire need for safe sexual behaviour;
- prepare church representatives to work as community agents for reaching and mobilizing community in the response to HIV and AIDS;
- to develop and publish manual on HIV and AIDS and the church.

It is difficult to speak of the overall position and attitude of the religious community about HIV and AIDS related education (i.e. prevention, social support and stigma) as the involvement of the church in HIV and AIDS education has only recently started.

I.4. Public perception of HIV and AIDS

I.4.1. Knowledge on HIV and AIDS

One of the reasons for the rapid spread of HIV in Armenia is the lack of knowledge among the general population about the disease. According to data from the Demographic and Health Survey, nearly all women and men have heard about HIV and AIDS. However, only 62% of women and 73% of men think that the HIV infection is preventable (Armenia DHS 2000). Youth – those living in villages or those not married – are less inclined than their peers who are married and/or live in urban environments to think that HIV is preventable. There is a strong positive correlation between the level of education and the opinion that there are means for preventing HIV infection. According to the same source more than half of the men and one-fourth of women mentioned the use of a condom as means of protection. According to the 'HIV epidemiological surveillance in the RA' source, and the results of behavioural surveillance in different groups of general population (IDUs, CSWs, MSM, youth, pregnant women) a portion of those surveyed (with different percentage in different groups – varying from three to 28%) think that HIV can be transmitted through kissing, sharing dishes, using public toilets, mosquito bites, or through body fluids such as saliva, urine, tears, and sweat. While the both of the aforementioned research projects show that the majority of those surveyed know that condoms can be used during sexual intercourse to protect oneself from HIV, very few practise 'protected' sex; only 7% mentioned that they had used condoms during their previous sexual contact (despite the rapid rise in contraceptive use over the past fifteen years), 5% of men mentioned that they had two or more sexual partners in the last 12 months, and more than half of the men living in Yerevan and single men with a higher education mentioned having one or more sexual partners.

Confronting the results of this research concerning knowledge about HIV and AIDS, the authors conclude that verbally the population expresses some awareness concerning modes of transmission and prevention. However, according to the same research it is obvious that in practice, in a wide layer of society, there is not a general cultural tendency to engage in 'protected' sexual relations. If we take into account that heterosexual contact is the second highest mode of HIV transmission (accounting for near-

ly 40% of HIV infections) it becomes clear that informing the general population about why it is critical to practice safer sex is imperative for public health, and overall economic and social strength and growth in contemporary Armenia.

Concerning injecting drug use, which stands as the primary mode of infection, the results of the Second Generation HIV Surveillance reveal that although more than half of the surveyed IDUs (59%) are aware that the use of disposable syringes will dramatically decrease the spread of infection, only one-third of them do so. Furthermore, slightly less than 20% of those sharing syringes and needles know that HIV transmission can be prevented in this way (Grigoryan, Mkrtychyan and Davidyants 2002). It is important to note that the results of the survey testify to practising 'unprotected' sexual behaviour among IDUs, which increases the risk of spreading of the epidemic to other groups, particularly their sexual partners, who may not be IDUs. If we take into account that the progress of the epidemic to wider layers of society is connected with specific behaviour common to so called 'linking groups' and 'linking forms of behaviour,' then the situation in Armenia is favourable for the rapid spread of the epidemic. The majority of IDUs are married, 7% of CSWs are married and 17% of them have experience with drug use.

Among MSM, 18% mentioned having used drugs at least once, 56% mentioned using drugs more than once, and in 22.5% cases drugs were used through injecting methods. Furthermore, 6% of those surveyed are married, and 72% of them consider themselves to be bisexual.

Taken together, these factors increase the risks for spreading the epidemic to social groups beyond these 'key populations' (IDUs, CSWs, MSM, etc.), especially through heterosexual practice. In the publication, 'Domestic Violence in the Republic of Armenia,' where sociological data concerning domestic violence are presented alongside information on knowledge about reproductive health knowledge among the general population (in the frames of the survey, 1,625 respondents all over the Armenia were surveyed), it is mentioned that 38.3% of those surveyed demonstrate limited knowledge about reproductive health, which raises serious concerns (Akunk Center for Ethno-sociological Studies, 2002).

These findings show that although the general population is to some extent informed about means of HIV prevention, the majority of people surveyed along different social sectors remain vulnerable to infection. These trends are directly linked to socio-cultural traditions, patterns of sexual relations, and gender stereotypes.

The following commentary made by a television news commentator illustrates the popular attitude: 'In our country a [person living with HIV] is either unaware of his status, or avoids medical testing, as our society is not ready to accept such people. Today the typical Armenian family, and the child living there, who later becomes an adult, [is] unaware of [HIV/]AIDS [...]and means of [...]prevention]. Neither the parents, nor the school gives him at least minimal knowledge' ('H1' television, 2001).

A radio reporter conducted a survey on the question, 'Do you feel protected from AIDS?' as received the following answers:

- 'One must have strong will to avoid the disease; as for the necessary information, if you have desire, you will find it. Anyway, you cannot be protected for 100%' (a middle-aged woman).
- 'Donkeys are infected with AIDS. I feel 100% protected, and received information from the Internet' (a man older than middle age).
- 'I feel protected, but as for information, when you do not hear something for a long time, you forget it, it would be better to have more information on that theme' (a young girl).
- 'The problem is not of that size to be solved on governmental level. Unemployment is a more serious problem for our youth' (a female school headmaster).

Thinking that 'AIDS will not touch me,' people do not consider it necessary to change their behaviour, which at times puts them at risk to HIV. Almost one-third of surveyed CSWs, MSM, and pregnant women, and 18.5% of youth, think that they are not at risk of contracting HIV, even though they practise risky behaviour. And according to the words of a CSW published in *Siravep*: 'I consider myself protected from becoming infected with AIDS,' this demonstrates a typical attitude towards condom use among sex workers. She continued: 'I provide my 'clients' with high-quality condoms, which are very expensive, three to five U.S. dollars, but are very reliable. I always use condoms, with the exception of one case, when I was in love and we had the intention of a more serious relationship'. (*Siravep* monthly journal, 5 August 2002).

The lack of knowledge among the general population, especially knowledge about modes of HIV transmission, sustains and encourages inaccurate stereotypes and fear. These processes stigmatise PLHIV

in Armenian society. The results of surveys conducted among different 'risk groups,' youth, and general population (Second Generation HIV Surveillance 2002) show that large segments mistakenly believe that HIV is transmitted through kissing (18% among surveyed IDUs, 26% of CSWs), sharing meals (28% among surveyed CSWs), saliva (25% among surveyed CSWs, 24% among surveyed MSM), and mosquito bites (21.5% among surveyed pregnant women).

I.4.2. HIV and discrimination

Despite Armenia's participation in international conventions ratified to eliminate the social exclusion of and discrimination against PLHIV, and secure access to health care services, (Grigoryan, Sargsyan and Harutyunyan, 2002),¹⁶ PLHIV in Armenia continue to live with stigma and are denied access to state-funded ARV treatment. It is important to note that stigma is expressed in almost all layers of society, and in many forms. There exists *cultural stigma* against PLHIV, as they are identified with marginalized key populations – IDUs, MSM, CSWs – and considered 'immoral' from the viewpoint of public norms and standards, they are marginalised by society, and 'guilty' of their problems.

According to the Demographic and Health Survey conducted in 2000 in Armenia, only 10% of women and 13% of men think that a HIV-positive teacher should not be allowed to continue teaching. This opinion is related both to stigma and to ignorance about transmission routes (Armenia DHS 2000). In response to the question, 'If one of your family members is infected with the virus that causes AIDS, would you like to keep the fact confidential or not?' 16% of women and 26% of men responded in the affirmative, which testifies to a fear of being judged by society and by their local communities. According to the same source, the majority of people have not been tested for HIV, more than 73% do not want to be tested. This is related, in part, to the fact that ARV treatment is not available, to the fear of being judged, and by widespread assumptions that 'infection cannot affect me.'

According to the book. *Epidemiological HIV Surveillance in the RA*, which is based on research conducted in different key social groups, 18.5% of youth, 32% of MSM, and 100% of surveyed pregnant women said they do not consider themselves to be at risk of contracting HIV (Grigoryan and Papoyan 2004). At the same time more than 90% of those surveyed support discussions about HIV and AIDS in the mass media, and recognize that these discussions can help eliminate stigma. According to another survey conducted by NCAP, 44.9% of PLHIV had difficulties answering a question about whether they had ever felt stigmatized, which suggests that they had, and were uncomfortable discussing the issue. However, 12% of PLHIV felt discrimination mainly by the police (as a significant number of PLHIV are/were also IDUs) and their relatives. This circumstance is interesting because stigma is displayed in a full range of distances between social groups: relatives at one extreme, and the police at the other. It is noteworthy that cultural stigma against HIV emerged in our society before the HIV epidemic had made a significant impact, and that HIV and AIDS was accepted as an 'evil of [the] West.' Public discussions can change this attitude by providing accurate information about HIV and AIDS, organizing broad discussions among different layers of the society and raising overall awareness level of the population about HIV and AIDS.

'The appearance of Human Immunodeficiency Virus, HIV, and the disease caused by it, AIDS, sent several challenges to humanity at once. Besides being incurable, the disease had 'concomitant effect,' the society began to be separated into 'our' and 'their' [problem]. Representatives of the first group were those who were not infected, the second group, people living with it, whom the first ones could discriminate [against]. The representatives of the first group decided that they must be protected from the incurable disease and couldn't find a better way than isolating the [ones living with HIV]. It received different expressions: to dismiss PLHIV and their family members from work, educational institutions, to refuse providing them with medical services, to expel them from their places of residence. There were even cases of murder. However, discrimination in the sphere of HIV and AIDS is looked upon as a serious violation of human rights, even if we forget, that from 'we' to 'they' is not too far.'

¹⁶ Particularly, 'Universal convention on human rights,' 'International covenant on civil and political rights' (Armenia joined on 1 April 1999), 'International covenant on economic, social and cultural rights' (Armenia joined on 9 June 1993), 'International covenant on the elimination of all forms of racial discrimination' (Armenia joined on 29 March 1993), 'Convention on the elimination of all forms of racial discrimination against Women' (Armenia joined on 9 June 1993), 'Convention on the rights of the child' (Armenia joined on 1 June 1992).

Aravot daily, "We' and 'They,' The Borderlines are Too Relative.' 22 November 2003. Statement written by newspaper's correspondent.)

Yet most men and women are still willing to care for a family member with AIDS. In the framework of the TV program, 'Shant,' that was broadcast in 2003, a journalist surveyed people on the streets of Yerevan. The journalist asked, 'Would your attitude change if you learned that your friend was a person living with HIV or AIDS?' The results are the following:

- A woman of 45:** I will I will avoid him/her, but it will be a pity
A woman of 25: I will stand by him/her and will take care
A woman of 45: At once [things] would change, but I cannot imagine such a thing
A man of 45: I will be more careful
A woman of 30: He/she is a person, what's from that he/she is infected, it wouldn't change
A man of 50: If you love him/her a lot, it wouldn't change as it is a disease, and the person does not change from that
A man of 60: I would probably avoid him/her, I do not know
A woman of 45: Very negative
A woman of 25: I would try to do so that he/she will not feel that he/she is ill
A woman of 20: It wouldn't change for the worse
A man of 20: I wouldn't have body contact, in fear of infection
A man of 50: Negative, of course, the name is already awful
A woman of 35: You cannot say it if you do not experience it
A woman of 60: It probably wouldn't change, on the contrary, I will support him/her
A man of 45: When a person has flu, the relatives already treat him/her in another way
A man of 45: Very little, but it wouldn't remain the same
A man of 45: I would have no contact, no meetings with him/her, only would speak to him/her by phone
A woman of 40: If he/she is a moral person, I would die in his/her arms

The results of the survey show that the attitude of the population differs radically about having HIV-positive friends. Responses range from total isolation to willingness to care and support those people.

In the same programme, individuals living with HIV were also asked about how people respond to news of HIV infection among friends and acquaintances:

However, the opinion of PLHIV on the discrimination they face is less optimistic. One PLHIV who was called by phone and spoke online during the programme has said: 'Though they have mentioned that their attitude will not change, I do not believe that they are sincere, I say this from personal experience, the attitude of the surrounding [people] changes [as much as] 90%. That's the reason I did not come to take part in the programme. The only people who have remained faithful to me are my wife, my children and my parents. My friends and my relatives betrayed me. I was convinced that the opposite [would be the case], but time showed the reality [of the situation].'

Even though family ties remain strong, overall social tolerance is not high. During another survey, the reporter suggested a situation for the audience, according to which each of them must imagine that he/she is an employer who has announced a contest for a job, and has chosen one person from a variety of people. The person chosen considered it his/her duty to inform the employer that she/he was HIV positive. When asked if they would hire this individual, 35% of the respondents would not employ him, and 65% would.

A young girl explains her decision in that situation in the following way: 'First of all, I would think about my other employees. If a person has passed his moral limit once, I cannot be sure that he will not do it again. He will have physiological needs and I'm not sure that he will not make a suggestion to someone. And besides, even if the infection is not transmitted through casual contact, it is possible that he will cut his finger with a knife or some other way, and in this case there will be a danger. I believe that society should reject such people. Otherwise we are promoting the spread of AIDS. If we want to fight against the infection, we must isolate those people, as our hero is dangerous even for his family and children. If we isolate mentally ill people, thinking that they do harm to the society, we must isolate PLHIV as well.'

Other opinions:

'There is no need to come to extremes, I wouldn't take him/her, not because I think they must be isolated, but because I would think about the staff, as the staff will not accept him. Even if they do not know

now, in the country like Armenia they will learn about it tomorrow or in a month.’

‘I would take him/her, as I’m not sure that there is not another PLHIV among others who has hidden it. At least he was so honest as to say that.’

‘What must be done to a woman, whose husband became infected and transmitted it to his wife? Must she also be isolated?’

The presenter suggests a third scenario, in which the audience must imagine that he/she is sitting in a dentist’s reception room. A person comes out of his room, whom you are acquainted with and you know that he is HIV positive. When asked if they would continue to use his/her services, 80% would change their doctor and 20% would continue.’

In addition to *cultural stigma* there exists also *institutional stigma* against PLHIV, at the level of government, health, church, business and other public institutions. It is necessary to mention in this context that the law on, ‘Prevention of the disease caused by human immunodeficiency virus’ was adopted by the National Assembly of Armenia, asserting that being infected with HIV cannot be the basis for limiting his/her rights and freedoms (Grigoryan, Sargsyan and Harutyunyan, 2002). According to this law PLHIV have a right to a non-discriminative attitude, medical confidentiality, employment security, and access to counselling services, as well as education about HIV transmission prevention. PLHIV receive counselling about their rights when being informed about the diagnosis, in NCAP. Those PLHIV who cannot travel to the Center are visited by specialists from NCAP. Though there is not obvious institutional stigma, the indirect stigma (i.e. the absence of governmental means necessary for HIV antiretroviral treatment to PLHIV) is evident.

Together with external stigma against PLHIV self-imposed isolation also exists. In this case, a PLHIV changes his/her attitude towards himself/herself, considering himself to be ‘imperfect.’ Individuals avoid contacts with people out of fear of facing a discriminative attitude. According to the surveys conducted by the NCAP, nearly half of people felt distrust towards their own strength and became isolated after finding out their HIV status. After receiving a positive diagnosis 42% had personal problems and 20.4% had difficulties in contacts with people (Grigoryan et al 2002). Mass media in its turn have touched upon the necessity of elimination of discrimination against PLHIV.

‘When we display a discriminative attitude towards PLHIV, we push them away from us and push away those who practise risky behaviour and would like to know their status. We must not play the role of a judge. PLHIV are not dangerous for the environment. Moreover, learning their status, many of them cease practising risky behaviour, having casual sexual relations, using drugs.’

Interview of **S. Grigoryan**,
National AIDS Center Director
Yerevan TV

In essence, PLHIV should be full members of society, but in reality this is not the case. Discrimination makes prevention work difficult.

Even the results of the survey conducted among medical workers show that though doctors’ and nurses’ awareness about some questions (factors, modes of HIV transmission, vulnerable groups) is sufficient, the level of knowledge about HIV and AIDS is in general low. Another reason for stigma is that HIV infection is a fatal disease (due to unavailability of ARV treatment medication), and the theme of death in Armenian society is a taboo and causes fear (Grigoryan et al. 2002). HIV is associated with poor health and ‘appearance’ and people are not informed much about HIV transmission modes (see section I.4.1. on awareness).

Furthermore, people associate HIV and AIDS with representatives of groups who are already discriminated against and subordinated in our society – CSWs, MSM, IDUs, women, and youth. Eleven percent (11%) of the youth preferred not to show an interest towards IDUs, and 7% supported the imprisonment of IDUs (Grigoryan, Mkrtychyan and Davidyants 2002), while 14% of youth supported the imprisonment of CSWs, and 20% of them did not want to show interest towards them at all. According to the same research, 54% of the surveyed MSM have mentioned that the surrounding community and society has a negative attitude towards them, and 70% of those surveyed have been discriminated for being MSM. In 58% of cases such attitude was displayed by the legal bodies, and in 42% of cases, by their parents.

It is noteworthy that stigma against marginalized groups is displayed at different levels of social surrounding: family members (close surrounding) and legal bodies (distant surrounding). It must be added

that HIV is connected with the themes of sex, which is taboo in Armenian society. This has deep cultural bases; traditional relations in Armenian families between sexual partners are still preserved, and the inheritance of Soviet period – ‘There’s no sex in the USSR’ – remains.

