

HIV and AIDS in the Caucasus Region: A Socio-Cultural Approach

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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

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Representative of the Flemish Government
Paris

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 summaries of the three national reports reviewing the current situation of the epidemic in each country as well as the existing responses from a socio-cultural perspective;
- The comparative study, authored by Professor Buckley, which synthesizes the findings of the three country-level reports and sheds light on the commonalities and differences of the socio-cultural and socio-economic aspects related to the HIV epidemic in the sub-region.

The full-length versions of all reports 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 programmes.

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.

Katérina Stenou
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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 these reports: Arshak Papoyan, Anoush Arakelyan, and Elmira Bakshinyan from Armenia; Telman Magerramov, Leyla Ismayilova, and Tair Faradov from Azerbaijan; Ketiv Stvilia, Khatuna Todadze, and George Nizharadze from Georgia. 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, in addition to developing the comparative sub-regional report presented in this publication, also 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.

Our special appreciation and thanks goes to the directors of the three country's national AIDS centers – Dr Samvel Grigoryan in Armenia, Dr Galib Aliyev in Azerbaijan, and Dr Tengiz Tsertsvadze in Georgia – for their kind cooperation, support, and valuable contribution to the entire project.

We would also like to acknowledge our partners at UNAIDS – in particular, Renate Ehmer, Country Coordinator for Armenia, Azerbaijan, and Georgia, and Elena Sannikova, of UNAIDS Headquarters, for their critical assistance throughout the project.

Special thanks go to Erin Koch and Heather Maher for their thorough work and efficient assistance in editing the publication.

Particular gratitude is extended to all three National Commissions for UNESCO.

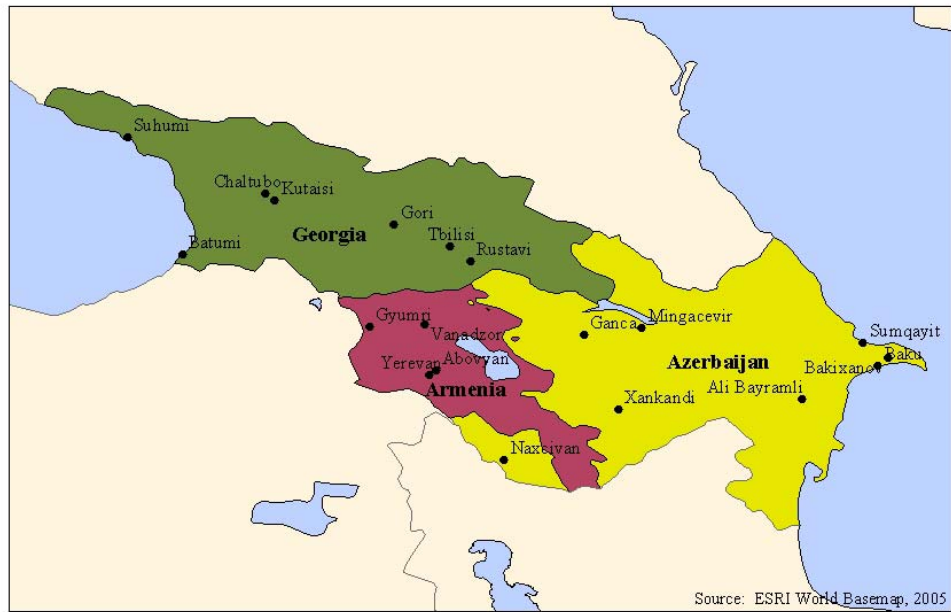
For her truly impressive dedication and hard work in organizing all activities related to this publication, we are all very grateful to Maka Dvalishvili, Executive Director of the Georgian Foundation of Arts and Culture.

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
BTC	Baku-Tbilisi-Ceyhan (BTC) pipeline
CBO	Community-based organisation
CDC	Center for Disease Control (USA)
CISID	Centralized Information System for Infectious Disease
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
DLHPR	Drug Law and Health Policy Research Network
FAO	Food and Agriculture Organization of the United Nations
FBO	Faith-based organisation
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with or Affected by HIV and AIDS
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IDP	Internally Displaced Person/People/Population
IEC	Information Education Communication
IGO	Inter-Governmental Organization
ILGA	International Lesbian and Gay Association
IOM	International Organization for Migration
IRC	International Rescue Committee
KAP	Knowledge, Attitudes and Practice
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
SCAD	Southern Caucasus Anti-Drug (SCAD) programme
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
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 the Caucasus regions: Armenia, Azerbaijan and Georgia



PART I. REGIONAL ANALYSIS

Chapter 1. The Socio-Cultural Correlates of HIV/AIDS in the Southern Caucasus

Cynthia Buckley,
Chief Scientific Consultant
May 2005

Introduction

At the close of 2003, global reports indicated that 38 million individuals were living with HIV, and that AIDS was responsible for 20 million deaths since 1981. The intensity of the pandemic is staggering. In 2003 alone, five million new cases of HIV were identified and an additional three million people lost their lives to AIDS (UNAIDS 2004). HIV and AIDS remain concentrated among the countries of sub-Saharan Africa, but as we continue into the third decade of the crisis, there is persuasive and growing evidence of geographic expansion. India, China, and the countries of the former Soviet Union are experiencing significant increases in the reported number of people living with HIV (PLHIV) each year. Often referred to as the ‘second wave’ countries of the HIV pandemic, these regions share sizable populations, represent high levels of cultural diversity, and have low levels of knowledge concerning HIV prevention and transmission. The paths of expansion of the epidemic and the potential for effective interventions within the countries of the second wave will be unique. Transmission patterns and intervention opportunities will be deeply embedded within culturally established beliefs concerning sexual knowledge and behaviour, the social context of injecting drug use, and the institutional settings for health care and education within these countries.

More than three decades of international efforts to increase HIV and AIDS knowledge and awareness, curb transmission, expand treatment, generate tolerance for those affected by HIV and AIDS, and mediate the political and economic costs of the pandemic have generated a vast body of knowledge and accrued experience. In moving forward to meet the challenges of the second wave, this wealth of information will only be effective when integrated into an appreciation of the social and cultural contexts found within specific locations. Recently-adopted UNAIDS principles stress the importance of ‘The Three Ones’ (partner coordination for the development of one HIV and AIDS action framework, the development of nationally coordinated, multi-phased responses administered by one national coordinating authority, and establishment of uniform and effective national monitoring and evaluation systems) in order to most effectively provide support, collaboration, and intervention efficiency in countries facing significant HIV and AIDS challenges. A socio-cultural approach to the study of HIV and AIDS highlights the ways in which social and cultural contexts inhibit or facilitate the ability to achieve consensus on action frameworks, unify the efforts concerning HIV and AIDS programming, coordinate diverse interest groups, and influence participation in monitoring programmes.

The work presented in this collection is the outcome of a year-long project directed by the United Nations Educational, Scientific and Cultural Organization (UNESCO), funded by the Flemish government, and assisted by the National HIV/AIDS Centers in Armenia, Azerbaijan, and Georgia. Utilizing a common research strategy and methodology stressing

the importance of local cultural traditions, social norms, systems of authority, trust and influence, national research teams developed comprehensive reviews of extant local research on HIV and AIDS, assessments of key populations, overviews of institutional responses to HIV and AIDS, reviews of governmental approaches (including legislation) to the issues of HIV treatment and prevention, and in-depth case studies of specific local reactions to emergence of HIV and AIDS. Results from the investigation are available in the reports contained in this volume, and in more detailed and lengthy country assessments completed by each of the national teams.

Placing the HIV- and AIDS-related experiences of the countries of the southern Caucasus (Armenia, Azerbaijan, and Georgia) into social and cultural perspective is uniquely important. Within these three 'second wave' countries of the former Soviet Union, alarming claims that 'drug-driven epidemics are spiralling out of control' (Barrett and Whiteside 2002, p. 295) run counter to the relatively low number of individuals officially identified as HIV-positive. The proportionate increase in the number of individuals affected has been substantial each year since the late 1990s, yet HIV and AIDS remain poorly documented, misunderstood, and highly stigmatised in the region. Analyses of the social and cultural factors influencing the ability of these countries to determine national strategies, implement effective prevention programmes, and develop better monitoring systems can assist in rectifying the differences between dire future predictions and the current modest prevalence rates.

The Southern Caucasus

Armenia, Azerbaijan, and Georgia gained independence with the collapse of the Soviet Union in 1991, but each country possesses a long historical memory and ancient, deeply-rooted claims to their regional territory. The region bridges the Middle East and Eurasia, bounded by the Caspian Sea to the east, Iran and Turkey to the south, the Black Sea to the west and the Russian Federation to the north. Historically an important economic and cultural crossroad, the history of the region is both prosperous and diverse, but it is also a land of consistently contentious boundaries. Current conflicts on both sides of the border to the north, such as Chechnya and Abkhazia, and unresolved territorial conflicts, such as Nagorno Karabakh, pose significant challenges to political stability and cooperation in the region. In the years since independence, armed conflict between Azerbaijan and Armenia has claimed the lives of thousands of people and generated large refugee and internally displaced populations. Civil war, charges of corruption, and ongoing internal conflicts (South Ossetia, Ajara, and Abkhazia) have posed serious challenges to the Georgian state. However, the shift from armed conflict to negotiation over Nagorno Karabakh and the success of 2003's 'Rose Revolution' in Georgia may mark the emergence of increased stability within this geopolitically important region.

The southern Caucasus is home to a wide variety of ethnic, linguistic, and religious groups. While each of the titular nationalities (Armenian, Georgian, Azerbaijani) constitutes the majority of their respective populations, to some extent each faces the challenge a multi-cultural state. In Armenia, the most homogeneous of the region, nearly 5% of the population does not identify as an ethnic Armenian alone. More than 11% of Azerbaijan's population belongs to non-Azeri ethnic groups, such as the Lezghin. Georgia is the most diverse country in the region, where 30% of the population identifies their ethnicity as something other than Georgian, and linguistic diversity poses serious communication issues. In each country the

symbolic importance of the national religion (Islam in Azerbaijan, Armenian Apostolic in Armenia, and Georgian Orthodox in Georgia) is palatable, with religious leaders attending inaugurations, openings of parliaments, and playing a significant role in social discussions. Yet the populations are far from religiously homogeneous. In Armenia, the Yezidi, comprising 2% of the population, follow Zoroastrianism, as do a similar percentage of the population of Azerbaijan. Georgia has a sizable Islamic minority (11%) as well as many adherents of Russian Orthodox (10%) and Armenian Apostolic (8%) faiths.

As seen in Table 1, demographic, economic, and social indicators for the region highlight similarity, but also point to a few areas of important difference. In 2002, the total population of the region was estimated at 17.8 million, more than half of whom reside in Azerbaijan. Adult literacy is nearly complete. Between one-third (Armenia) and one-half (Georgia and Azerbaijan) of the national populations reside in rural areas, some of which are in geographically remote areas, and most of which have significantly lower infrastructure development (water, sewage systems, gas provision, roads) than urban areas. Approximately 20% of the populations of Armenia and Georgia are under 15 years of age, while in Azerbaijan, over 30% of the population is composed of youth. The population dependency burdens in the region (the ratio of those under 15 and over 65 years of age to those 15 to 65) vary from a low of 0.38 individuals below or above the working age to every working person in Armenia (reflecting the dramatic decline in fertility in Armenia in the past ten years), to 0.49 in Azerbaijan (where fertility remains comparatively high).

Table 1. Selected Demographic, Economic, and Social Indicators, Southern Caucasus 2002			
	Armenia	Azerbaijan	Georgia
Population			
Population 2002 (mil.)	3.1	8.3	5.2
Adult Literacy	99.4%	97%	100%
Rural Population	35.40%	49.80%	47.80%
Population Under 15	21.40%	30.10%	19.20%
Dependency Burden	0.38	0.49	0.44
Development Indexes			
HDI Rank	82	91	97
HDI Score	0.754	0.746	0.739
Economic Indicators			
ODA Received (millions)	293.5	349.4	312.6
Estimate Male to Female Earnings	0.69	0.57	0.40
Gini Coefficient,	37.9	36.5	36.9
Health			
Life Expectancy	72.3	72.1	73.5
Public Spending on Health % of GDP	3.2	1.1	1.4
Private Spending on Health % of GDP	4.6	0.5	2.2

Source http://hdr.undp.org/statistics/data/index_countries.cfm

All three countries fall into the group of 'medium' developed countries according to their Human Development Index for 2002, a composite score based on measures of longevity, educational attainment, and gross domestic production per capita. The regional rankings are below the Russian Federation (0.795) and Ukraine (0.777), but similar to many other 'second wave' countries such as China (0.745) and Kazakhstan (0.766). As a group, the region ranks well above the threshold for low developed countries, which is 0.500.

Economically, the region has suffered significant hardship over the past fifteen years and experienced growing internal wealth disparities. Economic growth rates have recently improved, but many people remain in poverty. Each of the countries reports the receipt of over one-quarter of a billion dollars of overseas domestic assistance in 2002, with Armenia the highest per capita recipient. The importance of the shadow economy makes the estimation of precise figures difficult, but World Bank estimates place 51% and 49% of the populations of Armenia and Azerbaijan (respectively) below national poverty lines in 2001. Levels in Georgia are believed to be much higher. Economic deprivation is particularly acute among the over one million refugees and internally displaced persons in the region, concentrated in Georgia and Azerbaijan. Poverty has placed severe strains on family systems and contributes to declining birth rates, increasing divorce rates, and postponement of marriage, strains that often weigh most heavily upon women, who earn significantly less than men across the region. In Georgia, reported data suggests that the average earning of women is only 40% of that of men. The dearth of economic opportunities is associated with coping behaviours with negative health consequences such as drug use and alcohol abuse, especially among men. Poverty continues to promote large-scale labour migration out of the region, often to Ukraine and Russia, as migrant remittances play a critical role in family budgets, especially in Armenia (Buckley 2005). Press reports from Russia claim there are a quarter of a million migrants from the southern Caucasus in the city of Moscow alone (Migration News 2002).

Projected income from oil revenues in Azerbaijan holds tremendous promise for future economic development within the country. For Georgia, the planned Baku-Tbilisi-Ceyhan (BTC) oil pipeline is expected to generate much-needed employment and revenue. The Gini coefficients for the three countries of the southern Caucasus are grouped very tightly in the mid-30s (with scores of 100 representing perfect inequality and zero, perfect equality). These scores are more equitable than those reported for the Russian Federation (45.6) but markedly higher than those found in Ukraine or the Central Asian states. International assessments of the region recognize the potential for significant progress toward the United Nations 2000 Millennium Development Goals (which include curbing the spread of tuberculosis and HIV/AIDS) if actions are taken quickly on wealth distribution, basic social service provision and governance issues such as corruption (Oxfam 2005).

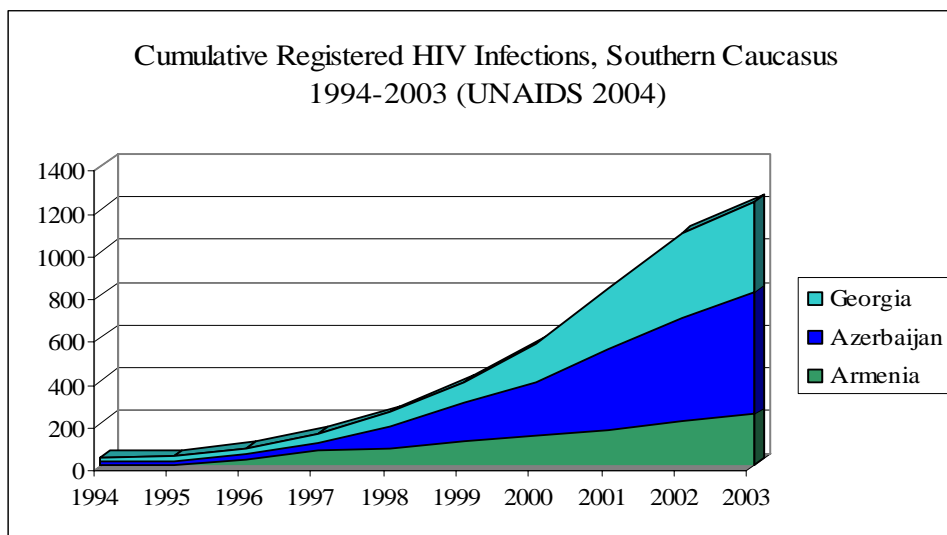
The provision of public health services in Armenia, Azerbaijan, and Georgia highlight the dual challenges of resource constraints. Each of the countries has shifted from Soviet-era public health systems with universal coverage to a blend of public and private medical provision. Costs for medical cases are high, and low pay for medical officials reinforces traditional under-the-counter payment for services, even when covered by the state or, in very rare circumstances, private insurance. Many people avoid seeking care due to anticipated costs, and prescribed drug treatments are often not followed due to scarcity and costs (Von Schoen 2004). Calls for the expansion of state involvement in health care provision are popular at the local level, however, adjustment policies advocated by the World Bank and other IGOs continue to stress the importance of public health privatisation for efficient use of resources (Gamkrelidze et al., 2002). In Armenia and Georgia, private expenditures for health

care far outweigh public expenditures. In relation to its GDP, Armenia spends the most on health care (7.8% based on public and private spending), followed by Georgia (3.6%), and Azerbaijan (1.6%) The health care sphere is often cited as problematic in terms of equity and access, a situation exacerbated by rising cases of tuberculosis, child anaemia, respiratory illness, and heart disease in the region. As reported by the national research team in Azerbaijan, concern over extortion and malfeasance has prompted Azerbaijan to exclude government oversight from private medical clinics as part of their recent anti-corruption movement.