Mobilisation of key populations to demand better education and/or treatment must be one of the main objectives of prevention programmes (e.g. forming self-help groups, etc.).

Improvements in the legal field, which are being implemented at a concrete level in Armenia, are critical in the fight against stigma and discrimination against PLHIV. This theme is mainly touched upon in the book, *HIV/AIDS and Human Rights* (Grigoryan, Sargsyan and Harutyunyan, 2002). However, as with any other law or legal act, the adaptation and improvement of the law on HIV and AIDS is not sufficient for eliminating discrimination against PLHIV. The last fifteen years of Armenian improvements has shown that the laws are not necessarily applied.

Regarding changes of people’s opinions about HIV and AIDS, other methods are needed. Education can play an important role, which can lead people to review their fears and false perceptions. It is important that people are educated not only about modes of HIV transmission, but also about the attitudes towards and rights of PLHIV. A better means for fighting against stigma is involving PLHIV at all stages in the response to the epidemic (e.g. Kofi Annan’s speech opening the XV World AIDS conference in Bangkok, July 2004)¹⁷, when PLHIV acquire knowledge and skills, overcome internal stigma, and oppose discrimination. Their participation in the process of decision-making on AIDS and representation in different public structures are very important.

I.4.3. Review of materials in mass media for HIV and AIDS awareness

The role of the mass media in forming public opinion and in raising the level of awareness of the general population is indisputable. It is necessary to systematically provide correct and comprehensive information about HIV and AIDS issues through mass media. The aim of this research is to find out to what extent the information provided by mass media tackles all the aspects of HIV and AIDS, and whether this information is sufficient for making correct idea on the issue.

Below, we present a brief description of materials concerning discussions about HIV and AIDS in Armenian mass media (TV, radio, printed press) from 1999 to August 2004. Research was conducted in archives collected by NCAP, by collecting publications on HIV and AIDS issues and materials broadcast by TV and radio on the issue.

Although it is possible that the volume of materials examined does not include all of the existing materials about HIV and AIDS awareness, the authors of this report believe that they either represent the majority of the volume and/or give a fair representation of the material presented by mass media in general.

The research has been carried out by quantitative and qualitative analysis of the materials in mass media. When carrying out quantitative analysis the categories of the analysis are separated. In this case the whole material concerning HIV and AIDS issues is divided into categories and quantitative units. Next, we express in numerical data how many of the published or broadcast materials have been included in that category. Qualitative analysis presupposes analysis of the content of the material. The interesting abstracts separated from the materials in mass media as a result of qualitative analysis are cited in the chapters of ‘Literature Review’ and ‘Institutional Evaluation.’

Below, the results of the quantitative analysis of the materials in mass media are presented. The categories of analyses are the following:

1. Which aspect of HIV/AIDS is addressed in the material:
 - ‘Armenicum’ medication.¹⁸
 - HIV and AIDS in the world
 - Statistics

¹⁷ <http://www.un.org/News/Press/docs/2004/sgsm9418.doc.htm>

¹⁸ ‘Armenicum’ medication is reported to be an antiretroviral HIV medication and it is currently being developed at the ‘Armenicum Center’ and is in the clinical trials stage. Even though little is known of this medication outside Armenia, World Health Organization and UNAIDS representatives have stated that they have no information on ‘Armenicum’ as an HIV ARV treatment medication.

- HIV and AIDS basic science, prevention, transmission, etc.
 - Steps taken to address the problem
 - Discussion of a specific case
2. To what extent the material concerns HIV and AIDS issues
- It directly concerns HIV/AIDS issues
 - It concerns other questions but it touches upon this problem as well

Researchers looked at eighty-four publications in the Armenian print media (press) from 1999 to August 2004 concerning HIV and AIDS. There were sixty-nine instances directly concerned with HIV and AIDS issues, and the other publications were devoted to other themes, with different references to HIV and AIDS. For example, one article was devoted to discussing homosexuality, but it also stressed that such relations are considered (by the author) dangerous in regards to HIV infection.

Usually the reporters do not present only one aspect of HIV and AIDS in the articles, but inform readers about the situation in the world and in Armenia. They also focus on the steps taken in response to the problem, ‘Armenicum’ medicine or questions concerning an important event that has taken place.

The majority of the articles were not on the front page, and all of them were addressed to providing information rather than to educating.

Statistics

Some articles included in this unit contain information about the situation in the world and in Armenia. The reporters pay special attention to the fact that during last years, the highest rates of HIV transmission in the world were registered in the region of Eastern Europe and Central Asia, which includes Armenia. The majority of the articles include statistics on prevalence rates, registered cases and possible development in the region and in Armenia (thirty-two articles). The alarmingly fast rate of progression of the HIV epidemic in the region is stressed everywhere, and a link is made to migration from Armenia mainly to two countries with a higher HIV prevalence than Armenia, the Russian Federation and Ukraine, and Armenians being in these countries for a lengthy time who practise risky behaviour.

References to steps taken in response to HIV and AIDS

Another important aspect frequently discussed in the press concerns the activities implemented in the country within the framework of HIV prevention. In particular the national strategic project of activities concerning HIV and AIDS conducted in Armenia with the support of UNAIDS and activities conducted within the framework of the National Programme on HIV/AIDS Prevention (twenty-six articles contain such information).

‘Armenicum’ medication

There are also articles that discuss the possibility of treatment, and more concretely, the activities conducted in this direction by the ‘Armenicum’ clinical centre, and about the effect of ‘Armenicum’ medication. Such information is given in twenty-one articles. ‘Armenicum’ medication is now in the stage of clinical experiments, is registered in the country as antiretroviral medicine, and has immunomodulatory qualities.

About HIV/AIDS – basic science, prevention and transmission

Here we include articles that provide information about HIV/AIDS epidemiology and clinical presentations or findings. However, it is necessary to mention that only two of the articles analysed were devoted to a detailed discussion about how HIV is transmitted, how HIV infection can be prevented, and the health effects of an HIV infection. In the remaining seventeen, the themes mentioned above were touched upon, albeit superficially. Attention was mainly paid to risky behaviour and the period between becoming infected with HIV and AIDS development. It was especially stressed that during this period (7-15 years) the individual can feel well, be healthy and may not be aware of his/her HIV positive status. In publications of 2004 there hasn’t been any material concerning this theme.

There were also publications in this group devoted to stigmatising and discriminative attitudes towards PLHIV, and to the importance of supporting sexual education. These articles have been includ-

ed in this group, as they address HIV/AIDS epidemiology and clinical presentations or findings in relation to the importance of activities directed to the response to HIV and AIDS.

Discussion of a specific case

We also include a section about thirty-five articles about the NCAP. In particular, eleven articles out of twenty-two published in 2001 touched upon the questions on unfavourable situation in the field of blood service in the context of transfusing infected donated blood from the blood centre in January 2001. The case of HIV transmission through blood transfusion registered in 2001 drew the attention of mass media and many articles concerning the case were published in newspapers, but the attention disappeared in a short period of time, and there are no further articles on the topic.

HIV and AIDS in the world

There are six articles that describe an event or case connected with HIV and AIDS in the world. There are numerous articles describing the statistical picture of the situation in the world, particularly in the region (also included in the unit of statistics). One of the articles included in this section has touched upon HIV and AIDS situation and several questions connected with the issue in the Russian Federation. One article discussed 'sex-terror' in Africa, where supposedly some PLHIV in Africa threatened to infect others.

Brief description of TV and radio programmes on HIV and AIDS issues

The studies of radio and TV programmes have been analyzed by the same method: the only difference is that here almost all the materials concern HIV and AIDS awareness issues. The programmes have not been addressed to a specific audience. It is also worth noting that most broadcasts occur during World AIDS Day, 1 December. They have included different programmes and have been broadcast in the evenings. Those materials broadcast or published by mass media have been studied, which have large/broad audience or are newspapers spread all over the country. All the articles were addressed to providing information rather than for educational purposes.

It is noteworthy, that although articles devoted to 1 December (World AIDS Day) did not find their real place in publications, the majority of radio and TV programmes were prepared it.. Another point of divergence is that if the articles in press were mainly intended to describe and analyses various aspects of HIV and AIDS, often all the aspects of the HIV and AIDS issue were not addressed in one article (with the exception of interviews). In radio and TV programmes the phenomenon was presented more completely mainly due to live interviews and answers to questions received through phone calls and paging services. During one programme issues such as the global HIV and AIDS situation and in Armenia, preventive articles, 'Armenicum' were touched upon. Occasionally, programmes discuss HIV and AIDS disease development, factors and modes of infection transmission, prevention. These themes are more frequently and wider spoken about, as compared to in the printed press.

Since 1999, during nine radio programmes and the programme of 'Ardzagank' radio station, these themes have been addressed. It is important to note that it has mainly been spoken about as statistical data and steps taken (during the programmes the mentioned themes have been spoken about twelve and fifteen times, respectively). 'Armenicum' was discussed in three programmes. Particular attention should be paid to the series of programmes directed to HIV and AIDS awareness issues broadcast on 'Ardzagank' radio station since May 2002 with the support of the UN Development Programme (UNDP) and the initiative of the NCAP. The total number of the programmes broadcast was sixteen. The aim was to raise awareness among the general population about the HIV epidemic, the main means and methods of its prevention, as well as to create a dialogue between wide layers of society, governmental bodies, international and non-governmental organizations and other beneficiary individuals and structures. During the programmes, detailed information about all the questions concerning the problem was provided.

Since 1999 there have been eight programmes on HIV and AIDS in the news, out of which seven were broadcast on World AIDS Day, 1 December. Only one was devoted to the International AIDS Conference in July 2004 (Bangkok, Thailand). All of the programmes contained statistical data on the situation in the world and in Armenia, five briefly spoke about programmes implemented with the support of the Global

Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and steps directed to responding to HIV and AIDS. In another five programmes, HIV was briefly spoken about, and a reference was made to 'Armenicum' in three of them. In contrast to TV news, there have been nine TV programmes and one TV talk show devoted to the issue. However, they were broadcast on 1 December and gave a broad perspective on HIV and AIDS, rather than offering in-depth looks at specific issues. Among them, five of the programmes made reference to 'Armenicum.' It is important to note the importance of TV shows, particularly because they facilitate open discussions among specialists, beneficiaries, the audience and, most importantly, PLHIV. These discussions promote stable and well-grounded viewpoints on the issue.

It is important to note that sometimes, social ads are broadcasted as commercials or public posters. However, they rarely display a constant message. For example, some social ads are broadcast during programmes on 1 December, or following a condom commercial, but they are also not systematic. Moreover, posters are mainly found in medical institutions.

There are few articles in the press that give the readers broader information about factors and modes of HIV transmission, means of prevention and HIV illness (cause and development). Increased educational efforts in the print media and television may help disseminate HIV/AIDS information to a broad audience. To date the media appears not to have played a significant role from an educational viewpoint.

I.5. What has been done and what is being done?

Between 2000 and 2004 in Armenia, various preventive programmes were implemented among specific key populations (migrants, prisoners, IDUs, MSM, CSWs), as well as among youth and the general population. The National Programme on HIV/AIDS Prevention in the Republic of Armenia envisages providing all pregnant women with VCT services in antenatal clinics.

Currently, the response to HIV epidemic in Armenia is carried out at the following three levels:

1. National Response to HIV epidemic in the Republic of Armenia at the level of executive power.
2. National Response to HIV epidemic in the Republic of Armenia at the legislative level.
3. National Response to HIV epidemic in the Republic of Armenia at nongovernmental and international organization level.

I.5.1. Activities carried out by the National Center for AIDS Prevention (NCAP)

The National Center for AIDS Prevention (NCAP) is the only specialized governmental institution (through the Ministry of Health) in this field, and its goal is the coordination and implementation of HIV/AIDS prevention activities in the RA.

NCAP regularly carries out activities aimed at prevention of HIV epidemic among vulnerable groups, training on skills of safer behaviour, information/education activities among youth involving mass media: TV, radio, newspapers, as well as providing support to people living with HIV. Among the above-mentioned, the following are the most significant activities:

Crisis Center

In February 2002 a Crisis Center was established in Yerevan with the support of the UNDP Regional Programme. The activities of the Crisis Center have been focused on people living with HIV and their family members, as well as on representatives of key: IDUs, CSWs, MSM, marginalized youth, and so on. The psychologist and lawyer of the Crisis Center provided Psychosocial and legal counselling for the aforementioned groups. From February to December 2002 psychosocial and legal counselling was provided for approximately fifty-two PLHIV and their family members.

Hot Line Services

In March 2002 a 24-hour hot line counselling service was established for vulnerable groups and the general population. The hot line counselling addresses HIV, STIs prevention and drug use-related issues. It is also aimed at promoting safer sexual behaviour. By 31 December 2002, the counselling service had received approximately 402 calls.

The data of preliminary analysis of the calls show that 53.7% of the callers were men and 46.3% - women. The analysis revealed that only 361 persons indicated their age, the majority of whom (61%)

belong to the age group 15-29. Only 304 persons mentioned their education level: 53.3% of the callers had higher education and 36.8% of them had secondary education; 42.2% of them were married, 49.1% of them were single and 7.6% were divorced. The majority of callers were from Yerevan (94%). Among callers, 67.1% learned about the hot line service from the newspapers, 13.7% of them had learned about the service from the radio, 11.1% had learned about the service from the informative leaflets, and 13.1% from friends. Of the total number of callers, 52.3% addressed HIV and AIDS issues, 16.5% of them addressed STI issues, and 6% of the calls addressed drug use.

Resource Center

In February 2002 the Resource Center was established. One of the Center's main goals was to design a web site and provide information about the activities of the NCAP, the HIV and AIDS epidemiological situation, and the statistical data, results of epidemiological surveillance conducted among general population and key populations, as well as the epidemiological surveillance and monitoring system in Armenia. It also provides information about the National Programme on HIV/AIDS Prevention in the Republic of Armenia (please see below, section 5.5 for more details), the National Interministerial Council on HIV/AIDS Prevention; the Inter-Standing/Inter-Faction Committee Parliamentarian Group on HIV/AIDS of the National Assembly of the Republic of Armenia; and the UN HIV/AIDS Theme Group¹⁹, declaration of Commitment on HIV/AIDS adopted at the United Nations Assembly Special Session on HIV and AIDS; participation of the specialists of the Republic of Armenia working in the field of HIV prevention in various national and international conferences, seminars, workshops; published materials on HIV/AIDS and related issues; as well as information about national and international partners, including civil society, NGOs, donor organizations and private sector. This information (regularly updated) was available at the website of the NCAP: <http://www.arm aids.am>.

Radio Hot Line Activities

From May to September 2002, the Resource Center regularly broadcast weekly radio programmes about HIV and drug use prevention on 103.5 FM, the 'Arzagank' radio station. Sixteen radio programmes were broadcast and people's questions were discussed through calls during the live broadcast. The programmes were conducted by qualified specialists on HIV and drug use prevention.

Studies

Within the framework of the project, surveys were conducted among health care professionals (200 medical and 100 paramedical professionals) of different medical institutions of Yerevan. The surveys were designed to assess the knowledge about HIV and AIDS and related issues of occupational safety and health in the light of the HIV epidemic, sterilisation of medical instruments used by health care professionals, and the discriminative attitude towards people living with HIV. The Second Generation HIV Surveillance (2002) behavioural survey was conducted among youth to address knowledge about HIV and AIDS, risky behaviour and assessment of their vulnerability to HIV.

Another survey was conducted among fifty people living with HIV, to study the level of knowledge about modes of HIV transmission and prevention, as well as to study the discriminative attitude of the society towards them and to assess their needs. PLHIV responded to questionnaires designed to study their present sexual behaviour, drug use, their accessibility to condoms, and means of personal health and protection. The surveys were also aimed at assessing the level of awareness among family members about their HIV status and their attitude towards HIV-positive family member, as well as the willingness of PLHIV to participate in self-help groups.

Surveys were also conducted among fifty family members of people living with HIV to study the level of knowledge about modes of HIV transmission and prevention, as well as their discriminative attitude towards their HIV-infected family member, as well as the discriminative attitude of society. The surveys

¹⁹ The UN Theme Group is comprised of heads of agencies (UNDP), World Food Programme (WFP), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations Department for Public Information (UNDPI), United Nations office of the High Commissioner for Refugees (UNHCR), United Nations joint Programme on HIV/AIDS (UNAIDS) and a government representative.

also studied their desire to get acquainted with other HIV positive individuals and their family members.

Enacting the Decree N 157 of 14 March 2002 of the Minister of Health of the Republic of Armenia about the implementation of the Second Generation HIV Surveillance, according to the National Protocol on updated system of surveillance for HIV, AIDS and STI in the Republic of Armenia (second generation surveillance), biological and behavioural surveillance studies were conducted among IDUs, CSWs, MSM, youth and individuals in penitentiary institutions. Behavioural surveillance in the format of the Second Generation HIV Surveillance was aimed at studying their knowledge about HIV and AIDS and risk behaviour, and assessing their vulnerability to HIV infection.

Seminars, training, lectures

During 2002-2003 four seminars were conducted in the Republican TB Center for the physicians, paramedical staff and clinical staff physicians of the Phthiopolmonology Department of the Yerevan State Medical University. A seminar was conducted in the Yerevan city TB Center about early detection of HIV infection, and prevention among TB patients and strengthening HIV epidemiological surveillance.