While Armenia, Azerbaijan, and Georgia differ historically, culturally, and economically, their shared experiences of migration within the region, increasing injecting drug use, common economic interests in oil transport, and attempts to reform Soviet-era public health systems generate binding overlapping interests. These shared interests are particularly relevant in terms of developing responses in the area of HIV and AIDS. In 2000, representatives from each country met in Odessa, Ukraine, to discuss the coordination of strategic national approaches to issues of social and political mobilization and discuss shared concerns in the realms of education, prevention, and treatment of HIV and AIDS. The meeting, which included representatives from UNICEF and UNAIDS, urged governments, international organizations and public interest groups to avoid postponing interventions concerning HIV and AIDS, stressing the importance of the experience of Russia, Ukraine and Belarus in demonstrating the rapidity with which the HIV epidemic can progress (UNICEF/UNAIDS 2000).

HIV Prevalence and Testing

The total number of individuals registered as living with HIV has increased rapidly in the southern Caucasus since the first cases were reported in the late 1980s. Comparative data for Georgia, Azerbaijan, and Armenia illustrates a swift and consistent rise in the number of individuals registered with HIV between 1994 and the end of 2003. Overall HIV prevalence remains low in the region, especially in comparison to other countries of the former Soviet Union. Rates per 100,000 in 2003 for Armenia, Azerbaijan, and Georgia were 0.76, 1.42, and 1.93 respectively, far lower than reported rates for Russia (27.64), Ukraine (20.77), or Belarus (7.08) (WHO/CISID 2005). Yet the dramatic increases in registered HIV cases in the region between 1998 and 2003 (from 200 to 1,200), as seen in Figure 1 (below), remain a cause for serious concern.



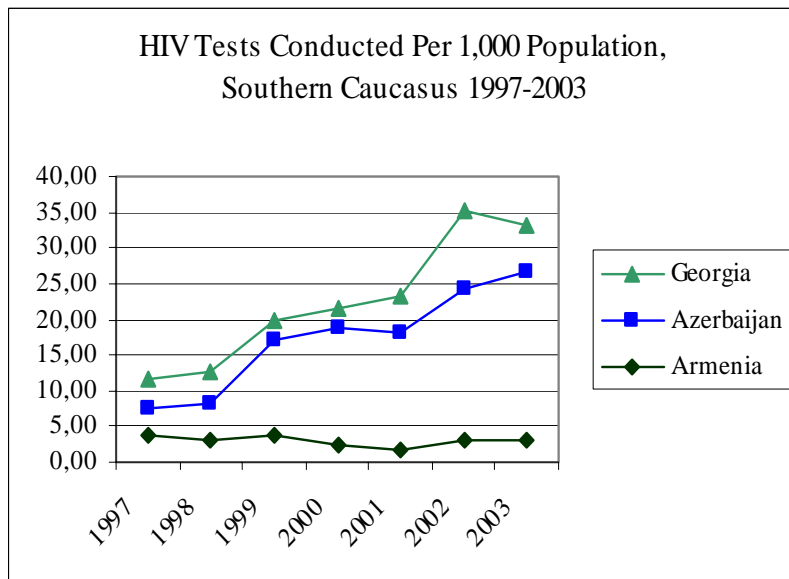
As Barrett and Whiteside (2002) point out, data on HIV and AIDS are typically confusing, variable in quality, constructed on sometimes hidden assumptions and open to interpretation, and the available information on HIV and AIDS in the Caucasus is no exception. UNAIDS contends that the registered levels in the region substantially underestimate actual HIV prevalence. They estimate the total number of individuals living with HIV in the region as between 3,500 and 19,100 at the end of 2003, far higher than the registered total of 1,200 (UNAIDS 2004, p. 196). Many local scholars agree that the actual HIV prevalence within these countries is vastly underestimated if only registered cases are considered, but little consensus exists concerning the precise level of the underestimation.

There is widespread consensus among international agencies on the challenge that HIV and AIDS present in the short-term future for the southern Caucasus. There is little agreement, however, on present prevalence levels or the trajectory of specific transmission paths. Underestimating present prevalence levels can encourage complacency and even hinder the development of national and regional treatment strategies. Overestimation of the number of individuals within the region living with HIV is also dangerous. Dire pronouncements of a mass epidemic on the horizon or blanket statements asserting that registered prevalence underestimate the actual prevalence by ten or even twenty times can hasten forms of 'crisis fatigue' or fatalism. Worse, overestimation can encourage disbelief in all information relating to HIV and AIDS. Evaluation of present prevalence requires carefully tracing the paths of transmission within the region and carefully assessing issues of testing prevalence, patterns, and coverage

The first occurrences of HIV in the southern Caucasus were registered near the end of the Soviet period (1987 in Azerbaijan, 1988 in Armenia, and 1989 in Georgia). Early cases were linked with migration and attributed to individuals travelling outside of, or recently moving into, the region. Unlike the highly publicized medically-acquired transmission outbreaks in the Soviet Union – such as in the town of Elista in Kalmykia – in the southern Caucasus many of the first individuals diagnosed with HIV attributed contact with the virus to heterosexual transmission or the use of injecting drugs. Nevertheless, all three countries in the region followed the mandatory testing approaches of the Soviet era throughout the early 1990s. This testing approach entailed wide-scale testing of all individuals coming into contact with the public health system, especially expectant mothers. Millions of HIV tests were conducted in each of these countries in the late 1980s and early 1990s, but very few individuals with HIV were identified. The population captured for testing during this period seldom overlapped with known, or suspected, key populations at heightened risk to HIV. Low levels of knowledge, distrust concerning the level of confidentiality, concerns over the safety of testing, and the high stigmatisation of HIV/AIDS discouraged potential key population members, such as IDUs and migrants, from seeking tests.

In the mid-1990s, selective testing procedures were advocated across the southern Caucasus in order to focus on populations with elevated risk for HIV, and in order to maximize the efficient use of testing resources. Armenia significantly decreased the extent of testing again in 1997 due to a shortage of testing kits, and has maintained a lower number of HIV tests per 1,000 people while attempting to focus on 'high-risk groups'. Georgia and Azerbaijan – countries reporting higher registered HIV prevalence – have conducted many more tests per 1,000 people than Armenia has. Both Georgia and Azerbaijan increased their testing rates between 1997 and 2003. HIV testing is confidential, by law, in each of the countries.

However, the strong social stigmatisation of HIV and AIDS in the region may well act to deter individuals at risk from being tested. As with many countries in the world, testing coverage is extremely difficult to evaluate, leading to differing estimates of overall prevalence and persistent questions concerning the actual composition of the population living with HIV. Recent recommendations from the World Health Organization (WHO) on HIV and AIDS in the Commonwealth of Independent States stress the importance of gathering systematic and uniform information every 30 days with regard to the number of patients screened and tests performed, in order to better assess issues related to testing coverage and to develop accurate assessments of the number of individuals tested for HIV each year (WHO 2004, pp. 117-120).



Sources: EuroHIV, 2004, p. 42; EuroHIV, 2002, p. 35; U.S. Census Department. 2005 International Data Base.

The number of registered AIDS patients is small but growing in the southern Caucasus. At the end of 2003, the reported AIDS cases per 100,000 were 0.26 in Armenia, 0.24 in Azerbaijan, and 0.83 in Georgia, yet as the total number of AIDS cases remains small, the overall country rates are rather unstable. As of mid-2003, a total of 243 deaths had been attributed to AIDS in the region (136 in Georgia, 76 in Azerbaijan, and 31 in Armenia) (WHO/CISD 2005). Access to anti-retroviral (ARV) treatments for individuals with HIV is severely limited. As of mid-2002 only Georgia reported individuals (a total of eight) enrolled in anti-retroviral therapy (ART), however Armenia and Azerbaijan requested assistance through the WHO 'Three by Five' initiative early in 2004. Given resource constraints, competing priorities, and the social stigma linked to HIV and AIDS, even with concerted scaling-up efforts, wide-scale acceptance of, and access to, ARV treatment is unlikely in the near term. The total number of individuals in the region who will develop AIDS, and the deaths due to AIDS, are likely to increase substantially in the coming years. Due to the specific nature of transmission routes, exposure likelihood, and behavioural practices, both HIV and AIDS will increase within specific population groups.

Transmission Routes and Key Populations

Though incomplete, official information from the southern Caucasus portrays a region with high concentrations of HIV within specific sub-populations, rather than a more generalized infection profile. While some trends suggest transmission profiles are changing, promising, small-scale sentinel studies conducted by the National HIV/AIDS Centers in Armenia, Azerbaijan and Georgia confirm patterns of concentration among individuals registered with HIV. In all three countries, injecting drug use is reported as the most common means of HIV infection. The second most often reported mode of transmission is unprotected heterosexual sexual activity, typically with a partner who is an IDU, a labour migrant, a commercial sex worker (CSW), or has sexual contact with other partners at risk. Medical transmission, mother to child transmission (MTCT), and transmission among men who have sex with men (MSM) are rare, typically comprising less than 5% of total registered transmission in each country of the region.

The composition of cumulative registered HIV infections in the southern Caucasus shows remarkable similarity across the region, as seen in Table 2. Men comprise more than three-quarters of all PLHIV in each country, reflecting the higher social priority placed on constricting female sexual activity (typically to within marital unions) and markedly lower drug use among females. As with many other countries around the world, both male and female PLHIV are heavily concentrated among the young. In both Armenia and Azerbaijan, approximately half of all registered individuals cited injecting drug use as their probable transmission route, while 67% cited this in Georgia. Reported heterosexual transmission plays the largest role in Armenia, at 39%, while in Georgia and Azerbaijan, it is identified as the transmission route by approximately one out of four individuals registered with HIV. Information regarding transmission through commercial sex workers is not systematically reported, and appears to be added to reported heterosexual transmission. Transmission attributed to men who have sex with men is rarely reported in any of the countries, representing the strong social stigma associated with alternative sexual identities within the region and perhaps that this specific sub-population, in this setting, has not been integrated into the dominant transmission routes. In spite of focused testing efforts of all expectant mothers in the region, mother to child transmission remains extremely rare. Nearly half of all individuals registered reside in the capital cities of their respective countries, reflecting increased testing availability and more importantly, the less restrictive social atmosphere characteristically found in major urban centres.

	Armenia Nov. 2004		Azerbaijan Jan. 2005		Georgia Nov. 2004	
	#	%	#	%	#	%
Total Number of Cases	296		718		597	
of whom:						
Male	229	77%	580	81%	501	84%
Female	67	23%	138	19%	96	16%
Age Composition						
Under 30		52%		37%		60%
Mode of Transmission						
Medical/Transfusions	2		1		4	
Maternal	3		9		3	

IDU	155	52%	336	47%	411	69%
Sex Workers	*		*		*	
Male to Male	2		3		16	
Heterosexual	115	39%	185	26%	160	27%
Other	19		184		3	
Location						
Capital City		49%		44.4%		43.5%

Sources: National Reports from Armenia, Azerbaijan, and Georgia, 'HIV and AIDS in the Caucasus Region: A Socio-Cultural Approach. UNESCO/Flanders 2005.

Injecting Drug Users

Local surveys and sentinel investigations completed in Armenia, Azerbaijan, and Georgia confirm the central role of IDUs in driving increased HIV prevalence. Across the region, targeted small-sample investigations indicate high rates of HIV prevalence among the IDUs tested (Armenia, 15%, Azerbaijan 13-19%). Similar to the estimates of HIV prevalence in the region, the reported size of the IDU population in the region is subject to wide-ranging approximation. In Georgia, high-end government estimates place the total number of IDUs in the range of 50,000-60,000, while some press reports claim the number to be as high as 100,000-300,000 (Peuch 2004). The official reported number of IDUs in Armenia is between 4,000 and 5,000, even though surveillance studies in 2002 estimated the number of IDUs in Yerevan alone at 19,000 to 20,000. In Azerbaijan, only 15,000 injecting drug users are registered with the government. However surveillance studies of youth in 2002 indicate that 5% of all young adults had injected drugs, which casts doubt upon this estimate.

Regardless of the range of present estimates, the number of individuals using injecting drugs is increasing as persistent economic and social instability increases drug demand, and the role of the region in international drug trafficking. Significant progress has been made through the cooperative Southern Caucasus Anti-Drug (SCAD) programme in curbing the rate at which drug trafficking is expanding, yet geographic, political, and economic factors continue to provide a welcoming environment for drug trafficking. The close proximity of the southern Caucasus to both the Balkan and Silk Routes for heroin distribution make it a logical transit point for drug movements between Europe and Asia, particularly as military engagements in the Balkans, Iraq, and Afghanistan have unsettled other routes. Political instability is also attributed to the growth in drug trafficking in several areas within the southern Caucasus. While such allegations may be tainted by political motivations, Abkhazia, South Ossetia, Adjara, and Nagorno Karabakh are identified as narcotics 'hot spots' in which contested authority enables illegal activity (Peuch 2004). As in many other countries of the former Soviet Union, the widespread, continued economic and social instability within the region plays a central role in the growth of drug transport and use (CEEHRN 2002). Expanded social and economic opportunities across the region, particularly for youth, are critically important in combating drug activity.

Across the southern Caucasus, the majority of IDUs are young adults, a growing segment of the population. Injecting drug use, concentrated among males, is seldom a solitary activity in the region. IDUs tend to engage in drug use within small groups, often sharing needles and other equipment. Social ties within drug networks are very strong and trust is highly valued. The strong ties within these groups may encourage the sharing of needles and the communal nature of drug use, making overt attention to the use of disposable needles or the avoidance

of 'contamination' uncomfortable. The high proportion of IDUs sharing needles points to need for educational interventions targeting issues of cooperative practices within groups and framing the use of safer injecting procedures as a form of trust of respect within networks. Innovation in group practices is possible. For example, Georgian IDU networks no longer utilize a drop of blood in the cooking process prior to injection, an innovation adopted many years previously to combat hepatitis C and now widely practiced.

Small scale studies in the southern Caucasus indicate that the IDU population, especially in Georgia, may be saturated (EuroHIV, 2004, p.8). In theory this would dampen the growth of the HIV epidemic in the region, yet as the experience in Ukraine illustrates, transmission among IDUs can easily jump to broader-based heterosexual transmission. The increasing proportion of people living with HIV reporting heterosexual transmission and the increasing female face of HIV and AIDS in the southern Caucasus points to the possibility of IDUs (who tend to be male) shifting from a bounded group of core transmitters, to a bridge population.

Evidence from Georgia and Armenia indicates that IDUs are not a negatively stereotyped or marginalized group. They are often highly educated and integrated members of society. Drug use, and especially drug trafficking, is not viewed favourably in these countries. The social sanctions and negative perceptions against IDUs in Azerbaijan appear to be stronger than in either Georgia or Armenia. However, across the region IDUs are not a clearly separate sub-population in terms of social or sexual networks.

Findings from surveillance studies indicate a high prevalence of multiple sexual partners and very low levels of condom use among IDUs. In Armenia, surveillance studies in 2002 found that over half of IDUs surveyed reported more than one partner in the past twelve months, but infrequent condom use. A 2004 study in Georgia also found high levels of multiple sexual partners, with only 28% of IDUs reported using condoms with regular sexual partners, and 55% with casual partners. In Azerbaijan, a small-scale study of 200 IDUs found that while the majority were aware of the effectiveness of condoms in preventing the transmission of HIV, between 2% and 7% reported using condoms when they last had sex with their marital, regular, or casual partner. Their potential as a bridge to wider-scale transmission among the heterosexual population is higher than in regions where IDUs are socially marginalized.

Commercial Sex Workers and Trafficking

Targeted studies on heterosexual transmission in the southern Caucasus often focus on commercial sex workers (CSWs), but to date studies only investigate women sex workers. In Azerbaijan 8.5 % of all CSWs are believed to be living with HIV, and the estimated prevalence increases to 35% among street based CSWs. Small scale testing found few individuals engaged in commercial sex work with HIV in Armenia or Georgia, but the majority of all CSWs in each of the three countries reported at least one sexually transmitted disease in recent years. In all three countries, CSWs report low condom use, even though in Georgia most CSWs are aware of the effectiveness of condoms in preventing the transmission of HIV and other sexually transmitted infections (STIs). In Armenia, CSWs were particularly unlikely to use condoms with repeat customers who may view the suggestion of condom use as a violation of trust (Babayan 2002). A study of 200 CSWs in Azerbaijan found 86% reported never using a condom.

Participation in commercial sex work is highly stigmatized within the southern Caucasus, and the individuals engaged in it (typically women) have little or no access to support. As elsewhere, women cope with the stress of transgressing social standards concerning sexual activity by framing their work as a temporary economic necessity, but remain ashamed of their activity. Many women engaged in commercial sex work, specifically those from rural areas, travel to another town or city in order to keep their activities from friends and family. Such strategies may assist in keeping their activities hidden, but also deny women access to the social support systems and safety nets that friends and family provide. CSWs are unlikely to seek assistance from the police. In Armenia, though illegal, commercial sex work is neither prosecuted as a crime nor officially tolerated. In Georgia, it is viewed as neither illegal nor legal. In Azerbaijan, police take responsibility for enforcing the mandatory HIV testing of all commercial sex workers. Across the region, the police are unlikely to be viewed as supportive, and more likely to be feared or viewed as a potential source of further exploitation. CSWs are often physically and financially vulnerable, making condom negotiation difficult, if not impossible.

The transmission possibilities stemming from commercial sex work are not limited to clients, especially within the southern Caucasus, where the profile of CSWs is diverse. Most women attribute their participation in commercial sex work to economic responsibilities toward their families. Many have non-commercial sexual partners. Although the number of married women engaged as CSWs is lower in Georgia and far lower in Azerbaijan, in Armenia nearly one in four CSWs is married. The difficulties associated with commercial sex work often leads to negative coping behaviours, such as drug use. In Armenia, 17% of CSWs who participated in studies by the National Center for HIV and AIDS reported using injecting drugs, indicating another expansion of transmission possibility and exposure.

Persistently high poverty and inequality levels in the region will drive more women into commercial sex work, while the development of oil and natural gas extraction and transport across the region is likely to elevate existing demand. Across the region, there is little social stigma for men who employ a female commercial sex worker. Survey results in Georgia indicate that 76% of young people surveyed found it acceptable for a young male to be taken to a sex worker for sexual initiation. Premarital sexual debut for young men is also viewed as acceptable in Armenia, and even preferable in Azerbaijan. For adult men, visiting CSWs is not subject to significant social sanctions; it is tolerated, if not accepted. As development of the oil and gas reserves in Azerbaijan progresses and the BTC pipeline across Georgia is constructed, there will be large concentrations of international and domestic male workers assigned to labour sites far from home. These circumstances are likely to generate substantial increases in the demand for commercial sex workers in the southern Caucasus. There is an immediate and pressing need for increased educational efforts for both CSWs and their potential clients concerning the prevention, symptoms, and treatment of sexually transmitted infections, including HIV.

Reports of increased trafficking activity in the region point to an associated problem, as young women are being sent to work, sometimes unknowingly, in the sex industry abroad and may return home with sexually-transmitted infections, including HIV. In Azerbaijan, organized systems of recruitment have been identified as networks that move these women across Georgia. While many of the women trafficked from the region were sent to Turkey, new routes to the Gulf, such as Dubai, have been documented (Zeinalova 2004). Increasing numbers of women are trafficked from Armenia, lured by the promise of high-paying jobs and international travel, but are instead forced into sex work (Reeve, Baruah, and Jekic.

2001). Estimates on the number of women – and increasingly children – trafficked from the region vary widely, but IGOs and NGOs involved in the issue agree that human trafficking will continue from the region until economic conditions stabilize and opportunities improve.

Temporary Labour Migrants

Heterosexual transmission is also driven by the hundreds of thousands of labour migrants who have left Armenia, Azerbaijan, and Georgia for temporary employment in other countries in recent years. Most temporary labour migrants are males, and leave their families for various periods of time for work abroad. Georgia asserts that 79% of the individuals registered with HIV were infected through drug use or sexual activity while in Ukraine or Russia. In Armenia, short-term labour migrants are more likely to use drugs, report more than one sexual partner, and have experienced a sexually-transmitted disease during their lifetime than non-migrants are. Azerbaijan reports that the majority of women contracting HIV through heterosexual relations claim exposure through their migrant spouse. The role of migration in the transmission of HIV is linked to the primary destinations for labour migration from the southern Caucasus: Ukraine and Russia, countries with the highest HIV prevalence in the former Soviet Union.

Estimating the number of people involved in temporary migration from the southern Caucasus and monitoring the transmission within the migrant population is very difficult, as most labour migration from the region is undocumented. Press reports claim that 250,000 migrants from the region reside in Moscow alone (Migration News 2002). Minimum estimates for out migration from Georgia and Azerbaijan to Russia and Ukraine since 1991 are approximately 500,000 each. The region continues to lose population through substantial negative net migration. Experience in other settings indicates that migration directly and indirectly elevates HIV risk. Migrants are more likely to engage in risky sexual behaviour at their destination due to decreased social monitoring. They also are more likely to employ drugs or alcohol at the destination, often in attempts to cope with the strains and stress of resettlement. As most of the migrants from the southern Caucasus in Ukraine and Russia are undocumented, their access to medical diagnoses and treatment at destination is severely limited. Lastly, as migrants within the CIS found to be HIV-positive are typically deported to their country of origin, there are strong incentives to avoid testing.

Wide-scale out migration does not affect migrants alone, but can transfer elevated HIV risk to entire households. Female spouses left at origin, often with children, are subject to both relational and behavioural risks. Relationally, returning migrants can pass sexually transmitted infections to non-migrating spouses, especially when the latter is unlikely to suggest the use of condoms. Behaviourally, migrant spouses or partners may turn to HIV risk-related coping behaviours such as alcohol, risky sexual behaviours or drug use to cope with the challenges of migration within the family system. Lastly, the long-term absence of the male head of household decreases the opportunities for the familial transmission of reproductive and sexual health knowledge to male children and adolescents, which takes place along strictly gendered lines (Buckley 2005). The pervasive nature of temporary migration out of the region, and the high HIV prevalence levels at the most common destinations, represent an important, and often overlooked, transmission channel for HIV, both for migrants and their families. Increased efforts to understand the relationships between migration and HIV transmission within family networks are very important, as migration is likely to become a major factor in the spread of HIV throughout the region.

Men who have sex with men

Only a small number of individuals registered with HIV identify as men who have sex with men (MSM), with most cases reported within the prison population. This may reflect low prevalence within this population sub group or, more likely, is the result of the pervasive social stigma associated with alternative sexual orientation in the southern Caucasus. The Soviet-era Article 113, which criminalized homosexual relations, was only recently abolished in the region (Armenia in 2003, Azerbaijan in 2000, Georgia in 1999) (ILGA 2004). Same-sex relationships remain highly stigmatised and individuals perceived as homosexuals are ostracized. Yet a study of university youth found that nearly 5% report having 'experimented' with male-to-male sexual relationships (Babikian 2004). MSM do represent a possible HIV transmission route in the region, but individuals at risk are unlikely to develop a group identity that would enable targeted efforts at testing, education, or treatment. The hidden nature of the population makes intervention difficult, and may increase potential transmission outside of the group.

The number of registered HIV transmissions attributed to men who have sex with men is quite low, but the intense social stigma directed at MSM does influence the ways in which HIV and AIDS are viewed in the southern Caucasus. The association between MSM and the spread of the HIV epidemic in Western Europe and North America is well known in the region. The mass media has raised the visibility of interest groups and activists from the MSM community in the arena of global HIV and AIDS advocacy. Even though local transmission patterns and prevalence indicate a very different local reality, HIV and AIDS are sometimes viewed as primarily the concern of the MSM community. This perception wrongly distances issues related to HIV and AIDS from the non-MSM community. While attempts to address the stigmatisation of the MSM community within the southern Caucasus are urgently needed, the development of educational efforts and interventions focusing on HIV and AIDS should be mindful of local transmission patterns and avoid reinforcing misperceptions concerning the main populations at risk.

Medically-acquired and mother-to-child transmission

Medical transmission of the HIV virus is seldom registered in the southern Caucasus, in spite of public perceptions and continuing challenges to blood supply screening. In Georgia and Azerbaijan, where historically blood banks have paid donors, blood tested in 2002 had a high HIV-positive rate relative to other countries with similar prevalence levels (over 20 per 100,000) (EuroHIV 2003; Butsashvili et al. 2001; Kressler 2001). Substantial efforts to improve blood screening and increase voluntary blood donations have met with success in both Georgia and Azerbaijan, and screening and collection procedures are still improving (Butsashvili et.al. 2001).

Although medical transmission accounts for less than one-half of 1% of all registered cases of HIV, the public continues to view the utilization of health care services (transfusions, dentists, other medical procedures) as a significant transmission channel. In Azerbaijan, among the 5% of women between 15 and 44 surveyed who indicated any self-perceived risk of HIV, 49% cited their use of health services as their main risk factor (Serbanescu, et. al. 2002, p.286). A similar survey in Georgia indicated that of the 32% of all women perceiving

some risk of HIV, 88% attributed their risk to health care services (Morris et al., 2001, p.281). The perception of health care services as the primary risk source held across reported sexual activity and marital status. These attitudes may reflect a lack of trust in health care services and health professionals, linked to the declining provision of public health services since 1991, or lingering social effects of highly publicized cases of medical transmission. More disturbing, attributing risk to medical transmission may reflect a disconnection with the risks associated with more obvious HIV- and AIDS-related behaviours (sexual activity or drug use), or a sense of fatalism in which exposure to transmission is divorced from individual decision making. The popular perceived importance of transmission related to health services far exceeds its documented role in the spread of HIV in the region, and may hinder the ability of national health ministries to effectively contribute to HIV and AIDS education, prevention, and treatment.

Social Correlates of Risk and Knowledge

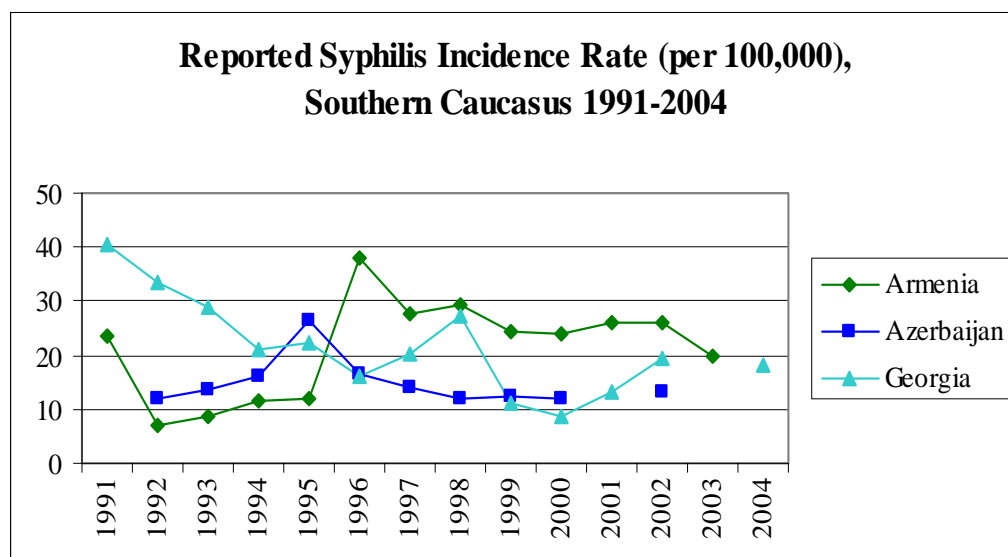
The risk of contracting HIV in the southern Caucasus is differentially constructed by gender and relatively highest among the poor and young adults. Social norms, reinforced by religious beliefs, exert stronger restrictions on female than on male behaviour, especially in terms of sexual activity. As in other contexts, with the exception of commercial sex workers, female HIV risk is typically viewed through their relationship with a male partner, whose actions may elevate transmission risk. Survey research in the region indicates women are responsible for health care and possess the authority to make health-related decisions within the family. Similarly, more women are engaging in risk-related behaviours such as smoking, drug use, and unprotected sexual activity. More analytical focus upon female decision-making and behaviour in the context of constricting social norms is sorely needed in the southern Caucasus.

Individuals living in poverty – many of them women – are less likely to access health education and care and more likely to become involved in risk-elevating behaviours including drug use, labour migration, commercial sex work, and alcohol abuse. Poverty exists throughout the southern Caucasus, but is highest in rural areas and small towns, where access to public health campaigns is low. Poverty is also concentrated among the internally displaced and refugee populations in the region, adding to the stress of forced migration and contributing to factors motivating decisions to engage in risk-related behaviours.

The influence of economic hardship and gender norms are clearly seen in the particular challenges faced by young adults. Changes in the educational systems in the region put the cost of post-secondary education, previously common in the region, out of reach for many young adults. Employment opportunities have dwindled and costs of living have risen dramatically. The past fifteen years have witnessed an influx of western, sometimes sexually explicit, media, music and film at odds with the traditional social values in the region. Social norms stressing modesty and abstinence before marriage are often challenged by mass media influences and rising ages at marriage. Economic and social pressures have encouraged the spread of negative coping behaviours such as increased alcohol and injecting drug use among males under thirty. Small scale studies indicate increasingly frequent sexual activity among young men and women, and state statistics indicate rising rates of syphilis and gonorrhoea among young males.

Newspaper advertisements, readily found in Armenia, Azerbaijan, and Georgia, touting hymen repair surgery to restore the virginity of women confirms the contradictory influences of traditional values stressing virginity and the behavioural choices made by young women. It also raises potential questions concerning the accuracy of national survey data reporting extremely low levels of sexual activity among unmarried women generally, and among young women in particular (Morris, 2001; Serbanescu, 2002; NSS, 2001). Anecdotal evidence indicates that local interpretations of what type of activities qualify as sex might be more narrowly defined than all sexual activities related to HIV transmission. Sexual activity, according to some reports, is inextricably tied to fertility and may not be viewed (or reported) as sex, if it is not associated with any possibility of conception.

As seen in Figure 3 (below), some form of sexual activity is taking place within the countries of the region. Reported incidences of syphilis for the overall regional population have remained fairly constant, or increased slightly since the early 1990s. Syphilis rates in Armenia have risen over the past thirteen years, while incidence rates appear to have increased over the past three years in Azerbaijan and Georgia. These figures question the effectiveness of recent informational campaigns concerning safe sex practices and reproductive health in the region.



Source: WHO/CISID 2005.

Among young adults, reported levels family planning knowledge as well as indicators of sexual health knowledge, are very low. Among unmarried young adults, most information concerning reproductive health comes from peer networks and mass media, with only a small number of young people obtaining information from parents, family members, or medical professionals. Many years after HIV and AIDS emerged as a regional problem, none of the countries of the region has implemented a national programme for health education that includes the topics of family planning and sexual health. Family networks, remarkably strong and resilient in the region, remain an untapped avenue for sharing information concerning reproductive health. However, for family networks to be effective in educational efforts, overall low levels of knowledge concerning HIV transmission, identification, and treatment must be addressed.

In 2004, a small-scale survey of 1,500 randomly selected adults in each of the country's capital cities was conducted by the Caucasus Research Resource Centers. Respondents were asked about their familiarity with HIV and AIDS, the identification of major transmission routes and their agreement with common misconceptions regarding HIV transmission. While the majority of all men and women in the region have heard of HIV and AIDS, substantial numbers of individuals have yet to understand how it is transmitted. Respondents in Baku indicated less familiarity with HIV and AIDS, and the main transmission routes of HIV, than those in Yerevan and Tbilisi did. IDUs are the main transmission route in Azerbaijan, yet surprisingly less than half of those surveyed in Baku agreed that sharing a syringe enables the spread of HIV. Misconceptions regarding HIV transmission were slightly more consistent across the three cities, with substantial numbers believing that sharing a towel, sharing a toilet, kissing, or sharing utensils with an individual living with HIV enabled transmission of the virus. More than one in ten respondents in Baku believes shaking hands enables transmission. The findings coincide with other studies of reproductive health knowledge in the region and indicate a dire need for additional educational efforts concerning transmission routes (Claeys et al., 2001). The prevalence of misconceptions concerning transmission can only serve to further stigmatize and marginalize people living with HIV.

Table 3. Indicators of HIV/AIDS Knowledge and Attitudes by Sex, Caucasus Research Resource Centres Survey 2004

Round One, Yerevan, Baku and Tbilisi

	Armenia (Yerevan)			Azerbaijan (Baku)			Georgia (Tbilisi)		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Have you ever heard of STIs?	85.0%	86.7%	80.4%	62.8%	61.0%	61.0%	95.4%	96.0%	93.5%
Have you ever heard of AIDS?	82.7%	84.7%	77.4%	59.8%	60.5%	57.5%	95.0%	95.7%	93.0%
Yes, you can contract HIV from sharing a syringe	79.9%	81.6%	74.7%	48.0%	47.6%	49.7%	91.2%	92.1%	88.4%
sexual intercourse w/o a condom	82.7%	84.4%	77.9%	55.8%	56.4%	53.5%	91.8%	92.5%	89.8%
shared bath towel or toilet	19.9%	20.2%	19.1%	19.0%	19.3%	17.9%	17.3%	17.4%	17.2%
Kissing	44.1%	45.7%	49.2%	31.6%	31.8%	54.1%	33.9%	32.8%	39.7%
sharing utensils	16.1%	16.8%	14.1%	18.1%	18.5%	16.7%	17.3%	17.6%	16.4%
shaking hands	9.9%	9.9%	9.7%	14.2%	14.7%	12.3%	4.5%	4.2%	5.4%
sample size	1,497	1,095	402	1,489	1,171	318	1,472	1,100	372

Source: CRRC Data Initiative Survey, Round One, 2004.