Lectures on HIV and AIDS-related issues were provided for health care workers of antenatal clinics in Yerevan city to raise awareness about HIV prevention issues among obstetricians and gynaecologists and on implementation of the Second Generation HIV Surveillance among pregnant women of Yerevan.

On 5-6 September 2002, the Criminal Executive Department of the Ministry of Justice conducted a national seminar on HIV and AIDS-related issues for the staff of penitentiary institutions.

In 2002 the lectures on HIV- and AIDS-related issues were provided for volunteers of the Armenian Red Cross Society, Illicit Drug Trafficking and Prostitution Division.

Specialists at the NCAP have developed and published information-educational materials, booklets, and leaflets for key populations, general population and blood donors. Books on HIV and AIDS issues were also published (No IEC has been developed for religious leaders).

I.5.2. HIV prevention among IDUs of Kapan city

In August 2003 the first Harm Reduction project among IDUs was implemented. Kapan city was chosen because it shares borders with Iran and is a high drug-use region. A behavioural survey was conducted among fifty IDUs of Kapan city covered by the programme. Within the framework of the project 'Peer Education,' outreach work was conducted. As a result of the training, three individuals were selected for outreach work among IDUs. Outreach workers disseminated information-educational materials, 500-600 syringes and 500 condoms monthly. The programme lasted for five months. At the end of the programme a behavioural survey was conducted among the same fifty IDUs in Kapan city. The results of the survey revealed that 85% of the surveyed IDUs (up from 77.3% before the programme) were aware that HIV can be transmitted through unprotected sexual contact, and 91.6% (up from 77.3% before the programme) knew about HIV transmission through injecting drug use. The percentage of those IDUs using disposable syringes has increased to 72.4% (52% before the programme). The percentage of those using condoms consistently during the last three months has increased to 59% (28.6% before the programme). The percentage of syringe return is 30%.

I.5.3. HIV prevention among street CSWs of Yerevan city

In 2003 an HIV prevention programme and outreach work among 150 street CSWs of Yerevan city was implemented. Condoms and booklets were distributed among the CSWs. The CSWs were provided with STI treatment information, as well as voluntary counselling and testing for HIV. Behavioural surveys were conducted at the beginning and at the end of the programme. Among them, 98% of those surveyed (94% before the programme) were aware of the sexual ways HIV can be transmitted and 80% (76% before the programme) of HIV transmission through contaminated syringes and needles. In response to the question about the modes of HIV prevention, 98% of those surveyed indicated condom use (84% used condom during the last sexual contact, up from 50% before the programme). With regards to alcohol consumption and sexual contacts, 40% reported using alcohol before sexual contacts during the last week (54.8% before the programme).

I.5.4. HIV prevention among migrants and their family members of Gavar city

In 2003 peer education was conducted among migrants and their family members in Gavar, a high migration area. Information-educational materials were provided. Counselling about HIV and AIDS, STIs, and drug use prevention issues were also provided through hot line services. The service received 167 calls over five months.

I.5.5. Support to the activities carried out within the framework of National Programme on HIV/AIDS Prevention in Armenia

The GFATM supported programme has ten objectives:

1. To reduce spread of HIV among youth. In order to reach the aim implementation of the following activities has been started since 2004: providing peer education in educational establishments to young people, HIV and AIDS educational programmes in schools and higher educational institutions, peer education programmes in the military, VCT activities, conducting awareness-raising informational campaigns and mass media activities (TV/radio and show programmes). Currently there are no school educational efforts.
2. To reduce the spread of HIV among IDUs. In order to reach this goal, in 2004 a harm reduction project was conducted in Yerevan, with VCT activities provided. In 2005 the programmes mentioned above continued. Moreover, harm reduction projects have been launched in Kapan (Syunik Marz) and Gyumri (Shirak Marz) cities. Needle exchange, provision of information/educational materials, VCT and STI syndromic treatment, and condom distribution have been implemented within the framework of these projects.
3. To reduce the spread of HIV among CSWs. In order to reach this goal two preventive programmes have been carried out in Yerevan city since 2004. Preventive programmes are being carried out in Gavar city (Gegharkunik Marz), Vanadzor city (Lori Marz) and Gyumri city (Shirak Marz) as well, and VCT services are provided. This year (2005) preventive programmes have been carried out in Vardenis city (Gegharkunik Marz), Kapan city, Agarak city (Syunik Marz) and Abovyan city (Kotayk Marz) in addition to the ones mentioned above.
4. To reduce the spread of HIV among MSM. In order to reach this goal, a prevention project is being implemented in Yerevan, and VCT activities are being provided. This project has been continued in Yerevan in 2005.
5. To reduce the spread of HIV among prisoners. In order to reach this goal, harm reduction programmes have been implemented in the 'Erebuni' Criminal-Executive Institution (CEI), and peer education programmes in all CEIs of the country are being implemented; VCT activities are being provided. This year the programmes have been continued. Harm reduction programmes is implementing in 'Artik' CEI and in 'Kosh' CEI.
6. To reduce the spread of HIV among migrants and refugees. In order to reach this goal peer education programmes among migrants and refugees in Yerevan city and in Abovyan city are being implemented, and VCT activities are being provided. This year, in addition to the programmes mentioned above, peer education programmes have been launched among migrants and refugees in Gavar city (Gegharkunik Marz) and will be launched in Artashat city (Ararat Marz).
7. To provide care, support and treatment to people living with HIV. In order to reach this goal, the following activities have been implemented since 2004: establishing laboratories for diagnostic of HIV and AIDS, setting up laboratory for diagnostic of opportunistic infections, providing HIV-infected individuals with ARV therapy, providing training to specialists, prevention and treatment of opportunistic infections, providing care and support for people living with HIV, and a hot line service.
8. Ensuring donated blood safety. In order to reach this goal, in 2004 laboratory equipment and HIV test-kits were provided for six laboratories, laboratory specialists received training, and a laboratory infrastructure was developed. This year activities including procuring laboratory equipment, establishing a laboratory infrastructure for another four laboratories, providing test-kits for HIV testing and providing training to laboratory specialists has continued.
9. Prevention of mother-to-child transmission. In order to reach this goal, the following activities have been carried out in 2004 and 2005: providing VCT services to pregnant women, providing

HIV-infected pregnant women and infants born to them with specific prevention using antiretroviral drugs, providing training to specialists, providing infants born to HIV-infected mothers with breast milk substitutes.

10. To reduce the spread of HIV among the general population. In order to reach this goal the following activities were implemented in 2004: conducting awareness-raising informational campaigns, TV/radio programmes, mass media activities, hot line service, VCT services.

I.5.6. Training of specialists

Within the framework of the National Programme on HIV and AIDS Prevention during the period of January 2004-January 2005, fifty-six training seminars were held with the participation of specialists from different spheres of Armenia's Marzes and from Yerevan, all of whom were provided with information-educational materials, guidelines and books. Participants included medical workers, laboratory specialists providing HIV testing, health organisers, members of the Armenian police, members of CEI, members of NGOs, representatives of key populations vulnerable to HIV, and experts working on HIV-prevention programmes. The following people have taken part in training-seminar:

- 166 obstetricians-gynaecologists
- 126 specialists working in the penitentiary institutions
- 63 policy makers in the field of health care
- 54 dermato-venereologists
- 51 therapists
- 37 physicians-infectious diseases specialists
- 29 doctor laboratory assistants
- 21 epidemiologists
- 14 narcologists
- 7 family doctors
- 7 medical specialists from NGOs
- 6 psychiatrists
- 4 neonatologists
- 2 paediatricians
- 1 toxicologist
- 1 doctor- statistic
- 1 cardiologist
- 17 laboratory assistants
- 37 nurses
- 2 laboratory nurses
- 127 peer educators implementing HIV prevention programme among youth including military servants and migrants
- 48 outreach workers, peer educators and project personnel implementing HIV prevention programme among IDUs
- 76 outreach workers, peer educators and project personnel implementing HIV prevention programme among CSWs
- 21 outreach workers, peer educators and project personnel implementing HIV prevention programme among MSM
- 21 mass media representatives
- 48 community workers
- 47 NGO representatives involved in HIV/AIDS prevention sphere
- 15 Hot line service specialists
- 15 monitoring and evaluation specialists
- 56 police representatives

PART II. INSTITUTIONAL ASSESSMENT

II.1. Health

Although the problem of health care among the population is amongst the priority issues of the government, the scarcity of financial resources makes it difficult to address the needs of the health care sector, which faces serious under-financing. The government of Armenia has approved a 'Short-term Project for HIV/AIDS Prevention (1999-2000)' and a 'Scientific Research Project directed at HIV/AIDS Prevention (1999-2000).' These projects were included in the State Budget for 1999, but they were never funded. The projects were intended to ensure the safety donated blood, to study and raise the public awareness about HIV and AIDS, to conduct research about distinctive features of HIV epidemic in the RA and its prevalence trends, and based on the results of the above mentioned research to take preventive measures. It is noteworthy to mention here, that until February 2005 HIV ARV treatment was not available in Armenia. Since 1 February 2005 twenty PLHIV have been provided with ARV treatment.

The treatment of tuberculosis, in-patient treatment of infectious diseases (syphilis, complicated forms of gonococci infection) and clinical aid at narcology clinics are provided by state funding. In 1999 the actual financing was only partially fulfilled and the rate of the funding level of the in-patient treatment of infectious diseases was 70%, and 56% for in-patient aid against drug use. This is the result of rather serious problems in medical care and service area.

In 1999 NCAP received funding that covered only 58.8% of the amount needed, as projected by the budget (this is typical for the health care sector overall for the years mentioned earlier; currently, following changes, the NCAP receives 100% of the projected budget). Under the budget line for test-kits and laboratory materials, only 32% of the budget was met. It is clear that under the conditions of such under-financing it is not possible to implement an effective program of HIV and AIDS control and prevention.

In Armenia the funding sources for provision of medical care and services are as follows:

- allocations from the state budget;
- insurance compensations;
- direct payments from individuals;
- other sources that are not prohibited by legislation.

The National Center for AIDS Prevention (NCAP) was established in Yerevan to implement and coordinate activities on HIV prevention in Armenia. The main objectives of the Center are:

- conducting epidemiological surveillance for HIV- and AIDS-associated diseases, research and analysis of trends over time of HIV and AIDS-associated diseases;
- providing moral and sexual education for different population groups (teenagers, youth, etc.), providing information and education on the issues of HIV- and AIDS-associated diseases (moral education guides, youth according to national traditions regarding the importance of family role, respect towards elders, and the importance of spiritual and cultural values such as literature and art, sharing information about HIV prevalence in the country according to the international agreements of Armenia, strengthening contacts with individuals and legal entities;
- implementing HIV and AIDS prevention and treatment and coordinating the activities of health-care organisations and bodies in the field of HIV and AIDS prevention and treatment;
- exercising control over the quality of all HIV testing laboratories (state and private) in Armenia, final laboratory diagnostics of HIV, clinical and laboratory diagnostics of HIV and AIDS;
- provision of training for physicians and paramedical personnel about HIV/AIDS prevention and diagnosis;
- developing new laboratory methods for HIV testing, as well as conducting scientific and practical research on HIV- and AIDS-associated diseases;
- preventing HIV and AIDS-associated diseases, implementing activities about HIV and AIDS prevention and treatment, developing strategic programmes addressing treatment and social protection;
- organizing and participating in national and international meetings and conventions, conferences, seminars, training, and counselling on HIV- and AIDS-associated diseases.

NCAP regularly carries out activities aimed at preventing the spread of the HIV epidemic among key populations, training on skills of safer behaviour, information/education activities among youth involv-

ing mass media (TV, radio, newspapers), as well as providing support to people living with HIV.

It is noteworthy that within the framework of the institutional evaluation, a series of experts interviews has been conducted with specialists from different fields related to HIV prevention (health care, education, culture) and with representatives of international and non-governmental organizations working in the field of HIV and AIDS in Armenia. Within the framework of the survey twelve experts have responded to questions on aspects of the HIV epidemic prevalence in Armenia, HIV prevention, socio-cultural factors related to HIV and AIDS, programmes implemented, information/educational activities, and several other questions. The selection of experts was made according to the field of activities directly connected with HIV and AIDS, and then by the 'snowball' method. The list of those interviewed is found in the appendix attached to the report.

Summing up the expert evaluations for the purpose of this report (one of whom is the National AIDS Coordinator at the NCAP), the majority think HIV and AIDS in Armenia is one of the primary health care problems. The establishment of an multisectoral commission and the fact that many organizations today implement HIV and AIDS-related programmes testify to this. In response to the question, 'In your opinion, what are the health care problems today?' answers include establishing health care standards and developing treatment standards, the absence of which is a serious obstacle for providing treatment. Standards are important for assessing the effectiveness of different diagnostic and treatment methods, and to determine budgetary needs. In the field of HIV and AIDS, much progress has been made in designing standards. In Armenia HIV and AIDS is one of the fields where the national programme has been accepted. At the same time we emphasize that there is a shortage of staff (specialists, professionals, and/or personnel), adequate medicine, and techniques in this field. While state policy is clear and well-intentioned, financing remains a serious problem.

The president of the NGO, 'AIDS Prevention, Education and Care' has said: 'Voluntary counselling and testing is a very subtle theme, treatment in general is a very subtle theme. The attitude of the society towards VCT is very important, so that a person can turn to the service. Confidentiality is not ensured, at least I know that it is ensured in Yerevan, in the National Center for AIDS Prevention, but I cannot say for other places.'

The overall impression of experts is that people trust that testing will be confidential. During the first quarter of 2005 nearly 2,000 people were tested for HIV by the NCAP, none of whom was tested mandatory, and all of whom were provided with VCT.

According to the observations of one expert, motivation should be created from within the government. People must realize that to care for health is not beyond their means. Rather, it is the responsibility of the state to support the necessary and appropriate policies for a person to be able to protect his health. 'Besides, preventive programmes of the Ministry of Health must not be limited to vaccination only. In the years of the Soviet Union the hygienic conditions of workplaces were regularly discussed. Now no one discusses this subject at all'. (According to one of the experts interviewed for the purpose of the current report – please see attached expert interviews)

Opinions differ regarding extent to which the problem of HIV/AIDS is primary in Armenian society. Attention is paid to the fact that the strategic plan on HIV prevention has been developed and accepted on the governmental level. Not only state structures are included in its implementation, but the public sector as well, which testifies to the fact that the problem is pressing. The UNAIDS Intercountry Coordinator for the Southern Caucasus opined: 'Activities conducted by the government in the field of HIV prevention testify to this. The state realizes that preventive activities must be initiated. Support by provided the Global Fund to fight against AIDS, Tuberculosis and Malaria also testifies to this, which is also the result of proper work of state structures'.

Others think that an in-depth analysis is necessary to evaluate the priority of the problem. In response to the question 'To what extent do you consider the problem to be a priority the president of 'AIDS Prevention, Education and Care' NGO, stated: 'if 10% considered the problem primary, we would have advanced. It is the opinion of the authors that even if many people in general do not prioritise this problem, but those who do have significantly increased in number when compared to the numbers before the year 2000. The evaluation reports from the experts express the opinion that the level of attention given to HIV/AIDS does not correspond to the actual severity of HIV epidemic. Although the problem is at the centre of attention of state and international organizations, there is great necessity in including the private sector and communities. Indeed, while Armenia has several other pressing public health issues (e.g.

TB), HIV/AIDS is viewed as one of the most important issues.

Regarding medical services provided for PLHIV, experts find that medical services must be made available everywhere. When policy is carried out in that direction, it becomes more possible to eliminate stigma. The policy states that, aside from antiretroviral or special treatment in all other cases, PLHIV can receive medical care in any medical institution. Current availability is generally connected with the lack of knowledge and prejudice. It is difficult to say to what extent this policy is applied in reality, as there is a problem of staff (specialists, professionals, personnel): to what extent a surgeon or a therapist are ready to provide services to a person living with HIV. Performing a great amount of relevant work among health care workers is currently a top priority. Past experience shows that a discriminatory attitude is displayed when an HIV-positive person discloses his/her status (this is the evidence of an expert dealing with PLHIV). This is mainly connected with the lack of knowledge of medical personnel, as well as concrete prejudice. As such, a great deal of work must be conducted with medical personnel as well, such as experts' evaluations. Different training seminars are organized for them, and questions about stigma and discrimination against PLHIV are also included in the agenda (training focused on different aspects of HIV prevention, antiretroviral treatment, VCT and so on).

According to the evaluation of the president of 'Real World, Real People' NGO, 'it is very important to create treatment opportunities for PLHIV. The role of state structures is to form public opinion. Our legislative field is one of the best in the world, but it does not function practically. The Ministry of Health must be more attentive in this sense. Until now the workers of Hygienic Antiepidemic Inspections (HAI: an executive state body functioning in the structure of the Ministry of Health, which implements controlling functions in the sphere of ensuring sanitary-epidemiological safety of the population of the RA) do not know what to do with PLHIV. They only demand the list of PLHIV living in their region. When asked why is it necessary for them to obtain such a list, the answer is often 'HIV is a dangerous infection'. Moreover, according to the plan developed in the seventies regarding infectious diseases, the response would be a general 'disinfection' of the living quarters of the infected individual. When told that HIV cannot be 'disinfected' they do not believe it. The Ministry has a lot to do in this sense'.