<http://www.crrc.am/index.php/en/41>

The prevalence of misconceptions concerning transmission can only serve to further stigmatise and marginalize people living with HIV. Many of the concerns over transmission (sharing utensils, shaking hands) are completely misplaced and likely to spread fear of people living with HIV. Recent studies illustrate that people who feel that HIV cannot be avoided hold significantly more negative attitudes towards people with HIV. A study of more than 5,000 women of reproductive age in Azerbaijan found that women who did not know the correct and incorrect ways HIV can be transmitted were significantly more likely to deny a teacher with HIV the right to continue teaching, and significantly less likely to frequent a shop where the owner is living with HIV, compared to women who knew there are ways to avoid HIV. In Azerbaijan, as shown in Table 4, women generally hold very negative attitudes towards individuals with HIV, and are unlikely to support their right to employment. These findings point to the pressing need for educational efforts regarding HIV transmission, and additional efforts against the social exclusion of PLHIV. With only 14.5% of those who are aware that HIV can be avoided supporting the right of an HIV-positive teacher to keep working, and approximately 7% of the same group willing to frequent a shop owned by someone with HIV, the likelihood that individuals in key populations will avoid being tested, or feel the need to keep their status secret, will be very high.

Table 4. Attitudes Towards Individuals living with HIV by Belief that HIV Can be Avoided, Azerbaijan MICS 2000

Should a School Teacher with HIV be allowed to teach?	Can Avoid HIV		Can't Avoid HIV		Do Not Know	
Yes	239	14.5%	202	11.3%	97	6.2%
No	1,358	82.5%	1,549	86.4%	1,362	86.4%
Don't Know	49	3.0%	41	23.0%	117	7.4%
Would you frequent a shopkeeper who had HIV						
Yes	114	6.9%	82	4.6%	42	2.7%
No	1,512	91.9%	1,689	94.3%	21	93.3%
Don't Know	20	1.2%	21	1.2%	64	4.1%
Chi-square significant at .001					total	5,014

Source: Azerbaijan Multiple Indicator Cluster Survey 2000.

<http://www.childinfo.org/MICS2/newreports/azerbaijan/Azerbaijan1.PDF>

Institutional Context and authority

The national governments of Armenia, Azerbaijan and Georgia have taken several steps to address the challenges related to HIV/AIDS in the southern Caucasus: establishing national centres and parliamentary task forces on HIV and AIDS and making legal efforts to conform to international standards regarding access to confidential testing and the rights of people living with HIV, including access to medical care. However, resource constraints and the importance of competing demands for state funding (social welfare payments, security, and infrastructure development) limit the ability of individual governments to mount large scale HIV and AIDS programmes. Additionally, the low registered prevalence of HIV in the region, the absence of visible advocacy groups, and the high stigmatisation of people living with HIV does little to encourage public support for expanded government action.

State efforts are also hindered by contradictory approaches to HIV-related behaviours and transmission. All three countries in the region are committed to anti-drug policies and the fight against drug trafficking through the region, complicating outreach efforts within the IDU community (DLHPR, 2002). The state's ability to effectively extend educational opportunities or treatment among commercial sex workers or undocumented labour migrants will be limited due to legal concerns. Armenia and Georgia have incorporated the transmission of HIV into their most recent criminal codes (Armenia Article 123, Georgia Article 131), and Azerbaijan has linked the transmission of sexually-transmitted infection to increased punishment in cases of sexual violence (Article 150 section 3.2). Such criminalisation may dampen the desire of individuals in known 'risk groups' to seek testing and identification, and do little to encourage reliance upon the state for assistance and treatment among people living with HIV.

National health care systems in the region have launched efforts to improve reproductive health knowledge and raise HIV and AIDS awareness, but their abilities are also limited by competing, higher prevalence health concerns. These include the high rates of TB found throughout the region, increasing cardiovascular disease, high levels of childhood anaemia and declining overall life expectancy, all of which compete for resources and manpower with sexual health programmes during a period of rapid privatisation and decreases in public health spending. In addition, popular perceptions of health care services as a source of HIV transmission may act to decrease the perceived authority of health care professionals and the willingness of the population to utilise health care services relating to sexual health.

Substantial efforts concerning HIV and AIDS education, prevention, and treatment have been made in the southern Caucasus by intergovernmental organisations (IGOs) such as UNAIDS, UNDP, UNICEF, and the Global Fund to Combat HIV/AIDS Tuberculosis and Malaria (GFATM) in addition to direct individual donor foreign aid and international non-governmental organizations (NGOs) such as the Open Society Institute and World Vision. These organizations benefit from expanded resource availability, links to international networks and significant accumulated knowledge concerning the global experience with the HIV pandemic. However, the unique transmission pathways, key populations at elevated risk, and cultural settings found in the southern Caucasus requires such international efforts to incorporate local knowledge and an appreciation of local cultural sensitivities into their programming efforts. The individual country assessments at the core of this project highlight several instances of well-intentioned educational efforts gone awry due to a lack of sensitivity. Local prohibitions concerning sexually-oriented discussion with unmarried women have stymied efforts at teacher training in Azerbaijan. Efforts to educate school children without incorporating parents into the process have met with resistance in Georgia. Similarly, peer education programmes aimed at improving sexual health knowledge among youth in Armenia have encountered opposition from parents and in some cases teachers. Attempts to establish a needle exchange for IDUs met with local opposition in Baku. Only through partnering with local interest groups and community members can international organizations effectively target their resources, develop appropriate programming interventions, and generate local authority and popular acceptance.

Identifying partner organizations is not always easy, as civil society in the southern Caucasus has experienced a highly differentiated and tumultuous history. Locally-based civil society organizations in the region are numerous, but typically small scale and often dependent on funds from international agencies. This resource dependence can sway organisational agendas and compromise the local status of grass roots organisations. Deeply-rooted local organisations with solid institutional reputations, such as the Georgian Federation for

Children, can still wield substantial influence, in part due to their tight ties to respected institutions within Georgian society: schools and families.

Religious organisations are also well respected and in many cases able to command significant authority in the southern Caucasus. Muslim religious groups in Azerbaijan have participated in efforts to expand voluntary blood donation and supported IGO efforts to gather the support of the religious community in Azerbaijan for HIV and AIDS programmes. In contrast, the Georgian Orthodox Church has used its considerable influence to block attempts at establishing a national health curriculum in Georgian schools. In Armenia, the role of the national church is complicated by the prominence of imported, and in some way competing, faith-based organisations, such as World Vision, taking a highly visible role in international HIV and AIDS efforts. The substantial cultural authority possessed by religious organisations in the region demands active engagement between religious leaders and organisations involved with HIV and AIDS education, prevention, and treatment efforts. While common ground may be difficult to negotiate, failing to incorporate national religious leaders in the development of interventions can prove disastrous.

In the assessment of institutional context and sources of local authority in the southern Caucasus, issues of trust, tradition and local networks are extremely important. The communal nature of the societies in Armenia, Azerbaijan and Georgia make social networks ties, shared histories and family systems extremely valuable. Working with these lines of authority and influence can enable more effective interventions needed to respond to the challenges presented by HIV and AIDS in the southern Caucasus.

Recommendations

Informed by local assessments of the social and cultural correlates of HIV transmission, prevention, and treatment developed by research teams in Armenia, Azerbaijan, and Georgia, the need for greater attention to the specific history, transmission patterns, social attitudes, and authority structures within the southern Caucasus is critical. Seven specific lines of recommendation emerged from this project.

- Enhanced regional cooperation in developing general guidelines and procedures to provide the best testing coverage of key populations would lead to more efficient use of testing resources, improve the accuracy of registered prevalence levels, and enhance the comparability of official information on HIV and AIDS across the region.
- Expanded support for sentinel studies of target populations (IDUs, CSWs, labour migrants, MSM) employing comparable sampling approaches, and assessment strategies can improve our current understanding of behaviours that place people at risk for HIV, provide valuable insight into the ways in which activity networks might bridge modes of transmission, and provide stronger empirical insights into the level of underestimation attributed to registered prevalence rates.
- Popular perceptions of health care utilisation as a major source of HIV risk require detailed examination and intervention if the medical systems within the region are to effectively participate in the testing, prevention, and treatment needs related to HIV and AIDS.

- HIV and AIDS educational efforts that integrate sexual and reproductive health issues are critically important for the region, both to encourage informed individual-level decision making and as a means of combating stigma and discrimination against people living with HIV.
- Local social networks, including lines of cultural authority and responsibility within the family, should be incorporated into prevention, identification, and treatment interventions in order to utilise the powerful influence of social ties on behaviours and attitudes.
- The incorporation of respected local institutions such as trade unions, religious organizations, and other groups is extremely important in providing cultural capital to HIV and AIDS intervention programmes, particularly as the authority of the regional governments and medical systems often face popular challenge.
- Concerted efforts to engage local institutions opposed to HIV and AIDS interventions in dialogue, debate and compromise is of central importance to the crafting of culturally-appropriate interventions, and provides an invaluable opportunity to turn opposition into alliance.

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PART II. NATIONAL REPORTS

Chapter 2. Armenia

HIV and AIDS in Armenia: a socio-cultural approach

Arshak Papoyan, Anoush Arakelyan, Elmira Bakshinyan

Introduction

The social, economic and political environment in the Republic of Armenia has had a profound influence on the course of the country's HIV epidemic. Effective responses to HIV and AIDS therefore, must take into account these realities, as well as the role of particular behaviours that have facilitated the epidemic's spread.

Even though the current number of people living with HIV (PLHIV) in Armenia is lower (0.76 per 100,000) than that of other Eurasian countries, such as the Ukraine (20.77 per 100,000) and Russia (27.64 per 100,000), incidence rates are continuing to increase annually. The official (registered) current HIV prevalence is 0.02% (although unofficial estimates indicate a prevalence ten times higher), with higher concentrations among key populations – up to 15% among injecting drug users (IDUs) and an estimated 3% among commercial sex workers (CSWs) (Grigoryan, Mkrtchyan and Davidyants 2002). In the context of the country's profound socio-economic, political, and cultural changes, numerous factors are directly contributing to the spread of HIV: social attitudes, discrimination against PLHIV, a low awareness among the general population about how HIV is transmitted and how an HIV infection develops into AIDS, and generally fertile soil for high-risk behaviour such as injecting drug use, unprotected sex, and commercial sex work.

In the wake of the collapse of the Soviet Union, and subsequently, the Soviet infrastructure, social systems like education and public health have suffered greatly and are still in a transitional rebuilding process. One consequence of this has been that many population groups in Armenia either cannot afford, or do not have adequate access to, quality medical services. The lack of trust in the emerging health care system, combined with severe budgetary crises in education and public health, has created the potential for the further spread of HIV.

Existing information on HIV prevalence and trends in Armenia

HIV infections in Armenia are diagnosed and confirmed at the National Center for AIDS Prevention (NCAP), which is located in the country's national reference laboratory. An HIV infection is confirmed when a double positive result has been obtained, determined first by the ELISA test and then confirmed with a Western Blot test. Blood samples of seropositive individuals registered in laboratories of the Marzes¹ of the country and/or in other laboratories in Yerevan, are double tested at the NCAP. The final diagnosis by the Western Blot method is made at the NCAP, and only those individuals who have tested positive at the NCAP are

¹ 'Marz' refers to country region and 'Marzes' refers to different country regions.

officially registered as HIV cases. AIDS diagnoses follow the 1993 recommendations of the U.S. Center for Disease Control (CDC), which are based on either the immunological status of an HIV-positive individual (CD4+ count <200/ μ l) or at least one of a series of AIDS defining illnesses (such as Kaposi Sarcoma, lymphadenopathy, etc.).

By the end of 2004 there were 74 Voluntary Counselling and Testing (VCT) sites in all regions of Armenia that were providing services anonymously and confidentially.

The first official case of HIV infection in Armenia was registered in 1988 and was reportedly contracted through heterosexual transmission. From 1988 to 1 November 2004, 296 PLHIV were registered in Armenia. Men comprised 77.5% (217 cases) of cases, women comprised 22.5% (63 cases), and four were children under the age of 15.

Data from the country's official HIV registry suggest that the predominant modes of HIV transmission are injecting drug use (52.5%) and unprotected heterosexual sex (38.9%). The remaining cases are attributed to mother-to-child transmission (MTCT), medically-acquired transmission (mainly through blood transfusion), and transmission through unprotected sex between men who have sex with men (MSM). The majority of male PLHIV (67.7%) have contracted HIV through injecting drug use, whereas the main transmission mode for women is through unprotected sex with men (93.6%).

According to research conducted by the NCAP, the majority of women officially registered as HIV-positive are not employed in the formal economy. Nearly half (48.7%) report their occupation as 'housewife' (48.7%), and more than a quarter (28.6%) identify themselves as unemployed. Unemployment is also high among officially registered HIV-positive men (43.3%). Among the 217 registered male cases, 29.9% identify themselves as migrants and 14.2% have a history of incarceration.

The first HIV-positive child (aged five) was registered in January 2001. The HIV status of some children born to HIV-positive mothers remains unknown, either because the parents do not want their children to undergo testing or because the child is less than 18 months old, the age at which an HIV antibody test can be used for diagnosis. (According to the law on the 'Prevention of disease caused by Human Immunodeficiency Virus,' testing of newborns from HIV-positive mothers is mandatory, but the reality is that parents who do not want to test their children simply do not. The law is in the process of being amended.)

Transmission routes have changed over time. Until January 1999, transmission was evenly divided between injecting drug use and sexual transmission, but between 1 January 1999 and 1 November 2004, twice as many cases were attributed to injecting drug use than to sexual contact. From the beginning of the epidemic (1988) through 1 January 1999, 41 cases of HIV transmission via heterosexual contact were registered. Between 1 January 1999 and 1 November 2004 this figure rose to 68, with the majority of reported sexual transmission cases between heterosexual partners. From 1988 through 1 November 2004, 125 registered cases of HIV infection were contracted through injecting drug use.

All the registered individuals who reported being infected via injecting drug use were men. Within this group, it is believed that those who had lived temporarily in the Russian Federation (in the cities of Moscow, St. Petersburg, Irkutsk, Rostov and Surgut) and the Ukraine (in Odessa, Kiev and Mareupol) were probably infected with HIV during that time (NCAP).

Since the first HIV-positive case was registered in 1988, fifty cases of AIDS and forty-two AIDS-related deaths have been recorded. The number of AIDS-related deaths reported in the past four years exceeds the total number of HIV cases registered during the preceding twelve years.

There is a correlation between the spread of HIV in some regions and development trends such as temporary emigration and seasonal employment. Regionally, registered cases are concentrated in the capital city of Yerevan, where nearly half (48.9%) of all PLHIV reside. The second highest regional concentration is in the region of Lori Marz, where 8% of currently registered PLHIV reside. Rates in other regions are: Ararat Marz, 7.7%; Shirak Marz, 7.4%; Gegharkunik Marz, 7%; and Armavir Marz, 7%. This breakdown reflects the high level of migration in Gegharkunik, Shirak and Lori Marzes, and the fact that injecting drug use used to be more widespread in Yerevan, Ararat, and Armavir Marzes.

Despite these figures, the official HIV registry does not reveal the real picture of the HIV epidemic in Armenia. Independent assessments of the situation have estimated that there are 2,800-3,000 PLHIV in the Republic of Armenia (NCAP). According to data from the Second Generation HIV Surveillance conducted in 2002, HIV prevalence among IDUs is about 15% (the study was conducted among a target sample of 201 IDUs), while the rate among CSWs is less than 3% (250 female CSWs were observed as a staged cluster sample) (Grigoryan, Busel and Papoyan 2002). This lower percentage of HIV prevalence among CSWs is further proof of the predominance of injecting drug use as a mode of transmission in Armenia.

Until now, antiretroviral (ARV) therapy has not been available in Armenia. The Minister of Health recently designed and ratified a National HIV/AIDS Treatment and Care Protocol and National Guidelines on Antiretroviral Treatment, policies that envisaged providing ARV treatment to twenty people with AIDS by the end of 2004, in accordance with the framework of the National Programme on HIV/AIDS Prevention. This goal has not been achieved, and has been pushed back to February 2005.

According to the law on the 'Prevention of disease caused by Human Immunodeficiency Virus,' the following individuals must undergo mandatory HIV testing: 1) donors of blood, biological fluids, tissues or organs; 2) medical specialists who come in direct contact with blood, biological fluids, tissues, or organs; 3) prisoners; 4) people with STIs; 5) pregnant women; 6) children born to HIV-positive mothers; 7) drug users; and 8) people who have been out of Armenia for at least three months. For everyone else, HIV testing is voluntary and anonymous. On average, 16-20,000 people undergo HIV testing (mandatory and voluntary) annually. People generally do not submit to voluntary HIV testing if they do not have a serious health problem. Thus, it is not uncommon for cases of HIV to be diagnosed at the same time as an AIDS diagnosis is made.

Key Social Groups

The results of the situational analysis that was conducted in 2000 within the framework of 'The Strategic Planning of a National Response to HIV/AIDS' programme, and data from epidemiological surveillance conducted periodically by the NCAP, show that Armenia is in the second, or 'concentrated,' stage of an HIV epidemic. The groups who are most vulnerable to HIV have been identified as IDUs (Injecting Drug Users), CSWs (commercial sex

workers), incarcerated individuals, migrants, and youth. The government has made ensuring the safety of donated blood² and promoting safe sexual practices its intervention priorities (Grigoryan, Mkrtchyan and Davidyants 2002), and it plans to carry out a situational analysis, a response analysis, and to develop a national plan.

Between 2000 and 2004, various prevention programmes targeting key population groups were implemented. These groups included migrants, prisoners, IDUs, MSM, CSWs, and young people.

Injecting Drug Users

The observed increase in injecting drug use in Armenia presents a significant risk for a further spread of the HIV epidemic. Estimates made by multiplier and nomination methods show that there are 4,000-5,000 injecting drug users (IDUs) in the country. This growth trend is being fuelled by the accessibility of illegal substances, but also other socio-economic factors.

In 2001, no healthcare institution (including narcology centres³, STI centres, AIDS centres, or clinics and hospitals) in the country was educating IDUs about the risks of sharing needles and syringes.

Under the old Soviet system for controlling and monitoring IDUs, there was a lack of trust between IDUs and the specialists conducting the preventive activities. On one hand, mandatory testing of IDUs provided an opportunity to register new cases of HIV infection. On the other hand, the practice of registering HIV-positive individuals with medical institutions (as well as by law enforcement authorities) and the mandatory treatment of IDUs served to isolate this group. As a result, it has been difficult to implement preventive activities.

The absence of rehabilitation centres also reduces the effectiveness of treatment and rehabilitation programmes for drug users (Grigoryan, Mkrtchyan and Davidyants 2002; Grigoryan, Busel and Papoyan 2002; Papoyan Grigoryan and Sargsyan 2004).

In Armenia, needle and syringe sharing among IDUs of the same circle is considered normal, and symbolizes both trust and close interpersonal relationships. Only strangers are treated with caution. Drug usage in small groups of three to five people in private locations is also typical. According to the results of the Second Generation HIV Surveillance, nearly 66% of those surveyed use drugs with friends and acquaintances. Almost 69% of the respondents reported using disposable syringes. About 44% of those surveyed reported sharing syringes or needles, 47% had a history of hepatitis B or C, and 60% had had an STI (Grigoryan, Mkrtchyan and Davidyants 2002; Grigoryan and Papoyan 2004).

IDUs tend to follow similar patterns of sexual behaviour. In the first stage – characterized by episodic drug use – the IDU typically has a large number of unprotected sexual encounters outside of his or her drug circle. During the second stage, systematic drug use leads to a loss of libido and potency. As in other settings, Armenian IDUs are at risk to HIV through sharing used and un-sterilised needles or syringes and may be more likely to engage in risky sexual behaviour when using drugs (Grigoryan, Mkrtchyan and Davidyants 2002).

² Only one registered case of HIV has been attributed to medically-acquired transmission from blood transfusion.

³ 'Narcology center' is a regional term for institutions providing drug-related care and/or treatment.

Commercial sex workers

In 2002, Second Generation HIV Surveillance research was also conducted among commercial sex workers (CSWs). Among the 250 CSWs, aged 15-49, who underwent HIV laboratory testing (all female; staged cluster sample), only three tested seropositive (HIV testing of sex workers was conducted by voluntary confidential and voluntary anonymous testing). Nearly all the CSWs surveyed (98%) said they knew that condom use by their male partners could prevent HIV transmission, but only 48% said they used condoms regularly. Three fourths of those who said they did not use condoms had contracted STIs in the year prior to the survey. A little more than half, 55.5%, live in Yerevan, and of the remaining CSWs who live outside the capital city, 16% reside in rural areas.

Some individuals are part of overlapping vulnerable groups, and thus can sometimes serve as a potential bridge between transmission routes. Seventeen per cent (17%) of the CSWs surveyed reported engaging in drug use, and nearly all (97%) said they use alcohol – activities that directly (through needles and syringes) or indirectly increase the risk of HIV exposure by compromising one's judgement of risky behaviour. Seven per cent (7%) of the CSW survey group were married, but only 63% of those said they consistently use condoms. This behaviour increases the risk to HIV not only for themselves but also for their spouses (Grigoryan, Mkrtchyan and Davidyants 2002; Manukyan, Grigoryan and Hakobyan 2004; Grigoryan, Manukyan and Jakobyan 2004).

Men who have sex with men

In 2002 voluntary and anonymous HIV laboratory testing was conducted among fifty men who have sex with men (MSM), none of whom tested seropositive. It is worth noting that public opinions of sexual relationships between same-sex individuals are extremely negative; traditional Armenian society rejects any display of sexual relationships other than between men and women.

The first survey in Armenia ever to provide information on the situational analysis of HIV among MSM was conducted in penitentiary institutions. In 2000, within the framework of the Sentinel Epidemiological Surveillance, 182 incarcerated people who were believed to be engaging in 'HIV-risk behaviour' underwent mandatory (with no pre- or post-test counselling) testing, in accordance with the law. The results revealed an HIV prevalence of 8.8% among prisoners, with the highest rate registered among MSM (10.1%) and injecting drug users (5.8%).

A 2002 sexual behaviour survey of university students in Yerevan (2002) revealed that 5% had either casual or permanent same-sex contacts.

In 2002's Second Generation HIV Surveillance of 50 MSM – identified by the 'snowball' method (according to the National Protocol of updated system of surveillances for HIV/AIDS and STI in Armenia) – 76% reported that they had their first same-sex contact between the age of seven and fifteen. Of those, 12% said the experience was not voluntary, 88% said it was of their own free will, and 38% reported said they were simply curious. Ninety-two per cent (92%) of those surveyed said they have more than one sexual partner during the course of a year, and 26.5% have a history of STIs. It is worth noting that only 18% of the surveyed MSM consistently use condoms. Also worth noting is that 24% said that they provide sexual services to other men in exchange for money; among this group, 46% had had more than one

client in the month prior to the survey. Eighteen per cent (18%) of the surveyed MSM reported that they have used drugs.

The majority of surveyed MSM (86%) began to be sexually active between the ages of 10 and 20, the range when vulnerability to HIV increases (Grigoryan, Mkrtchyan and Davidyants 2002; Grigoryan, Manukyan and Hakobyan 2004; Grigoryan 2004b).

According to a survey conducted by the NGO Education in the Name of Health, the severe stigmatisation of same-sex relationships by society has led MSM to create close-knit groups in which they can feel free to express their sexuality. Outside of these groups, however, MSM very rarely express their sexuality; some are married (with or without their wife's knowledge of their true sexual identity), some simply do not identify themselves as homosexuals, and many have not confided their sexual orientation to their families. One consequence of these tight, closed groups of MSM is that sexual relationships are kept within the circle, which increases the risk to HIV of the entire group if one member becomes HIV-positive. Currently, however, the HIV prevalence among MSM is considerably lower than other key populations (IDUs, CSWs, etc.)

Incarcerated persons

Four-hundred thirty-eight (438) individuals (a staged cluster) in Armenia's penitentiary system were tested for HIV in the frames of the 2003 Second Generation HIV Surveillance, which was conducted by the NCAP with support from UNDP/UNAIDS. Of these, twenty-four individuals tested seropositive. Although behavioural surveillance has not been conducted among incarcerated individuals, it is worth noting that 7.5% of those who tested seropositive had worked abroad, and 10% were former IDUs. It is also important to note that the majority of the seropositive individuals who had worked abroad had lived, and probably become infected, in the Russian Federation or Ukraine.⁴

Incarcerated populations are vulnerable to HIV when they increase risk-related behaviour (drug use, MSM), and then, upon release, often re-enter their previous relationships and may spread infection to their spouses (Grigoryan, Mkrtchyan and Davidyants 2002).

Youth

Youth (individuals 15-24 years old) are among the groups most vulnerable to HIV, given their lack of awareness about HIV and AIDS, including modes of transmission and prevention, and specific forms of high-risk behaviour. Raising the level of awareness about STIs, HIV, AIDS, and safe sexual behaviour among youth is one of the primary goals of HIV prevention. The majority of national experts who were surveyed for this report believe that youth must be provided with information about STIs, HIV, and AIDS in secondary school, for it is at this age that teenagers begin to acquire this type of information from their peers.

International studies suggest that increasingly, young people engage in sexual activity before marriage, and are unlikely to possess accurate knowledge concerning HIV-risk behaviours. They also fail to consistently employ effective strategies to mediate risk, and are more likely to experiment with drugs and alcohol.

⁴ The highest number of PLHIV in the region is in the Russian Federation, which has 860,000 cases, and where 1-2% of general population are IDUs. The number of registered PLHIV in Ukraine is 68,000 (AIDS Epidemic Update: December 2004. UNAIDS/WHO).

According to the results of the 2002 Second Generation HIV Surveillance in Armenia (500 young people aged 15-29 were surveyed, 40% of whom were sexually active), only 32.5% use condoms regularly, 15.5% have used drugs, and 60% have more than one sexual partner during the course of a year. According to the results of the same survey, of the two thirds who had more than one sexual partner during the previous year, only one third said they use condoms consistently, and approximately 5% 'sometimes or always' engage in same-sex practices. According to cultural norms, young girls, as a rule, are not supposed to have pre-marital sexual relationships. For this reason, having a regular partner is not socially acceptable for unmarried young people – a factor that can increase the risk of HIV infection (Grigoryan, Mkrtchyan and Davidyants 2002).

A pilot programme on peer-to-peer prevention education was launched in Armenian schools in 2004. The programme was implemented by a consortium led by the AIDS Prevention, Education and Care NGO, within the framework of the National HIV/AIDS Prevention Programme, which is supported by the GFATM. A case study was conducted in one of the schools in Yerevan to examine the effectiveness of the peer education pilot programme, and the positive findings led to recommendations that more schools be enrolled in the project.

The case study revealed that the pilot programme helped pupils and teachers to discuss HIV and AIDS more easily and revealed that most of the youth involved in the programme had a positive attitude towards peer-to-peer education, and realized the importance of receiving relevant knowledge on HIV and AIDS before finishing school.

Community participation is crucial to the success of peer education. Members of the local community – including school directors, teachers, university lecturers and parents – play a particularly important role in this process. Their involvement is needed to help form positive attitudes toward the programme among other members of the community. However, the case study also revealed obstacles to the successful implementation of peer education. These include a lack of clear understanding by programme coordinators regarding issues – such as who should be involved in the course – selection criteria, and how the overall process should work. In some cases, successful implementation is hindered by a lack of commitment from the teachers' collective.

A 'Life Skills' course was initially introduced in 282 secondary schools across the country, in grades one through seven (children aged 6-13), and in 2004 was expanded to an additional seventy schools. The focus of the course is psychosocial development and individual social responsibility. It is the first programme to explicitly articulate the significance of cultural values in addition to subject knowledge. Without question, the subjects taught in general education classes contribute to these goals, but building a core system of social values is the explicit goal of this course.

To reduce their vulnerability to HIV, it is especially important to expose Armenia's youth to healthy lifestyle education programmes. As a rule, health-risk related habits like smoking, alcohol use, and experimental or continuous drug use, are more common among young people than among other social groups in Armenia. The results of surveys conducted in 1999 by the Department of Sociology at Yerevan State University show that contemporary young people place less value on personal health. This could be a result of the post-Soviet collapse crises in social systems like public health and education (Arakelyan, 1999).

This is backed up by the results of a study conducted among university students (sample size 500) in Armenia in 2003. The results showed that 87.6% had used alcohol during the 12 months prior to the survey, and 70.8% had used alcohol in the previous 30 days. As far as drug use was concerned, 19.4% said they had used hashish or marijuana at some point in their life, 3.6% had used ecstasy, 2.8% had used amphetamines, 3.2% had used cocaine, 1.4% had tried heroin, and 1% had used LSD. (Annual report on Drugs, UNDP/DMS 2004). Unfortunately, information about the differences in drug usage between men and women, and drug use stigmatization was not included in the report from which this data has been drawn.

Migration, poverty and HIV and AIDS

According to official statistics, nearly 700,000 people migrated from Armenia between 1991 and 1997, 59.5% of whom were men, and 40.5% of whom were women (National Statistical Service of the Republic of Armenia). The main driver of migration is the country's poor socio-economic conditions, which also indirectly increases people's vulnerability to HIV. Very often, poverty supposes a lower level of education, which translates into limited awareness about effective means and methods of protection from HIV. It is acceptable in Armenia to call HIV and AIDS 'a disease of the poor,' because of the coping behaviours, lack of education, and lack of available health care treatment. Despite fairly stable economic indicators in recent years, the government has failed to spread the economic growth across a wide swath of the population, so what growth there has been has not brought about general poverty reduction.

Many Armenian families have chosen migration to cope with these conditions, and studies show that one in four families has someone living abroad. As a rule, the family member who goes abroad for the purpose of earning money, is male, and returns to the family from time to time. While abroad, they are more likely to engage in risky sexual behaviour and drug use, and consequently, they, as well as their wives, are vulnerable to HIV. Most migrating Armenians head to the CIS countries, especially Russia (75%) and the Ukraine (12%) (Grigoryan, Sargsyan and Harutyunyan 2002). In a migrant survey group, 31% said they regularly use condoms, 38.3% had had more than one partner in the year prior to the survey, 11.5% had used drugs (2.6% of these had used injecting drugs), and 24.7% had a history of STIs (Grigoryan, Mkrtchyan and Davidyants 2002; Grigoryan 2004).

Unemployment and poverty levels remain high, especially among women. For impoverished women, unemployment is the main factor contributing to high-risk behaviour, especially commercial sex work, and sometimes, forced trafficking.

HIV, AIDS and religion

Religious leaders, who have a strong social capital and influence, can play an important role in HIV prevention among their peers and their communities. Several activities are being conducted in Armenia to bring the church into HIV prevention schemes. For example, in 2003 a training seminar for church representatives was held by the Armenian branch of World Vision International, and supported by the NCAP, Armenian Apostolic, and Armenian Evangelistic Churches. The participants at the training seminar suggested the organizers conduct follow-up training that would include: a more detailed focus on principles of abstinence, family fidelity, and monogamy as key strategies for HIV prevention; efforts to

integrate churches in other regions of Armenia in HIV and AIDS training (importantly, the Armenian Church is open to working with other groups to initiate these types of programmes); special training for church activists so they can form a psychosocial support network to hear confessions from HIV-positive people, drug users and CSWs, and provide appropriate counselling and spiritual support; special training for church representatives to act as public speakers and promote safer sexual behaviour; training for church representatives to reach out to, and mobilize, their communities in a response to HIV and AIDS; and the development of a manual on HIV, AIDS and the church.

Public perception of HIV and AIDS

Knowledge of HIV and AIDS

As shown in this report, one of the main reasons for the rapid spread of HIV in Armenia is the lack of knowledge among the general population about the modes of HIV transmission and prevention. According to available data, nearly all adults have heard about HIV and AIDS, but only 62% of women and 73% of men know that HIV can be prevented through adopting safer behavioural practices (Griogoryan 2004b). While the general population is fairly well-informed on prevention, people remain vulnerable to infection because the traditional socio-cultural patterns of sexual relations and gender stereotypes promote the misconception that HIV and AIDS cannot affect ‘ordinary’ people.

Within survey groups, almost one third of the CSWs, one third of MSM, all pregnant women, and 18.5% of youth believe that they are not personally at risk of contracting HIV, even though they practice risky behaviour (Grigoryan, Mkrtchyan and Davidyants 2002).

One cannot ignore the role mass media plays in the development of public opinion and the level of awareness on HIV and AIDS. A review of media coverage shows that issues like HIV and AIDS, HIV transmission modes and prevention means, and clinical symptoms are inappropriately covered; reports are biased or inaccurate. But the 2000 Demographic and Health Survey (DHS 2000) determined that HIV/AIDS public service announcements on radio, television and in newspapers were acceptable, and that almost everyone has heard of HIV and AIDS, even if they don’t have very deep understanding of the issues involved.

HIV and discrimination

Despite international conventions against the discrimination and social rejection of people living with HIV (PLHIV), and the fact that Armenia has signed various international legal agreements prohibiting discrimination against PLHIV and ensuring their right to health protection (as defined by the Constitution of the Republic of Armenia), PLHIV in Armenia continue to lead highly stigmatised lives. This can be seen in almost all layers of society.

The existing cultural stigma against PLHIV classifies them as ‘morally corrupt from the viewpoint of public norms and standards.’ These marginalized individuals, the so-called ‘victims,’ are made to bear the weight of guilt for being HIV-positive, as HIV and AIDS are closely associated with already-marginalized groups, such as IDUs, MSM, and CSWs. According to the Armenian 2000 Demographic and Health Survey, only 10% of women and 13% of men think an HIV-positive teacher should be allowed to continue teaching. This view is related both to stigma and ignorance about HIV transmission routes. 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 said they would

not disclose the fact. According to the same source, the majority of people have never been tested for HIV, and more than 73% do not want to be tested. Unwillingness to undergo HIV testing can also be conditioned by the fear of being stigmatised as well as by the widespread held position that ‘infection cannot affect me.’

In addition to cultural stigma, PLHIV in Armenia also face institutionalised stigma from the government, health care system, churches, businesses, and other institutions. This institutional bias exists despite the ‘Prevention of the disease caused by human immunodeficiency virus’ law that was adopted by the National Assembly of the Republic of Armenia in 1997. This law guarantees the basic human rights of PLHIV and covers issues such as discrimination, employment, access to health care services, confidentiality, and counselling by specialists from the NCAP.