International experience shows that in those countries where antiretroviral treatment is provided and widely available, there is less discrimination and the epidemic spreads at a slower rate (experts' opinion) Although the Director of NCAP has affirmed that in general financing of the field can be considered sufficient, it does not cover the whole field of necessity. In, particular, within the framework of the programme it is envisaged to provide antiretroviral treatment medication to 20 individuals living with AIDS, and the number of those in need of it is much more.

ARV treatment will be provided according to the National HIV/AIDS Treatment and Care Protocols. Treatment provision is not concentrated only in Yerevan. PLHIV of all the regions who have criteria for the treatment, receive ARV treatment. Within the framework of GFATM supported National Programme on HIV/AIDS Prevention adequate supply and monitoring are ensured (the target is to provide ARV treatment to 20 people living with AIDS; the first 20 to successfully apply).

II.2. HIV and AIDS Legal Field and National Response to HIV Epidemic at the Level of Legislative Power

II.2.1. HIV and AIDS legal field

In the Republic of Armenia human rights and freedoms are determined by the RA Constitution. The Republic of Armenia has joined a number of international agreements over the past 15 years, to take on some of the responsibilities for protecting human rights. In particular, the 'Universal convention on human rights', 'International covenant on civil and political rights' (Armenia joined on 1 April 1999), 'International covenant on economic, social and cultural rights' (Armenia joined on 9 June 1993), 'International covenant on the elimination of all forms of racial discrimination' (Armenia joined on 29 March 1993), 'Convention on the elimination of all forms of racial discrimination against Women' (Armenia joined on 9 June 1993), 'Convention on the rights of the child' (Armenia joined on 1 June 1992).

II.2.2. Main principles determined by the RA Constitution:

- Right to health protection;
- The RA Constitution prohibits any discrimination and violation of human rights, if it is not envisaged by the law;
- Citizens and non-governmental organizations have right to take part in the development, discussion and adoption of decisions on sanitary/anti-epidemiological safety accepted by the government, as well as to monitor their implementation;
- The state implements programmes on health protection of general population;
- All the citizens, without discrimination, have all the rights, freedoms and responsibilities, and are equal before the law and are equally protected by the law;
- Every person has right to freedom of speech.

II.2.3. The RA law on ‘Prevention of disease caused by Human Immunodeficiency Virus’

In 1997 the law on ‘Prevention of disease caused by Human Immunodeficiency Virus’ was ratified by the National Assembly of RA. This law determines the regimen for implementing prevention, diagnosis and control of disease caused by HIV, and legal, economic and financial bases of implementation of prevention of disease caused by HIV.

According to the law:

1. The fact of being infected with HIV cannot be ground for restriction of and individual’s rights and freedoms, with the exception of cases determined by the law. Those who transmit HIV unknowingly are punished with correctional works: maximum for a 2 year period or arrest: maximum for a 2 month period or imprisonment: maximum for one year period.
2. Those who transmit HIV on purpose or knowing their HIV status but supposing that they would not transmit the virus are punished with imprisonment: maximum for a 5 year period.
3. Those who transmit HIV on purpose knowing that they can transmit the virus to:
 - two or more people
 - juvenile
 - evidently pregnant woman
 - are punished with imprisonment of 3-8 years period.

The above legal attitudes towards HIV transmission may influence the likelihood of testing and/or reporting to partners. However, more surveys need to be conducted for correct analysis of the extent of such influence.

- Laboratory HIV testing is voluntary and anonymous with the exception of cases determined by the law. In the functioning law the mandatory testing for the following sub-groups of the population is preserved: donors of blood, biological fluids, tissues and organs; medical specialists connected with blood, biological fluids, tissues and organs; prisoners; people with STIs; pregnant women; children born to HIV-positive mothers; drug addicts; people who have been out of the Republic of Armenia for at least three months.
- If an individual becomes HIV infected while receiving or providing medical care and service, individuals have right to compensation for the caused harm (legislative acts, which must regulate this statement haven’t been developed yet).
- HIV-positive people have the following rights:
 - a. to receive written information about the results of testing
 - b. to a non-discriminative attitude from medical professionals
 - c. to require medical confidentiality, with the exception of cases determined by the RA legislation. If the individual has committed a crime and is persecuted by the law, the medical confidentiality is not maintained.
 - d. to continue working, with the exception of cases determined by the RA government. According to the decision of the Government there is a list of professions, that HIV positive people are not allowed to practise. They are: transplants, blood transfusion, haemodialysis, anaesthesia and reanimation, general surgery, cardiovascular and pulmonary surgery, ear, nose, throat (ENT) surgery, neurosurgery, obstetrics and gynecology, burn specialists, ophthalmology and stomatology.

- e. to receive appropriate counselling and to get acquainted with prevention and transmission of HIV
- HIV-positive people cannot serve as an object for scientific experiments and testing without their written consent
- HIV-positive children under 16 enjoy the rights determined by the RA legislation for disabled children under 16.

II.2.4. National response to HIV epidemic at the legislative level

In 2002 the Inter-Standing/Inter-Faction Parliamentary Group on HIV/AIDS was established. This committee includes representatives of all factions and groups representing different parliamentary committees. The representatives have come together to improve the role of legislation in the implementation of the National Programme on HIV/AIDS Prevention.

The Parliamentary Group's Activity is focused on:

- Improving the legislation related to HIV and AIDS
- Exercising control of the legislature over the implementation of the National Programme on HIV/AIDS Prevention
- Stimulating the allocation of the necessary budget funds for this important component of the public health protection in Armenia
- Raising awareness on HIV epidemic among other representatives of the legislature
- Holding the Open Parliamentary Hearings on HIV and AIDS issues

In 2003, based on a new parliamentary election a number of deputies related to this group were not re-elected, and the group stopped working. At present attempts are made to reorganize and resume the activities of the parliamentary group already with new staff (and define the goals).

The urgency of the situation deemed it necessary to reconsider and amend the functioning laws and other legislative documents. The activities addressed to the amendments in the legislative field in the sphere of HIV/AIDS have already begun and are in the process. The new version of Criminal Code excludes the criminal responsibility envisaged for same-sex sexual contacts (The new Criminal Code was adopted on 18 April 2003). Till then according to the functioning Criminal Code criminal responsibility was envisaged for homosexual practices with up to five years imprisonment.

Nowadays the draft of 'Prevention of diseases caused by human immunodeficiency virus' project has been developed according to international standards. In the functioning law, the mandatory testing for a number of groups of population is preserved: donors of blood, biological fluids, tissues and organs, medical specialists connected with blood, biological fluids, tissues and organs, prisoners, people with STIs, pregnant women, children born to HIV positive mothers, drug addicts, people who have been out of the Republic of Armenia for three months on service or on business trip.

Since 2004 activities concerning amendments of this law have been activated. In particular, the specialists of NCAP cooperate with the experts and members of regular committee of the National Assembly on social questions, questions on health and nature protection for developing law amendments. A number of suggestions are presented for discussion, the most important of which is the review of the article on mandatory testing (the mentioned article hasn't been functioning in the last 4-5 years) and the development of several articles on social protection of PLHIV.

Drafts have been designed for making changes in the laws on education, advertisement and mass media, as well as in a number of articles of Labour Code and Criminal Code of the Republic of Armenia.

According to the Criminal Code, drug use was punished with imprisonment for a two year period or with correctional labour for the same period, or with fine at the rate of thirty fold or fortyfold of the minimal salary (RA Criminal Code). According to the new Criminal Code drug use is punishable by with fine at the rate of maximum two hundred fold of the minimal salary, or with imprisonment for a two month period. Though using drugs is still looked upon as a crime, reducing the punishment period from two years to two months can be looked upon as progress. This has had a positive effect on the implementation of preventive activities among IDUs and it is indirectly responsible for the increase of preventive activities among IDUs. Though this group still remains isolated and difficult to reach, it is easier to reach them compared to the period 1999-2001.

A memorandum on mutual understanding and support signed in 2002 between the Ministry of Health and the Ministry of Internal Affairs of the RA. This memorandum supported the implementation of preventive activities on HIV among IDUs, and contributed to the implementation of preventive activities among IDUs. It is intended to expand of cooperation in the field of HIV prevention, clarification of inter-relation of the Ministry of Health and the Ministry of Internal Affairs of the RA and the effectiveness of HIV prevention among IDUs. The aim of preventive activities is to reduce of the spread of HIV among IDUs and the general population of the RA. Preventive activities are conducted through complex activities, based on 'harm reduction' strategy in case of non-medical drug use. . According to that memorandum the Ministry of Internal Affairs of the RA does not hinder 'outreach' workers and implementation of HIV prevention activities, which include information-educational activities, needle exchange and condom distribution, transfers the implemented activities from IDUs to those, who are involved with preparing, storing, transferring and selling drugs.

According to expert evaluations, people living with HIV are to some extent protected legislatively in our country. While the level of enforcement and the ability of PLHIV to seek redress may be compromised. The change of legislative field demands solving of other questions, e.g. we have a great number of groups undergoing mandatory testing. Of course, donated blood, biological fluids, tissues and organs must undergo mandatory HIV screening. However, in other cases testing must be voluntary and must be accompanied by HIV pre- and post-test counselling. The law must be changed in this sense. These proposals have been developed, and the legislative body is discussing these changes. Some problems concerning social protection of PLHIV can also be included in the new law. The director of NCAP emphasized: 'There are countries, where these people get lifelong pension. Here we do not have it, and maybe the question of pension must also be raised – to give pension to PLHIV, which will give chance to take care of minimal needs. As HIV infection is a life-lasting disease some constant methods are necessary for PLHIV, so that they can ensure minimal elements of healthy lifestyle. The vast majority of PLHIV are unemployed. These grants will contribute to their social integration. Establishing places of work can also contribute to this goal, which is a problem not only for people living with HIV, but for the whole society' (Opinion of the interviewed national expert).

Viewing legalization of commercial sex work and opening of brothels as a possible means of HIV/AIDS prevention, it has been argued that brothels will legalize CSW, making it both easier to regulate and to locate CSWs for periodic testing. In Armenia the problem is that a CSWs are afraid to reveal their 'work', which is an obstacle for including them in different preventive programmes. Besides, our society is not ready for that yet (opinion of the interviewed national expert).

II.3. National Response to HIV and AIDS at the Level of Government

II.3.1. National response to HIV and AIDS at the level of executive power

The Strategic Planning Process for a National Response to HIV and AIDS started in the Republic of Armenia in 2000, when a Situational Analysis on HIV/AIDS and a Rapid Assessment of the situation on injecting drug use and HIV infection, Sentinel Epidemiological Surveillance among key populations (injecting drug users, sex workers, MSM, groups at risk to HIV in Penitentiary Institutions (migrants were not included in the Sentinel Epidemiological Surveillance) and Response Analysis were conducted (Grigoryan, Mkrtychyan and Davidyants, 2002). Based on the HIV/AIDS Situational Analysis and Response Analysis, the National Strategic Plan for a National Response to HIV/AIDS epidemic in the Republic of Armenia was developed and approved by the College of the Ministry of Health of the Republic of Armenia on 06.12.2000 (Minutes N 12/4) and by the RA Minister of Health (Decree N 14 of 12.01.2001). The National Strategic Plan served as a basis for the development (in collaboration with interested governmental agencies) of the National Programme on HIV/AIDS approved by the Government on 1 April 2002 and ratified by the President of the Republic of Armenia (National Programme on HIV/AIDS Prevention 2002).

The Programme has the following objectives:

1. Developing and implementing the national policy on HIV/AIDS prevention and treatment. (see section I.5.4 above)
2. HIV prevention among injecting drug users.

3. Forming safer sexual behaviour.
4. Prevention of mother-to-child HIV transmission.
5. Ensuring donated blood safety.
6. HIV and STI prevention among minors and youth.
7. Treatment and Caring for PLHIV.

The objective of developing the national policy for responding to HIV epidemic is to form multisectoral response to HIV/AIDS at the state level. It has the following strategies:

1. Develop a national policy on response to HIV epidemic
2. Improvement of the existing legislation on HIV prevention
3. Develop specialized services for HIV prevention
4. Implement programmes on HIV, STI and drug use prevention in educational establishments.

One of the especially important events in the area of HIV/AIDS prevention in Armenia was the establishment of the Country Coordination Commission on HIV/AIDS Prevention (CCM) by the decision made by Interministerial Council on HIV/AIDS prevention on 26 April 2002. The CCM was established to approve and submit to the Global Fund to fight AIDS, Tuberculosis and Malaria the project proposal on HIV/AIDS prevention, to determine current priority strategies on HIV/AIDS prevention, to allocate and monitor the Global Fund's finances. CCM is a multisectoral Commission where the representatives of Government, NGOs, International Organizations, UN Agencies, and People living with HIV are represented. Besides the Ministry of Health the representatives of 12 Ministries and State agencies are involved at the level of Deputy Ministers and Deputy Heads. CCM has regulation, according to which the main goals are: coordination of HIV/AIDS-related activities implemented by governmental, nongovernmental and international organizations, as well as private sector and civil society; identification of priorities in scientific research on HIV/AIDS, as well as prevention, diagnosis and treatment of HIV/AIDS; developing the HIV/AIDS preventive activities, forming multisectoral response to HIV/AIDS; ensuring more wide participation of NGOs, PLHIV and people affected by the epidemic, community representatives, International organizations and private sector in HIV/AIDS prevention activities; considering information submitted by the Ministries, Governmental Departments and Regional Administrations on their response to HIV/AIDS epidemic; carrying out monitoring and evaluation.

CCM has Chair, Deputy Chair in the person of Chief State Sanitary Doctor of RA, and CCM Secretary in the person of the Director of the National Center for AIDS Prevention.

Currently the CCM Chair was elected the representative of NGO sector, the President of Armenian Red Cross Society; he replaced on this position the Minister of Health of RA, as according to the Revised Guidelines on the Purpose, Structure and Composition of

Country Coordinating Mechanisms and Requirements for Grant Eligibility the CCM Chair and the Deputy Chair are to be elected from the different sectors.

Regional Programmes on HIV prevention have been developed taking into consideration specific aspects of every Marz. For example, in some Marzes the priority issues are related to injecting drug use spread, while migrations is a more prominent issue in others. The work on establishing Regional Multisectoral Councils on HIV/AIDS Prevention for coordinating activities of the National Programme on HIV/AIDS Prevention and Regional Programmes on HIV Prevention has concluded.

II.3.2. 'National Programme on HIV/AIDS Prevention'

According to the 'National Programme on HIV/AIDS Prevention' the strategies for prevention among IDUs included reducing delivery of drugs, harm reduction of non-medical drug use, and primary and advanced prevention of drug use. To solve the aforementioned problems, it is necessary to strengthen control implemented by relevant state organizations over illicit drug production, transportation, storage and sale, to raise awareness of vulnerable population groups, to promote safer behaviour, to form self-help groups, to design and introduce pilot needle exchange projects, and to introduce and develop the system of sentinel epidemiological HIV surveillance in the target group of injecting drug users. For primary and advanced prevention of drug use it is necessary to raise awareness about drug use prevention issues among general population through mass media, to develop and introduce drug use prevention issues into the educational programmes, to provide peer education, to form a rehabilitation system for drug users.

The strategies designed to promote safer sexual behaviour, reduction of HIV and STI spread through sexual contact are: to raise awareness about safer sexual behaviour, on HIV and AIDS and STIs among

general population with the help of information-educational materials, promotion and access to condoms, to design and carry out special activities about HIV and STI prevention among CSWs, to develop a system of sentinel epidemiological HIV surveillance in this group, to provide accessibility of STI diagnosis and treatment for all population groups, to expand network of cabinets for anonymous STI treatment. For promotion and accessibility of condoms it is necessary to implement programmes on condoms distribution among migrants, the military, and individuals in penitentiary institutions. It is also important to promote availability of condoms through regular commercial sales, as well as in places of entertainment, to provide control over the condoms quality in accordance with the international standards, to advertise prevention means through mass media, to print and distribute awareness literature. Socio-cultural approaches are taken into account when implementing these programmes, such as where to establish VCT sites, how to implement peer education programme, etc.

Experts share the opinion that information-educational activities should be conducted not only among key populations vulnerable to HIV, but through the whole population. It is of great importance to raise the level of knowledge and awareness about the disease, its modes of transmission and prevention, consequences. The activities should be conducted with different groups of the society. Programmes are addressed to all the key population groups – IDUs, CSWs, MSM, prisoners, migrants, refugees, youth and in the general population. For the latter, activities are mainly information-educational actions, shows, and TV and radio-programmes. There is a need for programmes targeted to all social groups. While the level of knowledge in cities is very important, it is more important in villages, where the level of awareness and knowledge is very low. Implementing activities among migrants is also very important. HIV prevention programmes among migrants include provision of peer education, distribution of information/educational materials, increasing access to STI treatment, access to VCT services, and condom distribution.

Activities with youth are also very important. At the same time it is mentioned that work with youth must be carried out with adults, as well. In other words, it is very important to include parents in educational programmes and to organize informational activities, meetings, and training for them. In this way not only children, but their families, will be educated. The views of one of the interviewed experts can be summarised as follows: ‘The most important things are educational activities with population. We must work with vulnerable groups, so that infection spread will be reduced, and we must surely work with the whole population providing information. Both mass media and educational programmes in schools must work...’