While this institutional bias is not explicit, indirect stigma (i.e. the inability of the government to provide antiretroviral treatment) does exist. In addition, PLHIV experience “internal” self-imposed isolation and withdrawal from society, out of fear of discrimination. According to surveys conducted by the NCAP, nearly half of PLHIV become isolated after learning of their HIV status. After receiving a positive diagnosis, 42% had intrapersonal difficulties and 20.4% had difficulties with interpersonal contacts (Grigoryan 2002).

HIV, AIDS, gender and culture in society

In Armenia the influence of women’s roles and status on the problem of HIV and AIDS is broadly connected to the health care sphere, women’s rights, and especially gender stereotypes. Women comprise 22.5% of PLHIV, and most contracted the virus through a sexual relationship with a man. Sexual contact, rather than injecting drug use, poses the greatest HIV risk for women, a reality that may be linked to social restrictions concerning women’s use of illegal substances.

Gender inequality renders women the dependent partner in marital and sexual relationships, where men wield considerably more power and control. The results of Armenian DHS 2000 showed that only 7% of married couples used a condom during their most recent sexual relations – condoms are primarily used for contraceptive purposes. According to the same source, if a husband has a sexually transmitted infection, or has another sexual partner (which increases vulnerability to HIV infection), more than 21% of women and 27% of men do not consider that to be reason enough for a woman to refuse sexual intercourse with her husband (Armenia DHS 2000).

Further, according to data collected by the NCAP, CSWs do not use condoms; in 68% of cases, CSWs said their clients disagreed about the necessity of using a condom, and 31.5% said they were sure that their clients were not infected with HIV (Grigoryan, Mkrtchyan and Davidyants 2002).

This trend mirrors the accepted model of sexual relations between married couples, where spouses who ‘trust each other’ do not use condoms. National experts have observed that, from the perspective of gender relations and modes of sexual behaviour, the dominant model in Armenia is patriarchal and conservative.

In one study, 67% of men and 14% of women reported having at least one other sexual partner, in addition to their regular partner, in the previous year.

Despite the fact that traditional roles and practices still exist, the status of women is improving. Thus, while gender stereotypes remain within the traditional framework, gender roles have become more flexible than customs would seem to allow.

Institutional assessment

The National Center for AIDS Prevention (NCAP) in Yerevan implements and coordinates activities on HIV prevention, and regularly carries out activities aimed at vulnerable groups. These include training on safe behaviour, information and education activities among youth, and support for PLHIV. Some of their most important efforts include the establishment of crisis and resource centres, hot line services, radio hot lines, an HIV prevention programme aimed at CSWs working in the streets of Yerevan, and a similar programme aimed at IDUs in the city of Kapan.

According to evaluations by national experts, HIV prevention is one of the priority issues of the health care system in Armenia; various programmes on HIV prevention are being implemented around the country by different governmental groups and NGOs, as well as international organizations. Moreover, a Country Coordination Commission on HIV/AIDS Prevention (CCC) has been established to provide an effective response to the HIV epidemic.

National experts have recommended that medical services be made accessible for PLHIV throughout Armenia (including the wide availability of affordable antiretroviral treatment medication). Past experience shows that very often, PLHIV face discriminatory attitudes by health care professionals when they seek medical care and disclose their HIV status, ranging from a lack of knowledge about their condition to outright prejudice. There is an urgent need to educate and train health care workers in how to properly care for, and treat, PLHIV. Indeed, several such training seminars have already been organized on issues like HIV prevention, antiretroviral treatment, VCT, and issues of stigma and discrimination. International experience has demonstrated that in countries where antiretroviral treatment is provided in combination with education on ARV treatment, there is a subsequent decrease in not only rates of transmission and infection, but also social discrimination.

National response to HIV/AIDS epidemic

Armenia is party to several international agreements that demonstrate its willingness to promote and protect human rights among its citizens.

In 1997, the National Assembly passed the 'Prevention of disease caused by Human Immunodeficiency Virus' law, which defines the strategy for preventing, diagnosing, and controlling HIV and AIDS and allocates resources to help slow the spread of HIV. In 2002, the Inter-Standing/Inter-Faction Committee Parliamentarian Group on HIV/AIDS was established. This group includes representatives of the different government factions and parliamentary committees, and was formed to create appropriate legislation to implement the National Programme on HIV/AIDS Prevention (approved by the government on 1 April 2002 and subsequently ratified by the president). The Parliamentarian Group's activity is focused on the following goals: improving the HIV and AIDS legislation currently in force in the country; exercising control of the legislature over the implementation of the National Programme on HIV/AIDS Prevention; stimulating the allocation of the budget necessary for

fulfilling this critical component of HIV prevention in protecting public health; and raising awareness about HIV epidemic among other representatives of the legislature.

The Strategic Planning Process for a National Response to HIV/AIDS began in 2000, when the following studies were conducted: Situational Analysis on HIV/AIDS; Rapid Assessment of the spread of injecting drug use and HIV infection; Sentinel Epidemiological Surveillance among key populations (IDUs, CSWs, incarcerated individuals who practice 'risky behaviour' such as injecting drug use, as well as individuals with STIs); and Response Analysis. 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 Armenia on 6 December 2000 (Minutes N 12/4) and by the Minister of Health (Decree N 14, 12 January 2001). The National Strategic Plan served as a basis for the development of the National Programme on HIV/AIDS Prevention (in collaboration with interested governmental agencies).

The National Programme on HIV/AIDS Prevention has the following objectives: developing and implementing the national policy on HIV/AIDS prevention and treatment; HIV prevention among injection drug users; promoting safer sexual behaviour; preventing mother-to-child HIV transmission; ensuring the safety of donated blood and blood products; promoting HIV and STI prevention programmes among youth; caring for PLHIV (Grigoryan, Mkrtchyan and Davidyants 2002; Republic of Armenia, The National Programme on HIV/AIDS Prevention, 2002).

Regional Programmes on HIV prevention have been developed that take into consideration the peculiarities of every Marz; for example, in some Marzes, the priority issues are related to the spread of injection drug use, in others, the needs of migrant populations.

In 2002, the HIV/AIDS Country Coordination Commission on HIV/AIDS Prevention (CCC) was formed, which includes representatives of the Interministerial Council on HIV/AIDS prevention, NGOs, UN HIV/AIDS Theme Group, PLHIV, and the private sector. The CCC coordinates all the activities designed to respond to HIV and AIDS in Armenia.

International governmental organizations and several NGOs – including the UN Theme Group, the United States Agency for International Development (USAID), OSI-Armenia, Médecins Sans Frontières-Belgium, World Vision Armenia, and the Armenian Red Cross – are active participants in the CCC. Various prevention projects among different key populations are being implemented with the support of international organizations.

A number of local NGOs – including the Armenian National AIDS Foundation, AIDS Prevention Union, Real World, Real People, AIDS Prevention, Education and Care – in the CCC are actively involved in HIV prevention efforts and have taken a leading role in the implementation of activities within the framework of the Strategic Plan. Interviews with the leaders of these NGOs reveal that they are working with a variety of social groups, including key populations vulnerable to HIV and PLHIV. Their activities could have a profound impact in the battle to overcome stigma and discrimination against PLHIV.

Conclusions

The social and socio-cultural factors that are impeding HIV/AIDS prevention programmes are as follows:

- The depressed economic situation of the Armenian population and inadequate government spending have led to an increase in migration and blocked opportunities to allocate more resources for HIV prevention. Migration from Armenia is mainly to CIS countries, namely the Russian Federation and the Ukraine, which are socially and somewhat culturally similar to Armenia.
- Low awareness of the gravity of the HIV/AIDS issue.
- Negative and intolerant attitudes towards key HIV populations (IDUs, CSWs, MSM), low HIV prevalence among the general population, cultural stigmatisation, and the widespread opinion that HIV/AIDS is associated with members of the aforementioned marginalized communities.
- Lack of public information about HIV and AIDS and insufficient coverage by the mass media of activities promoting healthy lifestyles and safer sexual behaviour (especially among youth). The mass media covers HIV-related issues in an irregular manner, and rarely provides thorough and unbiased information.
- Lack of knowledge about HIV and AIDS, and thus inadequate information about how it is transmitted and how it can be prevented. Thus, risky behaviour is continued, and stigma and discrimination deepens. A lack of sufficient knowledge among the older generation and within Armenian families – something that can be largely attributed to the widespread belief that questions about sexual practices and HIV/AIDS are embarrassing and should not be discussed openly – translates into an absence of HIV and AIDS education in schools.
- Lack of youth involvement in public life (such as club activities and organized leisure time) reduces the opportunity to launch awareness campaigns about prevention.
- Status of women: gender inequalities, and in particular the dominant role of men in society and within the family, discourages women from practicing safer sex and/or negotiating with their sexual partners on safer behaviour.
- A narrow definition of reproductive and sexual health that encompasses a reluctance to discuss sex openly and fails to define sexual behaviour as a health issue, translates into an absence of cultural beliefs and norms that support condom use.
- Insufficient involvement of PLHIV in prevention activities.

The social and socio-cultural factors contributing to HIV prevention activities are as follows:

- The status of HIV prevention as a priority at the national level, which resulted in a National Programme on HIV/AIDS Prevention and the law on ‘Prevention of the disease caused by HIV.’
- The availability of necessary human resources for work in the field of HIV/AIDS.
- The existence of the National Center for AIDS Prevention as a specialized state institution functioning in the field of HIV/AIDS with high-level scientific and practical capacities.
- The existence of NGOs with work experience in HIV prevention.
- The mono-ethnic structure of the Armenian population, which eliminates ethnic and linguistic problems that could hinder the implementation of preventive activities.
- The comparatively high level of education of the Armenian population.

Suggestions for raising effectiveness of HIV prevention activities in Armenia

Training on issues related to HIV and AIDS and the implementation of information-education activities are extremely important in the sphere of HIV prevention in Armenia. A survey conducted for the purpose of this report revealed that information about HIV and AIDS must be provided not only to the key populations (CSWs, IDUs, MSM, youth, migrants, etc.) via outreach and peer-education, but throughout the entire Armenian population.

As an example, in school programmes, it is crucial to include pupils and their parents, which will reduce the tension associated with family discussions about HIV and AIDS. Parental attitudes are very influential and play a large role in the effectiveness of prevention activities among pupils.

Along with providing information on HIV prevention, teaching practical life skills and ensuring the availability of prevention methods, people must be actively encouraged to adopt these practices. Research shows that safer behaviour practices must be promoted within the education system from an early age to be effective.

Judging from the rate of HIV transmission via injecting drug use, special attention must be paid to informational and educational activities aimed at IDUs. These activities should take into account the culture of 'trust networks,' gender roles, etc., with the aim of reducing syringe sharing and promoting safer sexual practices.

Furthermore, given the social power of the Armenian church, religious leaders can play an important role in changing public perceptions of, and responses to, HIV and AIDS. They can do this with programmes on HIV prevention through abstinence, fidelity and monogamy, providing support to PLHIV, as well as by conducting peer education among their fellow clergy members and priests.

The most obvious means of providing information to different sections of the population is through the mass media. However, the information presented should be thoroughly researched and reported to avoid spreading panic, and should be provided regularly, and in an authoritative and comprehensive manner. Information must also present the realities and seriousness of the HIV epidemic in Armenia.

It is also important to conduct training activities with members of the media in an effort to raise their awareness and interest in producing accurate coverage of HIV and AIDS. For example, to facilitate mass education and dissemination of information, there should be a regular schedule of television and radio programmes that address these issues, with on-air viewer phone calls and discussions.

To be effective, any prevention or education programme must take into account local socio-cultural norms and traditions, but it must also be age-specific, gender responsive, evidence-informed, grounded on universal human rights, and involve PLHIV at all stages. The greater involvement of PLHIV at all stages of development and implementation of HIV prevention programmes is not only crucial in fighting stigma and discrimination but also increases the effectiveness of such programmes.⁵

Given the current attitudes towards PLHIV, stigma and discrimination are key issues that need to be addressed, through sensitisation of the general public, training of professionals, and the social integration and empowerment of PLHIV. The number of those infected is relatively low, and therefore PLHIV are easily excluded.

⁵ The greater involvement of PLHIV at all stages of development and implementation of strategies, programmes and projects on HIV and AIDS has been called by many organizations working on HIV- and AIDS-related issues; most recently this issue was stressed to the international community by the UN Secretary General, Mr. Kofi Annan during his speech opening the XV World AIDS conference in Bangkok, July 2004; <http://www.un.org/News/Press/docs/2004/sgsm9418.doc.htm>.

It is more than clear that risky behavioural practices are the main drivers of HIV transmission in Armenia. The realities of the country's socio-cultural climate complicate the implementation of HIV prevention activities. These realities include: a high rate of migration; infrequent use of condoms by sexually active individuals; a general lack of knowledge about issues related to sexual behaviour and HIV and AIDS among adults; avoidance of open discussions of such topics within families; gender norms and inequalities and the dependant status of women in the family and throughout society; and the marginalisation of PLHIV.

All the same, the relatively high education level of the general Armenian population means that there is a potentially receptive audience for raising awareness about HIV and AIDS.

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Chapter 3. Azerbaijan

HIV and AIDS in Azerbaijan: a socio-cultural approach

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Introduction

The prevalence of HIV in the Republic of Azerbaijan is currently low (World Factbook, 2004), but the rapidity of the epidemic's spread is alarming: the number of people living with HIV (PLHIV) in Azerbaijan has multiplied over the past ten years (National AIDS Center, 2004). The first case of HIV infection was registered in 1987 (non-citizen; the first case in a citizen was registered in 1992). As of 1 January 2005, the number of officially registered cases was 718; of this group, 109 people have developed AIDS and 62 have died. Moreover, according to local and international experts, the realistic estimated number of PLHIV is approximately ten times higher than the number of officially registered cases (Kasumov et al., 2003).

Azerbaijan is currently facing a 'concentrated'⁶ HIV epidemic with a very low overall prevalence among the general population (0.008% out of 8,266,000 people) but a high prevalence among key populations that are particularly vulnerable to HIV infection: 16.5% among injecting drug users (IDUs) and 8.5% among commercial sex workers (CSWs) (Kasumov et al., 2003; UNAIDS/WHO, 2004).

The dominant mode of transmission is injecting drug use (47.14% of all cases) followed by unprotected heterosexual contact (26%). Transmission via unprotected sexual contact between men who have sex with men (MSM) accounts for 0.42% of cases; mother to child transmission (MTCT), 1.8%; and via blood transmission, 0.14%. It is worth noting that in 26% of the cases, the source of infection is unknown⁷ (National AIDS Center, press release, 2004).

The rapid increase in new HIV infections (and also STIs) in Azerbaijan is directly related to the increased number of injecting drug users. Although the epidemic is concentrated among IDUs, especially along the drug trafficking routes, an increase in the reported number of CSWs and migratory population has created a situation where the epidemic could easily spread to other parts of the population.

The dramatic socio-economic changes associated with the transition period have had a negative impact on employment, people's social well-being, and the social safety net. All these factors have contributed to a growth in drug use, commercial sex work, and migration. Current data and behavioural and social trends indicate a very high probability for further growth of the HIV epidemic. Its evolution could be explosive (UNAIDS/WHO, 2004).

⁶ 'Concentrated stage, also referred to as the 'second-stage' of the epidemic, refers to the biggest prevalence of the epidemic concentrated in distinct key populations – social groups at elevated risk for HIV.

⁷ Most of the HIV cases that do not have a known method of transmission were found in people who were anonymously tested and either did not return for follow-up consultations or refused to supply more information.

Socio-Demographic Profile of PLHIV

Available data suggest that 43.4% of HIV-positive citizens were infected outside of the country, mainly in Russia and Ukraine, and 4.9% are foreign citizens. At the present time young adults are the most widely affected demographic (33.2% of PLHIV are aged 20-29 and 43.1% are 30-39 years old; National AIDS Center, 2004). About 80% of all officially registered cases are among men. However, these figures do not reflect the real situation, since women and CSWs rarely choose to get tested for HIV or STIs. Out of 138 HIV-positive women, ninety (65.2%) were infected through heterosexual contacts.

Cases of HIV infection have been identified in all administrative regional districts of Azerbaijan; 44.4% out of all PLHIV live in the capital city of Baku (total population around 2.5 million).

HIV surveillance

HIV surveillance has been carried out in Azerbaijan since 1987. The testing policy has changed over time, and in 1997 voluntary testing was introduced for everyone, except for blood donors.⁸ Not surprisingly, the policy change – from mandatory to voluntary testing – has resulted in a considerable drop in the number of HIV tests performed annually. The first sentinel HIV surveillance was conducted in 2003.

From 1987-1997, out of three million HIV tests that were conducted, only twenty-three (23) were positive. Beginning in 1997, HIV testing was targeted at groups considered to be at higher risk for HIV and STIs. Out of the 960,000 tests conducted between 1997 and 2004, 695 new HIV cases were registered (about 100-fold rate increase; National AIDS Center, 2005).

Even though anonymous, 24-hour, voluntary HIV consultation and testing has been available in all cities and regions of Azerbaijan since 2002, it has been observed that few people are taking advantage of these services, especially counselling (UNAIDS/WHO, 2004). Everyone tested for STIs at a state clinic is also usually tested for HIV. However, private clinics that provide testing for STIs do not report the results to the state agency – the Republic's Skin and Venereal Diseases Dispensary – which makes it more challenging to control and track HIV and STIs.