While the messages on HIV/AIDS awareness and prevention must be expanded to reach a wider audience within the general population, they will only be effective if information is provided in a manner that is culturally appropriate for the target audience. According to a UNAIDS international consultant, ‘Information is effective only when it is directed to a listener. There is information for the general population, which should be like a background presentation. It should be done through TV, radio, and newspapers. The aim of such information is to focus attention on the problem. But it must be done so that it will not be misused by reporters – to write all kinds of unimaginable stories for having sensational material. This distorts people’s ideas about the actual situation of the disease. It also makes a person think that nothing depends on him/her. That’s why background presentations are not looked upon as basis for behaviour change. Further information must have a strict direction. If we speak about the youth, they are not homogeneous: a 15-24 year old person can be one who does not lead sexual life, or one who leads sexually active life, or one who is an injecting drug user or a man having sex with man, and so on. If we prepare information for IDUs and spread it at school, we will not have any result. It will also receive its negative public reaction. Information must be clearly addressed to its listeners. Only in this way a person can think about practising his/her behaviour or changing it. Of course works with small groups or individual are the most effective ones, which are not always possible. In this case a person is ready to act. And in the end information must be constantly provided, which will strengthen his/her safe behaviour. After a person has changed his/her behaviour, he/she must be constantly informed that his/her behaviour is important first of all for him/herself. This information can be provided as a background presentation, e.g. by a statistical picture in a cause-effect relation. E.g. if we mention that the number of those exposed to the epidemic has increased in such a year, and also explain that it is first of all connected with improvement of laboratory diagnostics system, it will not affect a person much. And if we mention that the increase of the number of people infected with HIV is connected with the fact that the level of rejecting

to share syringes and the level of condom use among IDUs and CSWs is rather low, which is closer to the real picture, a person begins to practise safer behaviour. This will strengthen the practice of safer behaviour in a person. The results will not be effective if we do not take into account the peculiarities of each group and audience. An eighth-grade pupil at a secondary school (14 years old) and a fifth-year student at a higher educational institution (about 21 years old) must receive different information.'

Also, according to a psychologist working with MSM, MSM are more interested in condoms which are being provided to them during their visits to a psychologist, as a part of VCT service. And not all of them read booklets and brochures. They view the problem more practically and it must be taken into account in future development of programmes. 'When peer educators come to us, they do not say that they need booklets, they say that such a person has sent them and he needs a condom. As for applying new methods, I anticipate that games will provide an important activity through which safe-sex behaviour can be introduced and taken up by participants.'

Experts find that in order to promote awareness and behaviour change, educational activities must be supplemented with other sorts of activities. In particular, cultural events and involvement in socially-powerful institutions are a successful means of effecting change. According to the NGO Armenian National AIDS Foundation, cultural activities attract people. A concert of classical music was organized by the NGO in Kapan city (Syunik Marz) and was widely attended. Throughout the two-hour concert, every ten minutes information on HIV and AIDS was provided, beginning from the simplest questions: what is HIV and AIDS, how HIV is transmitted, how it is prevented, questions on preventive means, STIs, and drugs. During this activity information educational materials and condoms were distributed to the audience. I think that the combination of cultural event and HIV prevention is very effective. Especially in Marzes, people are very active in such cultural events.'

According to many experts it is necessary to include structures in HIV prevention activities that will help provide information on HIV and AIDS more effectively. This can be combination of theatre, artistic and cultural activities, and Armenian national music, which will also attract people. The role of mass media is also very important, and here reporters have a lot to do, especially in overcoming stigma and discrimination, and in raising the level of awareness. But we also need to develop means of introducing information about HIV to the population without deepening stigma and discrimination.

The person who delivers the message can also shape the impact of the message to its target audience. When famous actors and artists speak about HIV and AIDS and prevention, their voice reaches the youth better, since they have authority. For example, a singer's speech about the disease can reach his audience easier than a specialist's speech about the disease. The NCAP has commissioned a new song addressing HIV and AIDS. The song has been composed and during the next step of the project, famous singers are planning to record it. Furthermore, people who have authority can express their point of view on safer behaviour during discussions of different social issues both on TV and on the radio. The church is also viewed as one of the social resources in the response to HIV and AIDS, as it has an important role in 'moral education.'

Taking into account the high vulnerability of youth to HIV, prevention activities among youth are introduced in the programme separately. The goal is to reduce the rates of HIV, STI and drug use prevalence among young people. For solving this problem it is necessary to raise awareness among minors and youth. It is envisaged in the framework of the National Programme to design and introduce education programmes on HIV and AIDS, STI and drug-use prevention in educational establishments, to work out and publish relevant methodological and didactic materials for educational establishments, to train education specialists in the field of teaching methodology, to design and implement information-educational programmes for the military and individuals in penitentiary institutions, to develop and implement programmes aimed at solving problems of young people outside the formal education system and those who do not work, and to design mass media target information-educational programmes focused on youth. The National Programme on HIV/AIDS Prevention was adopted in 2002 and it is envisaged to be implemented in five years.

An updated education conception has recently been adopted. In the near future, the National Assembly will adopt the new law on education, after which the Ministry of Education will develop concrete mechanisms for reaching a lot of objectives. Currently there are no other sexual health education programmes, other than those mentioned in this report.

When providing young people with information it is necessary to take into account the socio-cultur-

al context in which information on HIV and AIDS must be given. Traditionally in Armenia, the family deals with a child's upbringing, but as HIV and AIDS is connected with the topic of sexual life, other sources of information, particularly peers and school, become a very important source. Though experts' opinions on this question vary, all of them think that a person must get knowledge about HIV and AIDS when they are of school age, and that it must be strengthened throughout one's life. This topic must be spoken about very carefully, but also very openly and clearly for a child. It means that you must teach parents as well, since they do not always have accurate information. Even when they do, they cannot always tell a child without feeling ashamed. And a child is not always prepared to speak about the problem with parents. As Armenian traditions can cultural norms, there is still the obstacle that this topic is not spoken about with parents. Experts think that to be effective, all the structures can be involved in the process of information provision and they give correct information on prevention of the disease. A family member can also get a booklet and share it with family members. Peer education in schools is also very effective. However, the accuracy of the message is not necessarily guaranteed. Furthermore, peer-to-peer education on HIV and AIDS awareness and prevention has to be correctly organized.

Some experts give importance to the role of the family in HIV prevention (see Part III Case Study). Some have even offered proposals on how the parents can be involved in HIV prevention activities. Even within the framework of the peer education programme in schools, attempts are made to involve parents in HIV prevention activities. Lack of knowledge on how parents can be involved in HIV-prevention programmes is connected with the lack of practice in this field; there is no study to show its efficiency.

When speaking about HIV and AIDS, age-specific information and the people who deliver it are very important. Experience shows that the presence of knowledge in a person does not necessarily guarantee a change in his/her risk-related behaviour if certain ideas and behavioural patterns have already formed. The best agent to provide information to teenagers is school, as it is freely available to everyone. Informational courses for students can be held in educational institutes, and for workers in their place of employment. Relevant knowledge should become the basis for safer behaviour - young men and women do not get that knowledge before starting sexual life, and as a result, behavioural pattern is already formed, e.g. having sexual relations without condoms. Later s/he gets knowledge that s/he must apply, but he already cannot change the formed behaviour. And in future s/he comes across many problems. If s/he used condoms from the beginning the stereotype of sexual relations with condoms would be formed.

At the same time, according to Armenian culture, the mobilisation of the older generation can also serve as a very important source in providing information. Especially for Armenians – though it is specific for Asian countries as well – traditionally, older people are respected and can be used in activities surrounding the epidemic.

According to a specialist in the educational field, education about HIV and AIDS should originate in the family, which is the primary site of socialisation. At the same time, experts recognize that most parents lack knowledge about HIV and AIDS; they too are in need of education. In other countries, teachers organize parents' meetings to inform them about what their children will be taught. According to one expert, a parent and a child are not peers, and information provided via peer education is more effective. One approach is to bring a parent to this field with the help of a child. In one scenario, parents receive instruction through courses during parents' meetings. Families are educated by being included in different programmes. Potential limitations are conditioned by the fact that even if a parent has some knowledge on HIV/AIDS, sexual health, etc., it is difficult to speak about these issues with his child. In many cases parents don't know how to talk to their child about these issues. When involving parents in the programmes, it is important not only to give them information, but also to train the parents to know how to deliver that information to their children.

Providing information is only a small part of HIV prevention. Individuals should be taught life skills concerning disease prevention. These means should be available for the population as well. Three important and necessary elements are: information, life skills, and availability of preventive means. All should be strengthened through the mass media and different cultural activities targeted to general population. In this way, everything gained during school is strengthened and safer behaviour has a constant, not episodic, character.

As for the effectiveness of methods to provide information, particularly conducting courses of sexual education, some argue that such courses should be conducted separately for boys and girls. Girls cannot speak freely on these themes, as experience shows that in Armenia, women and men do not speak on

such themes together, even as adults. According to another observation there are universal experiences, and the Armenian case is not radically different; there are no methodological differences in the programmes (such as peer education, needle exchange, etc) implemented in other countries and in Armenia. They are only different in terms of implementation. For example, it is more expedient in Armenia to establish the site in medical centers, where different people visit anonymously, whereas in other countries the site may be someplace else.

According to other experts, 'discussions with large audiences cannot lead to success, and TV shows and talk shows can harm more than they help because they do not adequately address the issues. Small discussions in working places, in stations, in educational institutions - when you know that you are not being photographed and that you are free to express yourself - are more effective. If the same people in a TV studio listen and are not photographed they will have another effect than when they work, applaud, and express their meaning for a large audience, where there are people with different opinions. Currently, people here face time constraints, and there is lack of sincerity during these shows. The audience listens to the discussion, but does not take part in it; there is no mutual influence, there is no reflection from audience, no connection'. Here there is also the opinion that it is not possible to change attitude through TV programmes. According to one of the experts interviewed for this report, radio is more effective than TV, as it forces a person to listen more carefully. While TV is more powerful, it is not powerful in sense of changing opinion attitude. Effective programmes are also those programmes that are continual, which turn to the same topic periodically. However, it is imperative that they be based on very concrete information and must not be sensational.

According to the president of the NGO 'APEC,' A. Musheghyan, sensationalism in this field is harmful and dangerous. Sensational news is shocking news, which is forgotten very easily. When we say that spread of the epidemic is a daily phenomenon, we mean that we must deal with the problem every day. We shouldn't deal with the problem from sensation to sensation. There is attention to the problem, the problem is raised, the national strategy is accepted, and sensationalism is avoided. Sensationalism is a technique for attracting attention, and that stage is gone. That is if it is a continual TV programme, it can have another effect.'

Moreover, talk shows are easily forgotten. They attract large audiences, but cannot be a main means of education, as they do not encourage people to think differently. In this sense discussions in working places take place in smaller groups and only among familiar people. (Familiarity will increase the probability that people can speak frankly with each other and are more likely to be more sincere with one another. Unfamiliarity may discourage people from speaking openly with one another and lead them to be less sincere). To be sure, successful programs must be constant and interrelated, and they must be coordinated nationally to bring success. It is difficult to coordinate such programs nationally, especially given the widespread reluctance to change patterns of thought and action, as well as assumptions.

The next issue included in the National Programme is Prevention of Mother-To-Child Transmission (PMTCT). The strategies for reaching this aim are to ensure pregnant women's access to HIV testing and to provide preventive treatment for HIV-positive pregnant women and their infants born. It is envisaged to perform HIV testing among pregnant women accompanied by pre- and post-test counselling. With this aim it is necessary to provide relevant training for health care workers, to raise HIV/AIDS awareness among women of childbearing age, and to develop and issue guidelines on pregnancy and delivery course for HIV-positive pregnant women. It is also critical to develop and issue guidelines on feeding of infants born to HIV-positive mothers, to develop and introduce standards of preventive treatment of HIV positive pregnant women and infants born to them, to provide relevant training for health care workers, to provide HIV positive pregnant women and infants born to them with preventive antiviral treatment and to purchase necessary medicines, to provide infants born to HIV infected mothers with milk mixtures for artificial feeding.

Another important issue in the National Programme is ensuring the safety of donated blood and blood products. It is necessary to provide absolute control over HIV prevention with regards to donated blood and blood products transfusion, HIV testing and screening. With this aim it is envisaged to purchase high quality test-kits, and to develop and introduce a system of control.

The issues concerning caring for people living with HIV are also included in the programme. It is planned to develop treatment guidelines for adults and children living with HIV, to provide HIV antiretroviral (ARV) mediations necessary for their treatment. Today, no ARVs are available for PLHIV.

II.4. Non-Governmental Organizations

II.4.1. National Response to HIV and AIDS at nongovernmental and international organizations' level.

National and international NGOs are involved in the Country Coordination Commission on HIV/AIDS Prevention.

The UN Theme Group, U.S.A International Development Agency, OSI-Armenian branch, MSF-Belgium, World Vision Armenia, and Armenian Red Cross are also included in the Country Coordination Commission on HIV/AIDS Prevention.

A number of activities have been conducted with the support of international organizations and international NGOs. Various preventive projects among different key populations are being implemented with the support of international organizations (UNAIDS, UNICEF).

The NCAP, in collaboration with the NGOs and with the support of OSI, conducted a number of activities to support people living with HIV, including distributing personal hygiene kits and means of protection.

In 2002 World Food Programme supported PLHIV to receive food aid, which to some extent eases their basic food needs. In 2003 World Vision Armenia supported PLHIV on obtaining the clothes as and aid.

A peer-education project aimed at preventing of HIV, sexually transmitted diseases and drug use among youth was carried out in secondary schools in one of the Marzes by NGOs in collaboration with the NCAP and the financial support of UNICEF.

Under the auspices of a joint effort between the NGO and UNFPA, the NCAP developed and published modules of training programmes on HIV- and AIDS-related issues for biology teachers and high school students. The Center's specialists also conducted lectures for biology teachers of forty schools of Yerevan aimed at raising teachers' awareness about modes of transmission and ways of prevention.

The network of NGOs is established and strengthened for improving coordination in HIV prevention through awareness-raising campaigns.

II.4.2. UN System Support to the National Programme on HIV/AIDS in Armenia

The UN System in Armenia consists of:

- United Nations Development Programme (UNDP)
- World Food Programme (WFP)
- United Nations Children's Fund (UNICEF)
- United Nations Population Fund (UNFPA)
- United Nations Department for Public Information (UNDPI)
- United Nations office of the High Commissioner for Refugees (UNHCR)
- United Nations joint Programme on HIV/AIDS (UNAIDS)

The heads of agencies and a government representative have created a Theme Group on HIV/AIDS.

United Nations Development Programme

- Rehabilitation of the National Center for AIDS Prevention, Yerevan
- Capacity building and Procurement of medication (ARVs and/or medication for treatment of opportunistic infections), condoms, equipment and test kits (As of 1 February 2005, twenty individuals with AIDS have undergone ARV treatment.);
- Rehabilitation of laboratories in Yerevan and five regions (Goris, Gavar, Artashat, Ijevan, Vanadzor);
- HIV/AIDS and Uniformed Services (UNDP): Army, police and staff of penitentiary institutions:
 - Establish prevention system in uniformed services;
 - Capacity building;
 - Develop national strategy on HIV/AIDS in uniformed services;
 - Increase awareness.

United Nations Children Fund (UNICEF) projects

- Summer school for ninety-six peer educators from Yerevan and regions
- Setting-up sessions of peer educators on HIV/AIDS, STIs and Drug use issues
- Development of Healthy Life Style Curriculum (HIV/AIDS, STIs, Drug use, reproductive health) for upper grades of secondary school
- PMTCT (Prevention of mother to child transmissions) activities
- Guidelines and educational materials for health providers have been developed and endorsed by the Ministry of Health
- According to the decree of the Ministry of Health, training for trainers was conducted for twenty-six individuals
- A planned pilot training in Yerevan

United Nations Population Fund

- Improving RH services for women, men and young people
- Raising awareness on STIs/HIV prevention among women and men
- Condom Social Marketing to prevent STIs/HIV among young people and risk groups
- UN HIV/AIDS Campaign

United Nations Department of Public Information

- Information on HIV/AIDS issues
- Commemoration of UN Days
- Publication of UN bulletin and participation in MDG's advocacy campaign

According to the UNAIDS Intercountry Coordinator for the Southern Caucasus in Armenia, various programmes for AIDS prevention are being implemented among different groups – IDUs, CSWs, youth, and migrants. Because these programs are very young, it is difficult to speak about their influence and effect. There are indications that each programme implemented in Armenia attempts to integrate different ways into the specific cultural context of Armenia. Time is needed for their proper evaluation. Experience of other countries shows that such programmes are efficacious; they have been addressed to concrete groups and to the whole society. Local NGOs consider the inclusion of international organizations in HIV prevention activities very important. The co-president of the 'Real World, Real People' NGO has mentioned that there is no other functioning organization other than NGOs that works in the sphere of social and medical services for PLHIV. However, there are other organizations, mainly international, which provide support to PLHIV.

II.5. Non-Governmental Organizations in the Sphere of HIV

A number of local non-governmental organizations functioning in the RA are included in the Country Coordination Commission on HIV/AIDS Prevention. They are:

- 'AIDS Prevention, Education and Care' (APEC) NGO
- 'Antidrug Civil Union' NGO
- 'Education in the Name of Health' NGO
- 'The Scientific Association of Medical Students of Armenia' (SAMSA) NGO
- 'Youth Cultural Organization' (YCO) NGO
- 'Armenian National AIDS Foundation' NGO
- 'AIDS Prevention Union' (APU) NGO
- 'Real World, Real People' NGO

'The Scientific Association of Medical Students of Armenia' (SAMSA) NGO

The Scientific Association of Medical Students of Armenia (SAMSA) was founded in 1991.

The purpose of this association of medical students and junior doctors is to support and develop scientific potential, to protect their interests and assist them in acquiring scientific experience and practical skills in Armenia and abroad. The organization also trains doctors with high social activities that will

make a valuable contribution to the promotion of medicine in Armenia.

Public programmes related to HIV/AIDS:

In August 1995, SAMSA began to collaborate with AIDS Armenian Centre. In 1997-98 in 20 secondary schools of Yerevan carried out an 'Anti-AIDS project' sponsored by UNAIDS.

In 2000 SAMSA received a grant from UNFPA for a 'Reproductive Health campaign' project.

In 2001 SAMSA received a grant from UNFPA for the project 'HIV/AIDS Education in Secondary Schools of Yerevan', and the 'HIV/AIDS Prevention in Gegharkunik' project.

In 2002-2003 3 three projects were implemented: 'Towards Healthy Generation and Survival of Nation,' 'Social Marketing of Condoms to Prevent STI/HIV/AIDS in Armenia,' and 'Nutrition and Hygiene Information Education Communication Campaign.'

Currently SAMSA, jointly with the other local NGOs, organized and carried out information/education campaign activities, concerts aimed at raising the awareness about HIV and AIDS among youth and general population. These activities were covered in mass media. SAMSA in collaboration with ANAF developed education/information materials to introduce and HIV prevention education project in the secondary schools and higher education establishments. They also worked in close cooperation with the specialists of the Ministry of Science and Education of RA and NCAP. The education/information materials were for college and higher educational establishments students and for schools pupils and include the topics on HIV/AIDS essential issues, such as formation of safer sexual behaviour, prevention of HIV and drug use.

'Youth Cultural Organization' (YCO) NGO

The Youth Cultural Organization (YCO) was established in 1997. YCO regularly participates in and implements activities aimed at HIV/AIDS prevention among vulnerable groups, encourages safer behaviour among youth and conducts information/education activities among them. YCO involves mass media in these activities. The brochure, 'Our future depends on us' focusing on youth was developed, published and introduced to the students at Yerevan higher educational establishments; an Internet page devoted to World AIDS Day was also developed: <http://www.ycoaids.iatp.irex.am> (currently offline). The page contained information on HIV/AIDS and the information was regularly updated. According to the regulations of this NGO, only people between the ages of 16-35 can be members. But the NGO can implement activities in groups of people of different ages.

'Education in the Name of Health' NGO

The NGO 'Education in the Name of Health' was established in 2003. The objectives of the organisation are to contribute to the development of a healthy lifestyle among the general population, to take measures to reduce the effect of the factors of the surrounding environment on the health condition of people, to contribute to the elimination of behavioural practices harmful to health among general population, to implement preventive activities among key populations, and among general population of Armenia, to unite the youth and to direct the potential to HIV, STIs and drug use prevention, and to support and care for people living with HIV, STIs, and drug users.

Within the framework of the National Programme and with the support of the Global Fund, the NGO implements the 'HIV/AIDS prevention among MSM in Yerevan City' project. The overall goals of the proposal are:

1. To provide MSM in Yerevan with knowledge on HIV and STI prevention;
2. To prioritise the idea of safer sexual behavior and promote behavior change in MSM in Yerevan;
3. To provide VCT service for MSM in Yerevan.

This group receives support from medical professionals, lawyers and psychologists. This project works only in Yerevan, but their beneficiaries are not only those living in Yerevan. MSM in other cities and regions themselves find it more expedient for the programme to be implemented in Yerevan, because it's a comparatively big city.

'Real World, Real People' NGO

The NGO 'Real World, Real People' was established in February 2003, by people united around the idea of providing support to people living with HIV and AIDS in Armenia.

The purpose of organisation is to increase the quality of life of PLHIV by providing social, psychological and legal support, rendering assistance in employment, and increasing access to medical care. The organization also fights against HIV- and AIDS-related stigmatisation and discrimination. The organization carries out various projects on the prevention of HIV and AIDS among youth, vulnerable groups and general population. An important part of their activities is helping PLHIV to integrate with society.

The organisation gives the following services to people living with HIV and their family members:

- Social support
- Legal consultation
- Psychological consultation
- Outpatient care
- Financial consultation
- An information centre is established for PLHIV, their family members, personnel and for other NGOs working in the sphere of HIV/AIDS.

PLHIV and their family members actively participate in a self-help group, also created by the organization. The members of the self-help group take part in developing and performing the projects of the organization, that partly alleviates soothe the burden of unemployment of the PLHIV in Armenia.

Currently the organization has thirty-four members, some of whom are HIV positive. People from various specialties interested in HIV/AIDS-related issues also join the organization. Among them there are doctors, psychologists, lawyers, sociologists, the majority of whom have long-term experience working in the sphere of HIV prevention and support to PLHIV and their families. The involvement of PLHIV in the NGO and the fact that they make decisions and take part in all the processes of the NGO, contributes to the success of this NGO.

'AIDS Prevention Union' (APU) NGO

In August 2003 the 'AIDS Prevention Union' (APU) NGO was established in Yerevan.

The main objectives of the Center are:

- providing moral and sexual education (including training) for different population groups (teenagers, youth, etc.), providing information and education on the issues of HIV/AIDS, including health;
- sharing information on HIV prevalence within the country; strengthening contacts with individuals and legal entities;
- implementing activities on HIV/STI prevention;
- giving medical and psychosocial counselling to HIV-positive individuals and persons from key populations particularly vulnerable to HIV;
- experience exchange and collaboration with other countries in the field of HIV/AIDS.

The APU carries out activities aimed at preventing the HIV epidemic among vulnerable groups, training on skills of safer behaviour, information/education activities among youth.

The NGO staff consists of doctors, epidemiologists, PLHIV and representatives of vulnerable groups.

The members of APU NGO have great experience in implementing projects, conducting different research among CSWs, IDUs, and have taken part in the Second Generation HIV Surveillance in the Republic of Armenia (which was carried out in 2002). They have also conducted Biological and Behavioural Surveillance studies among CSWs in the Republic of Armenia.

In 2003 APU implemented SCAD (UNDP/EU) Project 'Drug Prevalence Survey among the Armenian Students'.

Currently APU NGO is implementing the project 'HIV/AIDS Prevention among CSWs in Yerevan' supported by the GFATM.

The President of APU NGO is a member of the Country Coordination Commission on HIV/AIDS Prevention in the Republic of Armenia (CCM).

'AIDS Prevention, Education and Care' NGO (APEC)

The NGO 'AIDS Prevention, Education and Care' NGO (APEC) was founded in 2001. The principle objectives of APEC NGO are:

- HIV, STIs and drug use prevention, promotion of healthy lifestyle among youth and general population.
- Provision of psychosocial support, human rights protection, counselling and care to PLHIV, drug users and their family members.
- Provision of prevention/education activities among general population and groups vulnerable to HIV.

Since 2001 APEC NGO has implemented the following activities:

- **World AIDS Day, 2001 – 'I Care, do you?' (part of the World AIDS Campaign for 2001)**

A procession with posters organized on 1 December, in the central streets of Yerevan; shooting and broadcasting of a film on issues of HIV/AIDS ('Monologue' – an Armenian film with participation of an HIV-positive person) on the central TV channels; airing of a number of radio programs aimed at drawing public attention to HIV prevention issues;

- **World AIDS Day, 2002 – 'Lets support each other'**

The campaign assumed multilateral work with Mass Media: Television, distribution of posters, booklets and condoms. The campaign was implemented in all directions simultaneously with a common style and shared messages and core concept. From 30 November an all-embracing PR campaign was running all over Armenia. The film 'Philadelphia' (1993) was aired on all central TV companies on 1 December. Video spots developed specially for World AIDS Day ('A Game with life is a short pleasure', 'Live and let live', 'Protect yourself and your dear people') were broadcasted during intermissions of the film. Booklets containing detailed information about HIV/AIDS, ways of transmission and prevention, as well as condom inside and 1 poster containing the most important message of this campaign regarding human rights of people living with HIV were developed. Four large posters were placed in the central streets of Yerevan devoted to promote tolerance and refusing discrimination of PLHIV. A concert with the motto 'HIV Positive People are Full Members of Our Society' was also organized in Yerevan.

- **Peer education activities among youth.**

Since 2001 APEC NGO has started implementing peer education activities for the prevention of HIV, STIs and drug use for youth in Syunik and Gegharkunik Marzes. Since 2004 APEC NGO jointly with Armenian Red Cross Society and other local NGOs has implementing the "Peer education among youth" (in secondary schools and high education establishments) Programme supported by GFATM.

- **Support to people living with HIV**

Since 2002 APEC NGO has been implementing activities to support PLHIV. The goal of these activities is to improve the living conditions of PLHIV and integrate them in the society. During these activities people living with HIV and their family members are provided with information materials, as well as psychological counselling and support.

- **Crisis Centre activities**

From February 2002 to July 2002 members of APEC NGO took part in the activities of the Crisis Centre established in collaboration with NCAP.

- **Radio programme activities**

In September 2002 APEC NGO was involved in development and preparation of 16 weekly programs about HIV and drug use prevention, which were organized and broadcast at 103.5 FM 'Ardzagank' radio station.

- **Drug use prevention activities**

In 2003 APEC NGO implemented a number of activities aimed at drug use prevention in Syunik region.

- **VCT activities**

Since 2003 APEC NGO in collaboration with other governmental and non-governmental organizations has implemented VCT service for key populations and people living with HIV.

‘Armenian National AIDS Foundation’ NGO

The organization was established three years ago, and has implemented a number of activities addressed at HIV prevention, the most important of which are:

1. Providing support to NCAP to implement activities devoted to 1 December, World AIDS Day, to carry out information-educational campaigns on prevention of drug use, HIV/AIDS and STI focused on key population, including adolescents and youth.
2. ANAF also supported the other local NGO to conduct a survey among students in Yerevan city within the framework of South Caucasian Anti-Drug program, supported by UNDP/EU.
3. In March 2004 ANAF worked with the American University of Armenia, UNDP, NCAP and World Vision International’s Armenian branch to organize a panel discussion about health care issues, called, ‘Women, girls and HIV/AIDS’ within the framework of the activities of AUA.
4. ANAF, jointly with the ‘Real World, Real People’ local NGO, and with a number of other organizations initiated the ‘Quilt 2004’ event in Armenia devoted to the creation of a memorial for those who have died of AIDS. These organizations also organized the ‘2004 International AIDS Candlelight Memorial in Yerevan’ event.
5. In 2004 ANAF, under the support of the ‘Open Society Institute Assistance Foundation - Armenian Branch jointly with other local NGOs, implemented activities within the framework of project aimed at reducing HIV spread among IDUs.
6. Currently ANAF has established the Capacity Building Center with support of GFATM and with technical assistance of the NCAP. The Center implements the activities aimed at training personnel working in the field of HIV and AIDS, developing, printing and disseminating education/information materials among youth, IDUs, CSWs, MSM, prisoners and prison staff, migrants/refugees, PLHIV, pregnant women and the general population. As of January 1, 2005 forty-four training-seminars had been conducted and 951 specialists had been trained within the framework of the project. In particular, out of 576 medical specialists, 392 were physicians, seven were medical specialists from NGOs, 126 were medical specialists working in penitentiary institutions, fifty-one were nurses and laboratory assistants. The guidelines have been developed, printed and distributed for conducting seminar-training for the aforementioned specialists. The Capacity Building Center also is eligible to provide hot line services to general population.
7. ANAF is also engaged in implementing the ‘Capacity Building in HIV/AIDS prevention’ project supported by UNFPA, UNDP, UNAIDS, UNICEF, which is aimed at supporting the National Programme on HIV/AIDS Prevention. Within the framework of the project training-seminars for community staff members from Yerevan and Marzes (regions) of Armenia as well as for representatives of selected NGOs working in the areas of community development, human rights, gender, education, health, and social services are underway.

This group is quite popular. People of different professions – doctors, specialists working in the field of HIV and AIDS issues, etc., apply to and cooperate with ANAF on various issues. They recognize that this organization is experienced in developing information/educational materials and conducting focus groups, training, workshops. Moreover, they develop materials for each group, taking into account specifications such as auditorium space.

‘Antidrug Civil Union’ NGO

The NGO ‘Antidrug Civil Union’ was established in September 2002 by a team of narcologists. The aim of the NGO is to fight the rise of drug use and to reduce drug-related harm in Armenia. Objectives of the NGO are:

- Conduct research about problems of drug use. Research includes ongoing observation, data col-

lection and evaluation, analysis and computerized data management;

- Contribute to the Armenian legislation on drug classification, legal and illicit drug trafficking and related issues;
- Create an internet page about drugs, drug use and drug addiction (Armenian, Russian and English versions, website is in the process of development);
- Actions against many areas influencing negatively on public health;
- Develop and implement of drug use preventive programs about protecting society from drugs;
- Develop and implement drug use harm reduction programs;
- Develop and implement programs about changing and further supporting of injecting drug users behaviour, preventing spread of HIV and sexually transmitted infections among them;
- Providing counselling, treatment and rehabilitation services to general population.

Currently, more than 30 specialists from different areas - narcologists, public health specialists, social workers etc, have joined to the 'Antidrug Civil Union' NGO.

Up to now, the following interrelated activities have been implemented by 'Antidrug Civil Union' NGO:

- Anonymous and voluntary counselling of drug users;
- Developing of informational-education materials;
- Develop and carry out radio-programs concerning HIV/AIDS and related topics (with 'Arzagank' radio-station);
- Conducting educational programs for members of Armenian Red Cross Society, mass media employees and policemen;
- Active participation in developing the National Programme on alcoholism and drug use;

Since February 2004, the 'Antidrug Civil Union' NGO jointly with 'AIDS Prevention, Education and Care' and 'AIDS Prevention Union' NGOs involved in implementation of the 'HIV/AIDS prevention among injecting drug users' Programme supported by the GFATM.

In general it is noteworthy that local organizations are actively involved with HIV prevention activities, and are responsible for implementing activities developed within the framework of the strategic plan. Based on interviews with NGO leaders, it is clear that they work with key populations (such as IDUs, CSWs, MSM), PLHIV, and the general population. According to their evaluations and suggestions it is necessary to continue and expand educational activities in different groups of population, especially among the youth. They stress that it is also important to include PLHIV in prevention activities, which will contribute to overcoming stigma. Finally, it is important that implemented programmes and activities are constant so that they do not have episodic character but function continuously.

According to the co-president of 'Real World, Real People' NGO they have limited financial resources, which constrains their capacity of effecting change. Very often it is necessary to provide support out of the planned, e.g. to purchase medicine. The NGO plans to increase raised funds by circulating 'charity basket' (the basket is circulated in different organizations). As for social and medical service of PLHIV, it has been mentioned that governmental support is necessary to ensure primary support to PLHIV. In the sense of social support today 'Empowerment' is emphasized. The approach of the organization is one of acquisition and assumption of self-empowerment by PLHIV.

Involving of PLHIV in the activities of the organization is very important. It is also very important to establish a network of PLHIV, who will always be available for support and aware of each other's problems. At the same time, they emphasize the obstacles they face to establish such a network; only 5-6 people out of 200 PLHIV are ready to be included in that network.

The activity of this organization can have a rather great effect in overcoming stigma and discrimination against PLHIV.

PART III. CASE STUDY

Peer-to-peer education among youth

During research conducted for this project, the examination of socio-cultural context of HIV prevention and spread in Armenia has shown that educational programmes have great role in preventing the epidemic. This progress must be constantly conducted among different groups, especially among the youth. Furthermore, raising the level of awareness and knowledge about HIV/AIDS among different groups will become an important and effective mechanism for overcoming stigma and discrimination. In the National Programme on HIV/AIDS Prevention, one of the main problems is prevention among teenagers and youth.

According to the majority of specialists contacted for the preparation of this report (presented in the previous chapter) a person must be provided with information about STIs and HIV/AIDS at school age. At this age peer-to-peer information is the main source of information. As such, the Case Study conducted within the framework of the programme has been conducted to show advantages and disadvantages of peer education implemented in Armenian schools and to develop suggestions for the further application of the method. For implementing the Case Study, peer education programme among youth implemented within the framework of the National Programme on HIV/AIDS Prevention, as well as the interview with Artak Musheghyan, the director of 'AIDS Prevention, Education and Care' NGO – the leading organization of the consortium implementing the given programme have been studied.

This case study highlights the socio-cultural approach by revealing attitudes of teachers, parents, and pupils towards peer education implemented in Armenian schools and their assessment; specifications of receiving information about HIV/AIDS issues and sexual behaviour in schools; and obstacles and achievements of peer education.