Key populations vulnerable to HIV

Socio-economic factors

The Great Silk Road passes directly through Azerbaijan, which has a shoreline on the Caspian Sea and whose location, in the eastern part of South Caucasus, has historically made it one of the main transport corridors between Asia and Europe. Rise of substance abuse and commercial sex, a heavy inflow and outflow of people – as well as nearly one million refugees and internally displaced persons (IDPs) – play a certain role in how the HIV epidemic is developing. Just one example: thousands of foreign workers are currently in the

⁸ Although mandatory testing only applies to blood donors, tests are recommended (often resulting in HIV testing) for registered IDUs, IDUs seeking treatment, those testing positive for STIs, and prisoners.

country temporarily to help build the BTC oil pipeline (Baku, Azerbaijan – Tbilisi, Georgia – Ceyhan, Turkey and the Baku, Azerbaijan – Arzurum, Turkey gas pipeline).

Injecting drug users (IDUs)

In contrast to the trend in many other countries (with the exception of Eastern Europe and Central Asia), the primary mode of HIV transmission in Azerbaijan is not unprotected sex, but injecting drug use; 47.14% of all PLHIV contracted the infection this way.

According to the Republic Drug (Narcology) Dispensary⁹ drug use has increased substantially in the last fifteen years; drug use prevalence per 100,000 people was just thirteen in 1988, but had risen to 135.1 by 2002 (Kasumov et al., 2003). Out of 17,000 drug users officially registered with the Republic Drug Dispensary in 2004, 87% were injecting drug users; 34% of all registered IDUs reside in the capital. However, in one of the surveys conducted among IDUs, only 4.8% reported being registered with the state narcology clinics¹⁰ or police (Abdullayev & Nasibov, 2004). Therefore, it is thought that the real number of drug users in Azerbaijan is even higher (UNAIDS/WHO, 2004).

Azerbaijan's proximity to major drug trafficking routes, including Afghanistan-Iran-Russia and Iran-Azerbaijan-Georgia-Europe, has deepened the country's drug problem by facilitating drug consumption (Kasumov et al., 2003). Poor living conditions and dissatisfaction with life, combined with the availability of illegal drugs, have led to an increase in injecting drug use and consequently, a heightened risk of HIV.

Unemployed people – 76% of IDUs are out of work (Abdullayev & Nasibov, 2004) – and young adults – 65% of IDUs are between the ages of 21 and 30 (Kasumov et al., 2003) – from the poorest rural areas tend to have a deep sense of hopelessness and are thus more vulnerable to drug use. Drug use is much lower among women (5%, Abdullayev & Nasibov, 2004) than among men; this is due to strong traditional gender roles as well as the bigger stigma associated with female drug use.

A UNICEF study (2002) showed that 77% of teenagers have never used drugs or other toxic substances while 5% reported using drugs on a regular basis. The highest rates were among street children and children who had come into conflict with the law.

The first case of HIV among IDUs was registered in 1995. WHO provided financial and methodological support for an epidemiological and behavioural surveillance survey (Kasumov et al., 2003) implemented by the National AIDS Center, which showed a high HIV and hepatitis C prevalence among 400 IDUs (65, or 16.5%, were HIV-positive, and 219, or 55%, had hepatitis C). The majority of HIV cases (61%) among the IDUs were in younger individuals, aged 21-25. The HIV-positive IDUs had a low level of education (they had either not completed, or only completed, secondary education).

According to the same survey only 19% of 200 IDUs used drugs when alone, and only 17.2% used sterilized syringes. Although almost 100% admitted having access to disposable syringes or needles and 70-85% knew that HIV can be transmitted through shared needles, only 32-43% had never used shared needles. Seventy-seven per cent (77%) of IDUs who are HIV-positive report sharing syringes and needles.

⁹ The Narcology Dispensaries (or Drug Clinics) in Azerbaijan are state agencies.

¹⁰ 'Narcology clinic' is a regional term referring to health institutions that provide drug-related treatment and care.

The prevalence of HIV is twelve times higher among the so-called ‘street IDUs’ than among IDUs who have registered with narcology centres. This indicates that the main part of epidemic remains outside national preventive and care efforts. IDUs who are registered with drug dispensaries tend to maintain regular contact with medical personnel and as a result, have a higher level of awareness about HIV and AIDS.

Drug and alcohol use is closely linked to unsafe sexual behaviour, and this, in turn, increases the risk that users will pass an HIV infection to their primary sexual partners. Although 170 out of 200 HIV-positive IDUs (44.5% of whom had regular partners) were aware that condom use can prevent HIV transmission, only 2-7% reported using condoms (with lower rates outside of the capital; Kasumov et al., 2003).

The public perception of drug use as a crime complicates the efforts to reach out to, work with, and collect comprehensive data from, IDUs. A fear of public disclosure and of being ‘officially registered’ discourages users from visiting medical facilities and reduces their access to treatment and prevention methods. (In accordance with current legislation, any drug user who enters a medical institution should be tested for HIV.) Despite widespread negative social attitudes towards drug users, families do not often reject a family member who is using drugs, and instead offer them help in an effort to keep them at home.

The ‘Republic’ and ‘City’ Drug Dispensaries provide free medical treatment to people dependent on drugs. In 2002, the Republic Drug Dispensary established the Rehabilitation Center and started a methadone programme. Currently two local NGOs – the Scientific-Analytical Centre: AntiNarcotism and the Azerbaijan Association of Public Health, funded by the Open Society Institute/Soros Foundation (OSI) – have been running needle exchange programmes.

However, the implementation of harm reduction programmes is complicated by the current legislation. Nevertheless, the existing number of programmes and organizations working on drug and HIV prevention is insufficient to respond for the current levels of drug use. Moreover, most of the programmes are located in Baku, while drug use is more widespread in other regions, mostly rural areas. Psychological support, treatment and social rehabilitation programmes are still not widespread in the country.

Sex workers

Poor economic conditions and a lack of well paid jobs or alternative employment opportunities is undermining the local traditional values and family relations. Desperate conditions have forced an increasing number of people to seek any source of income, including commercial sex work. As sex work is illegal in Azerbaijan, surveying the actual number of CSWs is very difficult and any estimate tends to be inaccurate.

The influx of considerable number of well-paid foreign workers who have arrived in the country as a result of major foreign investments in the oil industry, combined with new economic opportunities and rapidly-changing communities around the pipelines, have created a higher demand for CSWs, particularly in the capital and near remote pipeline worker camps.

Another consequence of the impoverished conditions has been a rise in human trafficking. According to the International Organization on Migration (2002), people who are driven by the desire for a high-salaried job abroad are sometimes deceived into situations where they are

trafficked for sexual exploitation. Women from Azerbaijan and certain other former Soviet countries (Russia, Ukraine, and Uzbekistan) are usually trafficked to Turkey and the United Arab Emirates (UAE).

In 2003 the National AIDS Center conducted the first sentinel epidemiological and behavioural HIV surveillance survey among 200 CSWs in Baku (Kasumov et al., 2003). The majority of female CSWs (64.5%) were between the ages of 20 and 30 (8.5% were under 20), and primarily from rural areas (only 32% were from Baku). Only one person was married, the rest were divorced (48%), widowed (18%), or had never been married (27%).

Women who do not have a male life partner often experience financial difficulties and come under social pressures that can push them into sex work as a way of making money. Out of the 200 CSWs surveyed, 17 (8.5%) were HIV-positive and 146 (74%) had other STIs – syphilis, 9% and chlamydia, 63%. Between 78-86% of the interviewed CSWs did not use condoms, and none of the seventeen who were HIV-positive had used a condom during their last sexual contact. Among the main reasons they cited for not using a condom was that the client had refused to wear one, or they themselves had simply not thought ‘there was a need.’

There are almost no educational programmes (including on HIV prevention) in Azerbaijan aimed at CSWs or their clients. In addition to sex work being illegal, CSWs are severely stigmatised and rejected by their families and communities and as a result, have a very thin network of social support. Often, CSWs are deprived of their rights, have limited access to medical services – including prevention and timely treatment of STIs, including HIV – and are rarely granted the right by their clients to negotiate safe sex.

Men who have sex with men (MSM)

One per cent (1%) of the total number of registered PLHIV are men who have sex with men (MSM) (National AIDS Center, 2005). Sexual relationships between people of the same sex are no longer against the law (since 1999) in Azerbaijan, but MSM are one of the most stigmatised population groups, and public admittance of one’s homosexuality is not common. Because of this, there is almost no reliable sociological and epidemiological data available on this group.

Incarcerated Individuals

Of all the current registered cases of PLHIV in Azerbaijan, 72% of infected individuals have a history of imprisonment (National AIDS Center, 2004). During the last two years, 4,000 prisoners (primarily IDUs) have been tested for HIV voluntarily after discussions on HIV prevention.¹¹ Currently, the country has seventy (70) HIV-positive prisoners. Although this does not necessarily mean that they contracted HIV in prison, being in a penitentiary institution may increase peoples’ risk of contracting HIV (drug use, same-sex sexual relationships, tattooing). Unsanitary living conditions and inadequate medical care increases the odds of prisoners becoming infected. Experts agree that if critical measures are not taken to improve health care and living conditions in the country’s prisons, the number of HIV infections can only increase. Clearly, although the penitentiary system seems even more resistant to change than society does, there is a pressing need for the implementation of large-scale HIV-related programmes (HIV prevention and harm reduction programmes, especially peer education for IDUs, HIV counselling and testing, and training of administration and personnel).

¹¹ According to the existing regulations, IDUs in prisons are urged to undergo testing twice a year.

Youth

As previously stated, youth are one of the most HIV-vulnerable populations in Azerbaijan. Teenagers have some of the lowest rates of HIV infection – just 2% out of all PLHIV (National AIDS Center, 2004), but people aged 20-30, who lead more independent lives and are more sexually active, comprise one third (33.6%) of all PLHIV and represent the most urgent priority for HIV/AIDS prevention, treatment, support and care programmes.

In the current difficult social circumstances, many young adults assume responsibly for supporting their parents and/or families and are under tremendous economic and social pressure, which makes them more vulnerable to labour migration, drug use, and commercial sex work. Young people aged 20-30 – especially those with a low level of education and thus, fewer employment opportunities – are strongly represented among key populations (65.5% among IDUs, 64.5% among CSWs, and a high prevalence among labour migrants although no exact figures are available; Kasumov et al., 2003).

Today's Azerbaijani youth is quite heterogeneous: there are several sub-cultural groups whose values, personal interests, and lifestyles vary greatly. Consequently, within each group the type and frequency of high-risk behaviour varies.

Most youth in Azerbaijan have been raised in traditional families and grown up in a quite conservative social environment. Their behaviour is controlled by family members and other social institutions (relatives, neighbours, public opinion, etc) who consider this method as the only effective way to protect their children from socially-unacceptable behaviour. But these adults may not be aware that raising children in such a strict environment may also leave them unprepared to face difficult decisions or resist peer pressure (especially on issues of sexuality and drug use).

Moreover, these young people may hold stronger prejudices and stereotypes against people who are infected and/or affected by HIV and AIDS, which can perpetuate their lack of awareness of and recognizing behaviour that may put them at risk to HIV.

In contrast, a smaller group of young people living in the more tolerant and liberal environment of Baku appear to be more accepting of changing social norms and behaviours. Members of the older generation often criticise their behaviour and believe that their less conservative lifestyle and personal relationship habits (e.g. premarital sexual contact) may increase their risk to HIV. In reality, however, fewer prejudices encourage openness to knowledge about HIV and AIDS, which in turn may reduce the risk of infection.

Migrants

Another major factor contributing to the spread of HIV in Azerbaijan is labour migration. Because of the insufficient number of employment opportunities, and the traditional expectation that a man should provide for his family, many men temporarily migrate to neighbouring countries (Russia, Ukraine, and Turkey) in search of jobs (Thouth, 2004).

Currently, the migrant population constitutes a substantial part (43%, or 299 individuals) of all registered PLHIV in Azerbaijan (National AIDS Center, 2005). Living abroad for months or even years at a time, and being away from their families, significantly increases the odds that men will have extra-marital sexual relationships and expose themselves to an STI or HIV.

And upon their return to Azerbaijan, if infected with HIV, increases the risk of transmission to their sexual partners.

Refugees and internally displaced population

Refugees and internally displaced persons (IDPs) (about 1 million, or 13% of the total population; UNDP Human Development Report, 2003) are vulnerable to HIV infection. Even though the current HIV prevalence among refugees and IDPs is relatively low (15 individuals or 2.12% of all PLHIV), refugees and IDPs have been relocated to regions that lack basic social infrastructure, employment opportunities, and medical and educational services, all of which elevates their risk of contracting HIV. With a high unemployment rate (UNDP HDR, 2003), refugees and IDPs are engaged to a large extent in labour migration. A significant number of refugees and IDPs are still living in refugee camps (UNDP, 2003), where HIV testing opportunities are considerably low in comparison to other settings (e.g. cities and towns). Additionally, living in isolated refugee communities exacerbates their social exclusion, which deprives them further of HIV- and AIDS-related information.

The government has been making significant efforts to improve refugee and IDPs' living conditions and access to social and medical services (building houses, public schools, hospitals, etc). The National AIDS Center is carrying out substantial work in refugee communities on HIV prevention and on creating the appropriate conditions for HIV testing. However, given the vast scope of the problem and the difficulty of establishing high quality social and medical services, this group remains at heightened risk for HIV.

The National AIDS Center, UNHCR, UNFPA, and other international and local organizations, have been conducting HIV education programmes and running contraception-awareness campaigns in refugee communities for the last few years. Even though, as a result, HIV awareness has risen to average levels and does not differ significantly from that of the general population, the need to continue educational programmes for this group is made clear by the fact that 30.4% of 1,272 female refugees surveyed have still never heard of HIV or AIDS (CDC Reproductive Health Survey, 2001). Moreover, HIV prevention programmes are often conducted within the framework of reproductive health projects, which mainly tend to target married women. Meanwhile, men, who play an undeniably principal role in the spread of HIV, are frequently overlooked.

Socio-cultural context of HIV- and AIDS-related behaviour

The risk of HIV infection is closely tied into social and cultural norms, traditions, beliefs, values, and stereotypes. Azerbaijani society can be described as more community- than individually-oriented, and collective values matter more than individual values. Accordingly, public opinion, social status, and status as a respected member of the community carry a high importance. Azerbaijani society, in general, is rather traditional, with close family relationships and conventional opinions on sexual behaviour. In this sense, the close relationships people forge with their relatives, neighbours, and friends are a positive factor, and source of support, for people experiencing hardship (e.g. IDUs, PLHIV).

At the same time, the significance of public opinion, and the expectation to maintain a certain social status (or image) creates serious difficulties for people who deviate from socially-accepted 'norms of behaviour,' like CSWs, MSM, etc. In an attempt to avoid becoming outcasts, these groups tend to adopt double lives and hide certain aspects of their private life

even from their closest friends and family members. According to specialists working with PLHIV, the majority of PLHIV also tend to hide their HIV status from others.

Furthermore, certain elements of socio-cultural behaviour can become risk factors for infection. For example, interfamily marriages (when a husband is a distant relative or cousin of his wife) can still be found in more traditional families, mostly in rural areas, and often lead to severe, hereditary blood diseases among children, like thalassemia and haemophilia. As these children are in constant need of blood transfusions, they face a heightened risk for contracting HIV.¹²

Family, gender roles and HIV/AIDS

The current number of HIV-infected men (76%) in Azerbaijan is much greater than the number of HIV-infected women (20%) (National AIDS Center, 2004). However, gender inequalities that are reinforced by socio-economic and socio-cultural norms are increasing women's vulnerability to HIV. Just as global trends have shown a 'feminization' of HIV occurring, the number of HIV-infected women in Azerbaijan seems set to rise.

Men are in a more privileged social and economic position compared to women, who often are financially dependent on their husbands. Widely accepted social norms permit a 'double standard' for men and women; there is much higher social tolerance towards a man's early, premarital, and even extramarital sexual relations. In contrast, women are expected to abstain from premarital sex and stay faithful during their marriage.

Since female virginity is highly valued, the average age of first sexual contact (22.3 years) tends to be the same as the average age of a woman's first marriage (CDC Reproductive Health Survey, 2001). Abstinence from premarital sexual relationships may contribute to the low HIV prevalence among young women. Premarital relations are not common and begin at a later age than in the majority of European countries (CDC Reproductive Health Survey, 2001). Nevertheless, they do take place as demonstrated in the UNICEF's study (1999) 2% out of 200 teenage girls under 18 reported having premarital sex.

The average age of marriage has not changed significantly over the past sixteen years: in 1987 it was 23.7 for women and 27 for men, in 2003 it was 23.7 for women and 28.6 for men. (State Statistical Committee, 2004). However, in some ways the socio-cultural norms surrounding marriage in the country seem to be changing. A small increase in the age of marriage has been observed among educated and employed young women in Baku, while in the rural areas the opposite trend has begun to occur.