Within the framework of the Case Study secondary school N113 of the 4th village of Shahumyan region of Yerevan city was chosen. and for studying the attitude towards peer education interviews were conducted with deputy director of school, with one male and one female coordinators included in the peer education programme, a parent of one of the coordinators, as well as with a pupil in tenth grade (16 years old) at a school where peer education is not conducted. Secondary school N113 has been chosen, because it is situated in the suburbs of Yerevan, and though it is situated in administrative and territorial division of Yerevan, before it was an adjoining village. As a result of development and administrative and territorial expansion of Yerevan the village was attached to Yerevan. Thus the survey of this case can best describe the general and average picture of peer education programme implemented in Armenia. This deputy director has been chosen, because he coordinates all the questions concerning education and he knows the details of the programme. The fact of the coordinators' being of different gender has been important. In this case there has been opportunity to analyze how the gender differences affect the understanding/interpretation of information provided within the framework of education and its further sharing with peers, as well as to underline the differences concerning gender differences between those teenagers who are included in the programme and those who are not.

Peer education among youth is conducted within the framework of the National Programme on HIV/AIDS Prevention in Yerevan City, in Ararat, Armavir, Aragatsotn, Gegharkunik, Kotayk, Lori, Syunik, Shirak, Tavush and Vayots-Dzor Marzes. The general objective of the programme is to reduce HIV prevalence among youth and to raise their capacity in the fight against the epidemic.

The concrete goals of the programme are:

1. To reduce vulnerability of youth to HIV infection; through all the mechanisms are stated below;
2. To establish network of peer educators.

For reducing vulnerability of youth to HIV it is planned to provide peer education among teenagers of secondary schools and students of institutes of higher education and to raise the level of awareness about HIV/AIDS related issues by:

- organizing round tables with headmasters, organizers, teachers of secondary schools and lecturers of institutes of higher education included in the programme;
- conducting survey among pupils and students with the aim of selecting peer educators;
- organizing parents' meetings in secondary schools;
- designing and publishing guidelines for peer educators;

conducting training among pupils and students for training peer educators.

The next aim is to establish a network of peer educators by:

- organizing meetings of peer educators;
- providing them with informational materials and counselling;
- designing and preparing necessary commodities for peer educators ('educational portfolio' – badges, pens, T-shirts, caps, visit-cards).

Armenian society the opinions of elder people are very important. To ensure their participation, meetings are organized with teachers, headmasters and parents, during which those who implement the programme try to explain the meaning of the programme, its advantages, what their children will gain. Only after receiving positive opinion from family elders will it be possible to start peer education in schools.

During the first year peer education activities were planned to take place in Yerevan (44 schools, 5 institutes of higher education) and in the centres of all Marzes (46 schools, 5 institutes of higher education). During the second year, from September 2004 peer education activities have been conducted in 88 school and 10 institutes of higher education in Yerevan and in 117 schools and eleven institutes of higher education in Marzes.

The direct beneficiaries of the programme are the youth of secondary schools and institutes of higher education, who must share the knowledge gained with their peers – classmates, pupils, peer neighbours, relatives and friends. The programme aims to contribute to a reduction of HIV prevalence among youth.

Attempt to implement analogous programmes

A draft programme on HIV, STIs and drug use prevention among youth has been implemented in Kapan and Kajaran cities of Syunik Marz of the RA.

As a result of project implementation forty-eight peer educators have been trained, who share their knowledge with their peers. The results of the survey conducted among young classmates of peer educators show that their level of knowledge about HIV transmission through sexual relations has been raised by 32%, the level of knowledge about HIV transmission through exposed needles and syringes has raised by 48%, and the level of knowledge about mother to child HIV transmission has risen by 50%. Studies indicate that peer networks are often used by young adults. A study improving the accuracy of these information channels is both an appropriate and effective strategy for raising the knowledge levels of young adults.

A programme on HIV, STIs and drug use prevention has also been implemented in Goris city of Syunik Marz and in Gavar city of Gegharkunik Marz of Armenia consisting of peer educators providing information about all these issues.

Ways of implementation of peer education

Peer education is implemented in the following manner: schools are selected, and preliminary meetings and round tables are held with selected schools to introduce the aims and functions of the programme. School headmasters are motivated when they are provided with information about the epidemic, their potential role in responding to the epidemic, and the extent to which the spread of the epidemic in the country depends on them.

Some of the schools refuse (or the director of the school does not ascribe importance to the programme and does not find it necessary to implement it in his/her school). As a result a smaller number of schools than initially planned remain in the project Pupils of grades 8-9 at the age of 13-15 are selected from these schools, to later take part in training. Those pupils are selected to take part in training, who are thought to have respect and authority among their peers, in other words, who are leaders. This selection is made at two levels: selection is made by pupils and form-masters²⁰, who work in those classes. Surveys are conducted among pupils according to questionnaires designed and discussed by focus groups. It's not obligatory to choose one pupil, two or three pupils can be chosen. As form-masters have had more contact with the pupils and are familiar with their capacities and qualities, if opinions of pupils

²⁰ Each class of all the schools has a 'form-master', i.e. one of the teachers, who leads and coordinates all the activities of that class.

and form-masters coincide, the opinion of the form-master is taken into consideration as well, and the pupil is included in the programme. After that individual interviews are conducted with all the selected pupils. The idea that those selected are leaders are not rejected, but during the interview their various qualities are evaluated, particularly their behaviour, attitude towards the problem, level of tolerance towards peers, towards other opinions, ability to avoid conflicts, skills in communication, non-verbal communication, desire to participate in the programme.

After the interviews a number of pupils are chosen. As a result, 740 of them were trained (out of 15,000 interviews, 2,100 candidates were selected, out of whom 740 underwent training). The sessions are conducted by trained specialists. During these trainings the pupils receive information about HIV and AIDS. Moreover, the trainings provide information and attempt to generate motivation and a positive attitude towards the problem. Direct communication is maintained with 250 of them, and the organization is aware of the activities and works carried out by them. Constant work is carried out with these 250 pupils, as it is believed that no matter how well they are prepared for that training, one-time training is not sufficient. Those students who remained in the programme are trained one more time. Students may participate in one or two-day sessions. Pupils then choose teachers whom they consider to be good counsellors and friends. Students and teachers work together to provide information in venues such as schools, classes, by visiting aqua park 'Water World', by organizing lectures, training utilising existing social norms about education, besides formal education, non-formal methods of providing education are also applied, information is provided in a non-formal environment, which makes it more accessible for pupils and teachers.

Selection of higher-education students is made differently. Leaders are selected by dean's offices and student councils. Interviews are conducted with them, during which they are explained their doings and are invited to training.

Main topics of the above discussed training were: Peer education. Peer-to-peer support. Basic concepts and principles. Stages of changes in behaviour. Historical reference. Concept about HIV infection, AIDS. HIV and AIDS disease and development, including symptoms and HIV treatment. Ways of prevention and transmission. Immune system. Basic directions of activity-informational-educational, work with population on the HIV and AIDS problem.

Importance of peer education in HIV/AIDS prevention activities

As has been mentioned in the chapter on NGOs in the field of HIV and AIDS prevention, peer education is implemented by the NGO, 'AIDS Prevention, Education and Care.'

The work of the organization is mainly directed to shaping how the youth address this issue. It is noteworthy that the aim is not to *change* but to *form* a new way of thinking as it is difficult to change an already-formed way of thinking.

The following is the president of 'AIDS Prevention, Education and Care' NGO Artak Musheghyan's observations concerning the importance of peer education in Armenian schools:

'In preventive activities great attention must be paid to works conducted with youth. [Surveys performed for the sake of saying they are performed] are not enough. The existing mentality leads to many negative attitudes, including discrimination and stigma. To change the mentality first it's necessary to break the old one and then to build a new one. I am speaking about young people aged 13-21, when they haven't yet made decisions and are not self-affirmed.

We must always remember that staff decide everything. We must deal with staff, and staff are today's children. When a doctor has been educated in a system where HIV infection hasn't been introduced correctly, policy of intimidation has been applied, it is very difficult to change his attitude. Again the question of breaking the old one and building a new one arises. Though there is no need to break, we just have to build a new one simultaneously, and in this case the old one will remain in the shadow.

The organization is guided by the idea that the most effective way of working with youth is work with small groups of already formed, somehow similar people, as here people know each other well and [thus makes it harder for them to lie. Moreover, in groups of strangers, people may not feel comfortable to say something because they want to, but because they have to].'

Participation of community is also important in the process of peer education, as members of local community, such as directors of schools, organizers, teachers, lecturers of institutes of higher education, as well as parents, also have some things to do in this process. The problem of bringing families, parents 'into the field' is also important, as parents are members of the society, of general population. From one point of view they can be included in the programme as parents, and from another point of view – as workers.

Strategy of Peer Education

Peer education is implemented by an interactive method, during which surveys, group discussions, as well as role games and situational tasks are conducted. Videos and informational materials are used during training. The aim of training is to raise participants' responsibility for their education.

Attitude towards peer education

The participants in the programme of peer education mainly have positive attitude, and share the idea that teenagers must receive appropriate knowledge about HIV/AIDS before graduating. According to the deputy director of school N113, which is taking part in the survey within the framework of the case study, such programmes are very important, as 'our teenagers enter ... life without enough knowledge about HIV/AIDS, and now HIV infection growth rates are rather high in Armenia. We hope that after graduating from school our children will have necessary knowledge about this disease. Our coordinators (those children, who have been chosen as leaders and have taken part in the courses) have returned after training from the courses with deep knowledge and can generate interest in the mentioned issue among their peers.'

Coordinators also have a positive attitude towards the programme. According to one: 'When I was to take part in the courses for the first time, I did not have any expectations, as I did not know what they were going to be about. Yet after taking part, I gained a lot of knowledge, which is rather important for life. What our parents had to tell us but did not because of cultural and family traditions, we learned from the workers of 'AIDS Prevention, Education and Care' NGO. During these four-day courses I gained new friends, new surrounding, and which is the most important, I learned a lot about HIV/AIDS.'

During an interview, a parent of one of the coordinators mentioned that she has a positive attitude towards the programme, otherwise she wouldn't allow her child to take part in the programme. At the same time, she mentioned that there are drawbacks to the programme as well. From her perspective, it is not necessary to speak to children about questions concerning sexual life prematurely: the time will come and they will learn everything. Indeed, information is necessary to some extent, as 'you cannot isolate a child from the society, and it is necessary for a child to be able to find a clever way out with the help of his knowledge. That's why each person must be informed and fight consciously. A child must be informed to such extent, so as not to be embarrassed when hearing about AIDS, and so that they can make informed decisions.'

Both the conservative and negative attitude on the part of some parents can obstruct peer training.

In some parents' opinions, people who think that there is no need to speak to children about questions concerning sexual life prematurely do not admit that development presupposes the loss of some traditional norms. Parents are in favour of their children getting information. In this sense, it is interesting to know the opinion of the teenager in whose school peer education is not conducted. In his opinion, he is not very aware of the disease, and it would be interesting to implement such a programme in his school.

Influence of peer education

It's also important to observe the impact of the programme on those who are directly and indirectly involved. In this context the deputy director of the school has mentioned that after introducing the programme, both the pupils and the teachers discuss the theme of HIV/AIDS more freely and easily. 'To tell the truth, we were even blushing while pronouncing or hearing this word in the presence of children. But now we realize that this attitude was not appropriate [given the severity of the epidemic] This was confirmed after returning from the course where coordinators conducting the seminar introduced the problem so naturally and clearly, without being embarrassed, that everybody was surprised at their honesty. Overcoming embarrassment.' Therefore, the teachers and educators need to be targeted and by focusing

on the schoolchildren with peer education, teachers are indirectly trained.

It is necessary to mention the influence of the programme on attitudes and views of the participants. One of the coordinators stated that after the course her world outlook has changed and this change affects her surroundings, especially her girlfriends. In her words, 'Before, I had another attitude towards people infected with HIV, CSWs, IDUs. Now I think I am milder, I have another point of view: maybe [that person – living with HIV, CSW or IDU] did not want [to be in that situation], but this is life, everything happens. I hoped we would visit the National Center for AIDS Prevention, 'Armenicum' medical centre, to see how they collect blood for testing, to communicate with PLHIV, to get acquainted with their emotions and feelings. I would like to come in touch with PLHIV, to know how they live.' This implies that stigma can be altered relatively easily and that bias is not so deeply ingrained in children. Clearly, activities among children are more important in sense of attitude and behaviour change than in already formed adults.

It is interesting and revealing to contrast this opinion with that of another pupil of the same sex and age, who did not participate in peer education programme. In response to a question concerning how she would behave if suddenly it turned out that her interlocutor was HIV positive, she answered that she would do nothing at that moment but the next time she would probably avoid meeting him or would communicate more cautiously.

Another coordinator has spoken about knowledge acquired during the programme, mentioning that after finishing the course he can say for sure that he did not know anything about HIV/AIDS before. All he knew was that there was a sexually transmitted infection called HIV. Again, it is appropriate to compare this fact with the opinion of a pupil who has not taken part in peer education. He himself has mentioned that he knows very little about HIV/AIDS, particularly about the modes of HIV transmission.

One of the coordinators of the programme commented on sharing the knowledge gained with the peers: 'In our school five pupils have taken part in the course; these five have given fundamental information nearly to thirty people, and almost 100 people have been informed lightly. If more pupils took part in the course, e.g. pupils of grades 7, 8, 9, 10 (only pupils of 9th grade have taken part), more people would be informed. I speak about getting information and knowledge. However, it does not mean that a person being informed cannot take wrong steps. An informed person can take wrong steps, but anyway, the programme has its influence. My friend will not take that step, but a person who has only heard about it, can do it. I introduce the issue more clearly. Some are ashamed to ask their teacher questions, but they are not embarrassed to ask me. I think that teacher's words can be accepted not the way my words can be, and maybe they will have contrary effect, i.e. they can do what is not advised to.'

Description of an example of sharing knowledge gained by coordinators

Returning from the courses, the coordinators conduct a seminar in the presence of the form-master. Pupils listen and carry out discussions with their form-master, or ask their classmates to clarify issues if necessary. In grades 8-10 the trained coordinator can conduct courses, interviews at any time. The school does not devote concrete hours for form-master's lessons.

Concerning the process of providing knowledge one of the (female) coordinators has mentioned, 'We promised that after the course we would organize a seminar for sharing our knowledge with our peers. We informed the pupils about the event. We set a date and gathered those people who wanted to listen. Nearly forty people gathered, mainly pupils in 9th grade. There were teachers as well. At first it was a little bit unusual, they thought the theme wasn't proper for their age. But then they understood that the goal was to share information. In less than fifteen minutes they got used to the topic, and as they were our peers, it was rather easy to communicate with them. The issue was discussed. The level of pupils' interest was neither so high, and nor absent at all. Those who asked questions were mainly my friends. After that discussion, conversations on the theme occur very often, especially among my girlfriends. More often such discussions occur among close girlfriends. Probably the reason is that we are of the same sex, it is possible that boys discuss such questions with a male coordinator.'

The deputy director of the school has the following opinion concerning sharing the knowledge: 'We are not in the state of being unconstrained, no matter how free they are, they are shy. It is possible that one may be courageous in this viewpoint, and another not. In fact general information is given to everybody, and deeper information is given to the class and close friends. Comprehension of information also depends on the attitudes people have towards the coordinator. Those who have positive attitude compre-

hend well. For example, there are pupils in the class who study well, but who have not been selected and have not taken part in the courses. Consequently they submit with difficulty and have negative attitude. Besides, there can be groupings in classes, or class can be not united, and the words of the representative of one group can be ignored by the representative of another group.'

As for further programmes of spreading knowledge, the coordinators are getting ready to organize new activities.

Main difficulties arising during peer education programmes

The implementors of peer education programmes faced the following obstacles performing their work:

- False comprehension within society concerning who should participate in the course: sometimes director of the school offers a pupil or a teacher as a good candidate, in case when there is a special procedure for selecting candidates;
- Obstacles arise in teachers' collective: it is necessary for a teacher to fulfil all his responsibilities, if he/she does not, the work fails;
- It is mentioned amongst the complications that the directors of schools have a superficial approach towards the problem and are influenced by whether the school will have any benefits from participating in such programmes. Some may refuse because the directors do not realize their direct benefit from these programmes which they will gain by responding to the HIV epidemic.

No information is available on how the religious orientations of either parents or educators support their reluctance to participate.

Technical problems also exist: before entering a school in the programme, the consents of both the Ministry of Education and the director of school are necessary.

Taking into account the information received during the case study we assert that peer education has a number of advantages. In particular, it creates an important opportunity for providing concrete information about HIV and AIDS from a school age, and more importantly, to influence behaviour change. Another important fact is that parents and teachers are also involved in the programme together with pupils.

PART IV. CONCLUSIONS AND RECOMMENDATIONS

This research has shown that in Armenia, the socio-cultural background can both contribute to and hinder the activities on HIV prevention.

Factors hindering activities on HIV prevention are:

- The economic situation of the country, namely poverty among the population and inadequate government budgets. Migration also hinders introducing more resources in the field of HIV prevention. Migration from Armenia is mainly directed to CIS countries, the Russian Federation and the Ukraine, which were also part of the former Soviet Union. As such they are socially and in some respect culturally close with Armenia.
- Insufficient realization of the importance of the HIV and AIDS problem in wider layers of the society. Negative, intolerant attitude towards HIV vulnerable groups-IDUs, CSWs, MSM. Low prevalence of HIV infection outside these key populations, cultural stigmatization, attitude of most people to the problem as to a virtual one result to the above-mentioned.
- Lack of information about HIV and AIDS provided to general population. Insufficient inclusion of mass media in activities directed to promotion of healthy lifestyle and safer sexual behaviour of the youth. The mass media cover HIV-related issues irregularly. Conservative sexual attitudes not welcoming public discussions of sex and many other factors are some of the main problems resulting in the lack of mass media coverage.
- Lack of knowledge about HIV modes of prevention and transmission, which serves as a cause for practising risky behaviour, deepening stigma and discrimination, and the absence of necessary education from school age. Lack of sufficient knowledge among older generations and in Armenian families and the reluctance to discuss questions concerning HIV and AIDS and sexual life.
- Lack of an active role by youth in the public life (such as organizing their leisure time, development of club activities, etc.), reduces the possibilities of awareness campaigns reaching the youth and thus may increase their risk to HIV.
- Gender imbalances, and in particular, women's status and the dominant role of men in society and in the family, which discourages women from practicing and/or negotiating with sexual partners on safer sexual behaviour specific to Armenia.
- Absence of a 'condom-use culture.'
- Insufficient involving of people with HIV in preventive activities. This may be conditioned by the fact that it is difficult to find a PLHIV who is ready to take part in a TV programme and raise the questions connected with needs, problems of PLHIV.
- Factors contributing to activities on HIV prevention are:
- Realization of the problem priority at the state level and the existence of law of RA on 'Prevention of the disease caused by HIV' resulting in increasing of efficiency of the implemented HIV/AIDS Prevention Programmes, Awareness of the necessity to improve current legislation on HIV/AIDS and starting implementation of relevant activities on that matter.
- Availability of necessary human resources for the work in the field of HIV/AIDS. Existence of the National Center for AIDS Prevention as a specialized state institution functioning in the field of HIV/AIDS and having great scientific-practical capacity. Existence of NGOs having work experience in the field of HIV/AIDS prevention.
- Mono-ethnic structure of the population (and thus, minimizing ethnic and religious conflicts) of the country and density of population.
- Comparatively high level of education of general population. High level of education of general population could facilitate implementing preventive programmes through sexual education programs in schools, for example.

Suggestions directed to raising effectiveness of HIV prevention activities in Armenia

International experience shows that it is possible to reduce the further spread of the epidemic by carrying out effective activities on prevention. Thanks to wide activities on prevention, reduction and stabilization of HIV infection rates is observed in a number of countries. Great experience has been gained in

the field of HIV and AIDS and its response during the past twenty years. Experience has shown that a response to HIV and AIDS is not only the problem of health care, and that overly simple activities or those that only attend to biomedical issues of diagnosis and treatment are powerless against the epidemic. It is clear that the further development of the epidemic can only be prevented through more generalized and socially-oriented efforts. This presupposes the prioritisation of HIV and AIDS by the government, community leaders, population, individuals and donor organizations, and their unanimous, coordinated participation in implementation of activities against the epidemic. It is necessary to display a comprehensive, holistic approach to the problem and to use all the possible socio-cultural resources. Furthermore, the provision of ARV treatment medication to people with HIV will not only reduce the number of AIDS (and AIDS related deaths) cases, but it will help encouraging people of getting tested for HIV.

Education

Training and information-educational actions are important in HIV prevention activities in Armenia. The survey has shown that awareness, knowledge and information about HIV/AIDS must be provided not only to the groups vulnerable to HIV (CSWs, IDUs, MSM, youth, migrants, etc.) by performing outreach work and providing peer education, but to other groups of population as well. It is very important to include not only pupils, but their parents as well in educational activities, which will reduce the tension within the family connected with HIV/AIDS problem. It is also necessary to conduct intensive work with migrants and their family members.

Together with providing of information about HIV prevention, building necessary skills, ensuring of availability of preventive means, it is important to encourage people to use them. It must be done particularly through mass media, different cultural actions, for safer behaviour to be strengthened, to become constant rather than sporadic. It is easier to achieve these goals by providing appropriate education at school age. We have not yet provided such education here. As a result, information provided to different groups rarely serves as basis for behaviour change. The research shows that formation of safer behaviour must be implemented from early age, ideally, school age.

Based on the prevalence of cases of infection transmission through injecting drug use in the country, special attention should be paid to information-educational activities implemented among IDUs with the aim of reduction of the level of sharing exposed syringes and formation of safer sexual behaviour.

Educational programmes on prevention have already begun to be intensively implemented. It is more expedient if:

1. Educational programmes on HIV and AIDS and sexual life are the part of educational programmes directed to formation of healthy lifestyle, and the whole educational system, as well as communities and families must be included.
2. Educational programmes on healthy lifestyle are developed in cooperation with different ministries, youth centres, NGOs.
3. Awareness and advocacy directed to protection of sexual, reproductive health of the youth are implemented through communities, mass media.
4. Formation of safer behaviour is initiated from school age, taking into account ethnographers', psychologists' and other specialists' opinions on this question.
5. Peer education is applied in all educational institutions taking into account its effectiveness.
6. General mechanisms and standards of application of peer education are developed.
7. Teachers and parents are included in information-educational programmes implemented in schools, particularly appropriate training are organized for teachers, and parents become interested through different materials on HIV/AIDS provided to children.
8. Substructures organizing working activities and rest for youth are established (re-established): youth camps, clubs, centres and provide efficient framework for out-of-school education.
9. Mobilize artists and creative industry in the response to the HIV epidemic.
10. Increase participation of women in the response to HIV and AIDS.

Providing knowledge to wider layers of population

The most available means of providing information to different layers of the general population is through the mass media. However, the information should be carefully developed to avoid panic among

people. It must also emphasize the actuality and importance of the problem. The topic of HIV/AIDS must not serve as material for sensational theme for mass media. The assumption that more information about the problem from mass media will improve the public attitude towards the problem is unjustified. Today, social problems are addressed by mass media stressing sensational 'bad news' without mentioning the possible solutions. It is preferable that mass media introduce concrete typical situations connected with HIV/AIDS, which will make audience think them over, and will help them to evaluate correctly their risk of becoming infected with HIV, rather than enforce the assumption that they are not susceptible to HIV and AIDS.

Taking into account the current small role of mass media in HIV and AIDS prevention in Armenia, it is important to conduct activities with the aim of raising interest of mass media towards the problem and promoting organization of constant, periodical series of programmes. In this connection it is expedient:

1. To organize seminar-training for representatives of mass media.
2. To create periodical series of programmes by initiative and cooperation of the National Center for AIDS Prevention and interested organizations, which will address and answer questions on HIV and AIDS.
3. To organize public discussions in mass media with participation of decision makers and authoritative figures (famous public, cultural workers).
4. With regards to TV and radio programmes, the number of programmes with live phone calls and active discussions should be increased, as in the case the problem is enlightenment deeply and comprehensive.

In addition to the mass media, information-educational activities organized among different layers of the society can contribute to raising the level of awareness and knowledge throughout of the general population. In this connection it is expedient:

1. To apply peer education in information-educational activities for older generation: e.g. to organize discussions on the problem in working places.
2. To organize specific seminar-training for medical personnel emphasizing questions on stigma and discrimination against PLHIV.
3. To include activities in preventive programmes directed to elimination of gender inequality in sexual relations, formation of skills in women to negotiate on safer sexual behaviour.

Fight against stigma and discrimination

Some ways of fighting against stigma and discrimination against PLHIV are through continuous training, sensitisation of the public, and ensuring of social integration and empowerment of people living with HIV. In this connection it is necessary:

1. To provide people with knowledge not only about modes of transmission, but about human rights of PLHIV, and about negative consequences of stigma and discrimination against PLHIV.
2. To provide PLHIV with necessary knowledge and skills, which will give them opportunity to lead active public life.
3. To ensure participation of PLHIV in the process of making decisions on HIV and AIDS issues.
4. To ensure representation of PLHIV in different public structures.
5. To include private sector in fight against stigma and discrimination, to raise the level of awareness among employers.
6. To provide antiretroviral treatment to as many PLHIV as possible as a factor contributing to their social integration.
7. To involve church in the fight against stigma and discrimination faced by PLHIV.

Improvement of legislative field

Improvements of legislative field in the sphere of HIV/AIDS mainly refer to the need to reduce mandatory testing of targeted groups, and to ensure the availability of and access to social support for PLHIV. In this connection the law on 'Prevention of the disease caused by HIV' must be changed:

1. Donated, biological fluids, tissues and organs must undergo mandatory HIV screening,
2. HIV testing must be voluntary and it must be accompanied by HIV pre- and post-test counselling. Mandatory testing must be eliminated for certain groups and be replaced with access to VCT in

all the regions for everyone, irrespective of membership to any social group.

3. PLHIV must be included in the groups requiring social support and active social policy should be conducted towards them by the state.

In summary, behavioural patterns are the main drivers for the spread of HIV. The socio-cultural background in Armenia both facilitates and hinders the implementation of HIV prevention activities. The socio-cultural background in Armenia is characterized by high rate of migration and lack of condom use culture, lack of knowledge about HIV/AIDS among adults and taboos concerning issues related to HIV/AIDS and sexual life for Armenian families, and gender inequalities especially in regards to the lack of ‘decision power’ held by Armenian women in the society and in the family. This subordinate position is an obstacle to discussing safer sexual behaviour by sexual partners and practising it, association of HIV and AIDS with marginalized, key population groups. At the same time it is important to note that with appropriate strategies, the relatively high educational level of people could be better utilized in efforts to promote knowledge about HIV and AIDS. HIV prevention activities will be more efficient if all the aforementioned specificities are taken into consideration.

REFERENCES

Arakelyan A. 1999. Health according to the evaluation of Armenian girl students of the last course. Final thesis research work. Yerevan State University, Yerevan, Armenia.

Armenia Demographic and Health Survey (DHS) 2000. Calverton, Maryland. National Statistical Service, Ministry of Health and ORC Macro. 2001, p. 369.

Armenian Centre for National and International Studies (ACNIS). 2002. Armenia 2020: A Strategy paper for development and security. Yerevan, Armenia.

Buckley, Cynthia. 2004. Reproductive and Sexual Health Information Channels: Insights on Reliance and Accuracy from Armenia, manuscript.

Consolidation of democracy. The civil society in the perspective of globalization. Yerevan, 2003.

'Akunk' centre for ethno-sociological studies. 2002. 'Domestic violence in the Republic of Armenia' Sociological research. Yerevan, Armenia.

Grigoryan S.R. et al. 2002. HIV infection. Manual for physicians. National Center for AIDS Prevention, Yerevan, Armenia, p. 232.

Grigoryan S.R. 2004a. Human rights and HIV/AIDS in the Republic of Armenia. 15th International Conference on the Reduction of drug related harm, Melbourne, Australia, p. 94.

Grigoryan S.R. 2004b. Second generation surveillance among men who have sex with men (MSM) in the Republic of Armenia. 15th International Conference on the Reduction of drug related harm, Melbourne, Australia, p. 103.

Grigoryan S.R., Busel A.P., Papoyan A.S. 2002. Rapid Assessment of the situation on spread of injecting drug use and HIV infection in Yerevan, Armenia. International Journal of Drug Policy, Vol. 12, pp. 433-436.

Grigoryan S. R., Manukyan A. V., Hakobyan A. Z. 2004. Evaluation of HIV-related risk among female sex workers of Yerevan city. Materials of the 'Human Health' III National Medico Scientific Congress. National Health Institute named after S. Kh. Avdalkbekyan Ministry of Health of the Republic of Armenia. Yerevan, Armenia, p. 23-24.

Grigoryan S. R., Mkrtchyan A., Davidyants V. 2002. HIV surveillance in the Republic of Armenia, 2000-2002. Yerevan, Armenia, p. 208.

Grigoryan S.R., Papoyan A.S. 2004. Behavioural patterns driving the epidemic among IDUs. 15th International Conference on the Reduction of drug related harm, Melbourne, Australia, pp. 54-55.

Grigoryan S. R., Sargsyan N. A., Harutyunyan G. K. 2002. HIV/AIDS and Human Rights; Impact of migration, poverty and other socio-economic factors on HIV/AIDS epidemic. Yerevan, Armenia, p. 112.

International Organization for Migration (IOM). 2001. Trafficking in women and children from the Republic of Armenia: A study, p. 73.

Semerjian, J. 2002. The Armenian character and Psyche. <http://www.hyeetch.nareg.com>.

Manukyan A.V., Grigoryan S.R., Hakobyan A.Z. 2004. HIV/AIDS Prevention Interventions among female sex workers in Yerevan. XV International AIDS Conference, Bangkok, Thailand, pp.167-170 (CD-ROM).

Margaryan, T. 2003. 'Network practices and their role in formation of market economy in Armenia. Networks as a value and survival strategy.' CISR Publications. <http://www.indepsocres.spb.ru>

National Center for AIDS Prevention (NCAP), <http://www.armajds.am> (Accessed May 2005)

National Statistical Service of the Republic of Armenia, <http://www.armstat.am> (Accessed May 2005)

Ohanyan R. O., Grigoryan S.R., Hakobyan A. Z. 2004. Evaluation of HIV-related risk among MSM of Yerevan city. Materials of the 'Human Health' III National Medico-Scientific Congress. - National Health Institute named after S.Kh. Avdalbekyan Ministry of Health of the Republic of Armenia. - Yerevan, Armenia, p. 42-43.

Papoyan A.S., Grigoryan S.R., Sargsyan R.R. 2004. Harm reduction among IDUs in Armenia. XV International AIDS Conference, Bangkok, Thailand, pp. 119-123 (CD-ROM).

Petrosyan H. 2003. 'New problems - trafficking and commercial sex work', Observer. Human Rights in Armenia.

Republic of Armenia, the National Programme on HIV/AIDS Prevention. 2002. Yerevan, Armenia.

UNAIDS/WHO. 2004. AIDS Epidemic Update: December 2004.

UNAIDS. 2004. 2004 Report on the global AIDS epidemic, 4th global report.

UNDP. 2001. 10 Years of Independence and Transition in Armenia. National Human Development Report. Armenia, p. 171.

UNDP. 2002. Education, poverty and economic activity in Armenia. Report on situational assessment. Yerevan, Armenia, p. 96.

UNDP/DMS. 2004. Annual Report on Drug. Republic of Armenia. - Yerevan, Armenia, p. 49.

UNICEF. 2001. Ten years of transition. Regional monitoring report. Florence, Italy. p. 199.

UNICEF. 2002. Social Monitoring, 2002. Social trends in transition. HIV/AIDS and young people. Quality of learning in schools. Florence, Italy. p. 125.

**LIST OF NATIONAL EXPERTS
INTERVIEWED BY THE RESEARCH GROUP**

1. Director of the National Center for AIDS Prevention, CCM Secretary,
Adviser to the Minister of Health on the issues of HIV/AIDS and sexual health
2. Co-President of 'Real World, Real People' NGO
3. UNAIDS International Consultant
4. UNAIDS Intercountry Coordinator for the Southern Caucasus
5. President of 'AIDS Prevention, Education and Care' NGO
6. Chief specialist of Public Education Department of the Ministry of Education and Science,
responsible for the programme 'Healthy lifestyle'
7. Deputy Minister of Culture and Youth Affairs
8. A psychologist, 'Education in the name of health ' NGO
9. World Vision, Middle East and Eastern Europe Region, HIV/AIDS Adviser
10. 'AIDS Prevention Union' NGO, president
11. President of 'Armenian National AIDS Foundation' NGO
12. Sociologist, Center of Gender Research
13. A psychologist, 'Education in the name of health ' NGO

BIOGRAPHY OF AUTHORS

Arshak Papoyan received his MD from the Yerevan State Medical Institute, Department of Medical Prevention, in 1998. In 1999 he was an intern at the Center of Epidemiological and Hygienic Control in the Arabkir district, Yerevan, Armenia. He also completed the '12th Annual Summer Course on Principles of STD and HIV Research' at the University of Washington (Seattle, Washington, U.S.) Since 2004 he has been the head of the Epidemiological Surveillance Department of the National Center for AIDS Prevention. He has been a member of the working group for the Second Generation HIV Surveillance in Armenia (2002) and a member of the working group of the national monitoring center for drug abuse information systems within the 'Southern Caucasus Anti-Drug Programme' (2003). Since 2002 he has been a national trainer and facilitator for multiple seminars, trainings, workshops supported by the GFATM, WHO, UNAIDS, and UNDP. His writings have been published in more than 30 books, in education materials, scientific articles, and abstracts in various scientific publications.

Anoush Arakelyan earned both her bachelor's degree (1999) and master's degree (2001) from Yerevan State University, Armenia, where she studied in the Faculty of Philosophy, Sociology and Psychology, Department of Sociology. She is a sociologist in the department of sociological research at 'ALM-HOLDING LTD.' She also prepares the daily broadcast of the information programme, 'Press Review.' She has collaborated in and co-organized many researches on public relations issues, media monitoring, health and gender issues and public opinion polls.

Elmira Bakshinyan is currently a master's student in the Department of Sociology at Yerevan State University. She received her bachelor's degree in 2002 from Yerevan State University, Faculty of Philosophy, Sociology and Psychology, Department of Sociology. She is currently a sociologist in the Real World, Real People NGO and she has been involved in many researches, particularly she was a co-organizer of research on the project: 'The quality of life of People Living with HIV' sponsored by the Real World, Real People NGO/National Center for AIDS Prevention. Her main areas of professional interests are social marketing, public relations, human rights, and sociological methodology.



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Division of Cultural Policies and Intercultural Dialogue

1, rue Miollis, 75732 Paris cedex 15

Tél.: +33-1 45 68 43 30, Fax: + 33-1 45 68 55 97

E-mail: culture.aims@unesco.org

<http://www.unesco.org/aims>