Sexual behaviour

The use of modern methods of contraception remains relatively low, especially in rural areas (14-18% of married women of reproductive age, UNDP, 2003). Unprotected sex is not only considered normal between regular partners, but also in casual sexual relations. In a research study conducted by the International Rescue Committee (1999) in one of its beneficiary communities, 20% of men said they use condoms with their wives, and 50% said they use condoms when they are with other women. The frequency of unsafe sexual practices is even higher in 'high-risk groups' (IDUs and CSWs). Another survey (Abdullayev & Nasibov, 2004) showed that 61.3% of IDUs do not use condoms at all, 3.2% always use condoms, and

¹² According to the National AIDS Center, during the last six years, only one case of HIV transmission through blood transfusion was reported.

35.5% only do when they have sex with a casual partner or when a condom is easily available. The majority of IDUs respondents reporting condom use lived in Baku.

The low use of contraception has probably less to do with general unawareness than it does with some socio-cultural stereotypes and norms regulating family and intimate relations. Research has shown that 44% of 7,668 women surveyed knew how to use and where to buy a condom, but only 3% said they use them (CDC, Reproductive Health Survey, 2001). One of the stereotypes that hinders safe sex practice is that condom use is considered a sign of distrust rather than care for one's own, and/or one's partner's health. Furthermore, negotiations over safe sex are not very common and men are the ones who usually make the decision about condom use. Finally, condoms might be simply unaffordable for many people (a pack of two condoms of average quality costs between 0.60 and 0.80 USD, compared to the average monthly salary of 50-70 USD in 2003).

Additional obstacles to HIV prevention exist with regard to local values and norms, which do not promote open discussions of topics related to sex and sexuality. Since sexual contacts are a prominent route of HIV transmission, HIV therefore is one of the topics considered unacceptable for public discussion. Discussions about sex, sexual life, and intimate relationships are rare, not just within the family (between children and parents) but also at school and mass media.

Religion and HIV/AIDS

Azerbaijan is a secular state, meanwhile Islam, as the predominant religion, has an impact on socio-cultural norms, values, and behaviours, including attitudes toward HIV and AIDS. On one hand, according to Gray (2004), HIV prevalence is lower in Muslim countries because of religious attitudes toward sexual practices and alcohol consumption, and also because male circumcision reduces the risk of STI and HIV. On the other hand, some local religious figures consider HIV to be 'punishment' for a promiscuous sexual lifestyle and/or drug use, and promote a 'decent' lifestyle as the only means of prevention. In addition to the negative attitude towards HIV and AIDS and PLHIV, poorly informed religious figures sometimes perpetuate distorted and even biased information.

In general, religious figures are respected in Azeri society and their participation in HIV prevention campaigns can have a strong influence on people's attitudes. The first attempts at this have been made by the State Committee for Work with Religious Organizations (SCWRO) and UNDP within the auspices of a joint project called, 'Religious communities respond to HIV/AIDS.' The project is aimed at involving Muslim and non-Muslim religious figures in HIV prevention activities in Azerbaijan (UNDP press release, Sep. 2004).

Care and emotional support for PLHIV and their relatives is one obvious task that religious figures could adopt, which would set a positive example and go a long way toward creating a more tolerant public attitude towards PLHIV.

Public awareness of HIV/AIDS and attitudes towards PLHIV

A wide-ranging reproductive health survey (CDC, 2001) conducted among 7,668 females aged 15 to 44 showed that the majority of respondents (74%) have heard about HIV and AIDS. The actual depth of knowledge varied, depending on the social and demographic characteristics of respondents – the lowest level of knowledge was among respondents under

20 (56%), respondents with only secondary or incomplete secondary education (55%), and those living in the southern regions of the country (55%).

Women living in rural areas and women with no previous sexual experience were less aware of HIV and AIDS. A survey conducted by the Caucasus Research Resource Center-Azerbaijan (CRRC-Azerbaijan, 2004) of 1,500 people also demonstrated an average level of general public awareness of HIV; the overwhelming majority of respondents (95%) knew that HIV can be transmitted sexually, that risk factors include unprotected sex (93%) and syringe sharing (80%). However, knowledge of other modes of transmission was imprecise and inaccurate. In comparison with the situation in the capital, the level of HIV awareness in other regions, and especially in rural areas, is lower, which can be at least partly attributed to people's limited access to HIV-related programmes, IEC materials, as well as to stronger psychological barriers and traditional stereotypes associated with the topic.

Overall, the general public mainly thinks of HIV and AIDS as a much more urgent problem for other countries than for Azerbaijan. Public opinion holds that only IDUs, CSWs, MSM, and recipients of donated blood and blood products are at risk for HIV. Therefore, although the general population is aware of the illness, the majority (60.9%) do not acknowledge a personal risk of HIV infection or practice preventive healthy life skills, and indeed seems largely indifferent to the topic (CDC Reproductive Health Survey, 2001).

Currently, only a narrow group of professionals and people infected with, or affected by, HIV and AIDS are focusing their work, attention and activities on HIV and AIDS. The perception of HIV/AIDS as a 'shameful disease,' and the stigmatising and rejection of PLHIV is still widespread in Azerbaijan. Surveys conducted among various social groups of different ages and occupations revealed rather intolerant and negative attitudes towards PLHIV (CRRC, 2004; IMC, 2002; UNICEF, 2002). Up to 80% of respondents say they would not want an HIV-positive friend, business partner, neighbour, or teacher. Such attitudes discourage people from knowing their HIV status and getting voluntarily tested.

HIV awareness and prevention programmes

Despite substantial public education efforts, the reality of the country's HIV situation is still not publicly acknowledged, and generally speaking, the level of HIV/AIDS-related knowledge is inadequate. Many prevention programmes have failed to take into account local norms and behaviour, and simply use generic HIV programmes to deliver information on modes of transmission and prevention methods. The lack of culturally-sensitive programmes and appropriately trained trainers, has created a degree of public resistance, even prejudice, that prevents people from absorbing and using the information they receive.

Over the last several years, HIV prevention projects targeted at youth have been widely implemented by government agencies and international and local NGOs:

- The National AIDS Center developed a 'Save yourself from AIDS!' programme for university and school students and sent leaflets to parents. The Ministry of Education approved the programme and now requires all schools (from sixth to eleventh grade) and universities to conduct an hour-long lecture every year on 1 December - World AIDS Day.
- UNICEF developed a 'healthy lifestyle' educational programme for secondary schools that includes a section on HIV and drug use prevention along with other health related topics (reproductive health, anti-smoking, emotional health,).

- The Open Society Institute-Assistance Foundation/Azerbaijan (Soros Foundation Network) developed a curriculum and trained school psychologists and biology teachers to introduce health education at schools that include a component on HIV, drug prevention, and reproductive health.
- World Vision International introduced a training manual and video, developed by Street Children International, on HIV and drug prevention among children, and trained representatives of various children's NGOs on how to use the materials.

HIV educational programmes are more widely available to students who live in Baku and the country's regional centres. Many of these educational programmes and youth campaigns target school-aged children (10-16 years old), but teachers sometimes run into parental disapproval when they try to introduce and teach HIV awareness programmes. These obstacles arise because neither parents nor teachers are accustomed to having open discussions, especially with teenagers, about HIV, AIDS and sexual behaviour. Even when parents recognize the importance of HIV-awareness among adolescents, they still believe that this information is best delivered only to children older than 14, should not be accompanied by the distribution of condoms at schools, and is presented by a specialist instead of themselves (parents).

Because most HIV education and prevention programmes target school children, little has been done to educate young adults (one of the key at-risk groups) and adults, who still hold strong prejudices and misperceptions. HIV education programmes also sometimes miss hard-to-reach population groups, such as out-of-school youth, housewives and people who are unemployed or live in rural areas.

Moreover, sometimes, educational programmes fail to produce substantial behaviour changes because they don't challenge existing attitudes, patterns of human interaction (e.g., "condom use is a sign of distrust instead of care") and social stereotypes that reinforce risky behaviour (e.g., "unprotected intercourse is sometimes seen as a sign of machismo").

Possibly, ignorance about HIV prevention strategies (including voluntary HIV testing) to some extent, may be explained by the people's general negligence toward their own health. Avoidance and postponement of preventive testing and treatment are deeply-rooted habits, so educational programmes that emphasize the importance of personal health responsibility are much needed.

People living with HIV

Even though PLHIV are eligible for disability status and receive certain social benefits (including a pension and free public transportation) financial security is still a major concern. The majority of PLHIV in Azerbaijan are unemployed and live in poverty.

Moreover, ARV treatment medication is not available and as of spring 2005, 300 HIV-positive, low-income people are expected to be in urgent need of it. The situation is expected to change as of the second-half of 2005 because of support from the Global Fund, which is planning to provide PLHIV in Azerbaijan with HIV ARV treatment medication.

The majority of HIV-positive persons are pessimistic about the future and believe that their diagnosis signalled the end of life as they know it. Some, however – particularly younger

PLHIV – still hope to have families and children and believe that one day a cure will be found.

Institutional Assessment

Health care system

During the transition period, the provision of medical services, especially in remote rural areas, has been weakened. Improvement of the health care system and social service infrastructure are among the government's highest priorities, and requires significant national and international resources.

The Ministry of Health (MHA)¹³ is in the midst of implementing extensive reforms to improve the primary health care system, establish a more flexible management and administration system, and eradicate infectious diseases (poliomyelitis, tuberculosis, malaria). Substantial financial, technical, and methodological support for this effort has been provided by international organizations, including the World Bank, WHO, and UNICEF.

Legislative basis of HIV activities

Significant legal efforts have been made over the past several years to establish an effective system of HIV prevention, testing, and diagnosis. A strong base of HIV-related legislation is now in place that guarantees rights and services for PLHIV and establishes organizational mechanisms for the prevention and treatment of HIV and AIDS.

In 1996 the Law on the 'Prevention of the spread of the disease (AIDS) caused by HIV' was adopted.¹⁴ The law includes legislative guarantees that take a non-discriminatory approach to all PLHIV and their families. Two guarantee the safety of blood supply, two other decrees, 'On Donor Blood Testing for HIV, Syphilis and Hepatitis' and 'On Safe Blood and Its Components Supply' were issued by MHA in 1997. In 2002, the MHA issued another decree "On Establishment of Around-the-Clock Anonymous HIV Counselling and Testing Service in all cities and regions of the country". According to the current legislation, PLHIV are eligible for disability status and pensions.

The National Commission on Prevention of HIV/AIDS developed the new National Strategic Plan (NSP) on HIV prevention for the period 2002-2006 that was approved and ratified by the Cabinet of Ministers in 2002. The NSP promotes a multisectoral (multidisciplinary) approach and cooperation between various ministries, state departments, NGOs, and international organizations as partners in the implementation of related actions.

Despite some improvements, there is still a pressing need to improve the system of identifying and reaching out to key populations (IDUs, CSWs, MSM), to increase awareness of healthy life skills among the entire population, and most importantly, to provide treatment and care to PLHIV.

National AIDS Center

The National AIDS Center was established in 1992 by the MHA and has been carrying out significant work on education, treatment, prevention, and control over the spread of HIV. The National AIDS Center works on: 1) conducting epidemiological surveillance, testing, and

¹³ <http://www.mednet.az>

¹⁴ HIV/AIDS Resource Center: <http://www.undpaids.az/respaz.html>

registration; 2) ensuring the safety of donated blood and blood products; and 3) providing medical, psychological, social, and legal services to PLHIV. Currently the National AIDS Center's twelve regional branches with diagnostic laboratories operate throughout the country. The Center coordinates activities and provides organizational and technical support to the country's rural areas on HIV prevention issues.

The Center also carries out educational and informational activities to raise awareness among the general population and has developed training programmes for public health experts, medical personnel, law enforcement officers, culture workers, sociologists, and mass media representatives. The educational programme for youth was also introduced at all secondary schools and higher education institutions across the country.

Currently the Center is working toward improving the system and the mechanisms for identifying and reaching out to key vulnerable populations (e.g. IDUs, CSWs, MSM), introducing HIV counselling to key populations in medical settings, increasing awareness and healthy life skills among them, and most importantly, providing free treatment and medication to PLHIV.

Efforts by international agencies and local non-governmental organizations

A number of international agencies and local non-governmental organizations have done important work on HIV and AIDS initiatives in Azerbaijan. Obviously, effective implementation of HIV awareness and prevention activities requires the close cooperation of governmental, NGO, and public organizations. NGOs, who are particularly successful at working with key at-risk populations, could have a bigger impact if they extended the geographic scope of their projects; NGOs are badly under-represented in outlying regions and rural areas.

- Imdad-SOS was established, with the active support of the National AIDS Center, to provide social, financial, psychological, and legal assistance to PLHIV and currently unites around 100 PLHIV and their close relatives, as well as lawyers, psychologists, sociologists, teachers, and medical specialists.

- The HIV/AIDS Resource Center¹⁵ (focuses on prevention programmes, reduction of vulnerability through increased public awareness, sharing best practices, training and providing information about HIV to the NGO community and various demographic groups in the country. Since 2002, The Resource Center has been implementing a broad range of activities within a UNDP project on strengthening the capacities of civil society in response to HIV/AIDS.

- Ikhlas is actively involved in prevention programmes and awareness-raising campaigns, including working with the media.

- The Scientific-Analytical Centre "AntiNarcotism" carries out a number of HIV-related projects for drug users, including needle exchanges.

- UN agencies – UNDP, UNHCR, UNFPA, UNICEF, and UNAIDS – and WHO have been actively contributing to Azerbaijan's response to HIV and AIDS. Their projects have been aimed at raising public awareness, assisting in establishing a safe blood bank, addressing needs in reproductive health and family planning, and strengthening government and civil society capacities.

- The International Medical Corps, with the financial support of British Petroleum (BP), has implemented a joint programme with the National AIDS Center to prevent the spread of STIs

¹⁵ <http://www.un-az.org/undp/aids.php>

and HIV among BTC pipeline construction workers and people living in the regions along the pipeline.

Conclusions and Recommendations

Although HIV prevalence in Azerbaijan is currently low, there is a high potential for the rapid spread of the epidemic. The progression of HIV is strongly influenced by socio-economic and socio-cultural factors, including: the challenges of a transitional economy, forced and labour migration, growth of drug use, as well as some socio-cultural norms of behaviour, family, religion, and gender issues.

Recommendations:

Policies and Programmes:

- More programmes and services specifically targeting the key populations and their partners should be designed and implemented;
- Activities aimed at solving problems indirectly connected to the spread of HIV must be encouraged and supported (income generation and poverty reduction programmes to provide economic security for the population, in order to reduce the number of migrants and CSWs; drug use prevention and treatment programmes; programmes to ensure gender equality and increase opportunities for women, as a basic element of reduction of women' and girls' vulnerability);
- HIV prevention should be mainstreamed into all other prevention and health promotion programmes and become a component of broad-based school health programmes. Schools can provide wider access not only to adolescents but to their parents, as well. Special programmes and services for young people beyond secondary education (18-25 years of age), and for young people who don't attend secondary or higher educational institutions, should be designed and introduced;
- The number of programmes aimed at the improvement of financial, social, and psychological well-being of people infected and/or affected by HIV should be increased, and affordable ARV treatment medication for all PLHIV should be available.

Information, Education, Communication:

The following components should be addressed while designing, developing, and modifying HIV educational programmes and awareness-raising campaigns:

- **ACCESS TO INFORMATION** - Ensure wider access to HIV-related education programmes for underexposed groups (housewives, people aged 30-40, the unemployed, villagers); Develop informational and human resources (trainers) that can give people access to more information when educational programmes have ended;
- **PROMOTION OF DISCUSSION** - Promoting a new approach to discussions of issues such as HIV in order to reduce the population's reluctance to, and non-acceptance of, open discussions on sensitive topics (prior to delivering HIV-related information in educational programmes);
- **PROMOTION OF BEHAVIOURAL CHANGE** - Programmes should be targeted at discussing stereotypes that reinforce behaviour that puts people at risk for HIV, to overcome barriers to healthy lifestyles. Promote early identification and treatment of STIs and HIV, voluntary and confidential counselling and testing within health promotion programmes;
- **GENDER SENSITISATION and RESPONSIVENESS** - Should become an important component in HIV education and prevention programmes, to reduce stereotypes that foster gender inequalities and increase women's vulnerability to HIV;

- **HUMAN RIGHTS APPROACH** - Effective strategies on prevention, care, support and treatment of HIV should be conducted within the framework of human rights to change public attitudes toward key populations and PLHIV. Ensure that medical, educational, and other social services use non-discriminatory approaches and provide equal access to everyone;
- **CONSIDERATION OF LOCAL SPECIFICITIES** - Take into account cultural values and greater involvement of PLHIV, religious figures, parents and youth, when designing prevention programmes in order to encourage acceptance of HIV information.

Training/Capacity-Building:

Strengthening human resources should become one of the priorities in efforts to deliver effective HIV and AIDS prevention, care, support, and treatment services.

- Specialists providing and designing HIV prevention programmes should be aware of the current socio-cultural atmosphere surrounding HIV and key populations, and be prepared to provide unbiased, age-specific, and gender-responsive information;
- Strengthen training of professionals outside the educational services (e.g. psychological and social support services to key populations and PLHIV, including palliative care).

Information and Research:

- Most HIV/AIDS surveys in Azerbaijan were conducted among the general population to identify the level of awareness of HIV and attitudes toward PLHIV. More studies should be conducted among key populations and PLHIV to collect more specific and in-depth information;
- More comprehensive information on the following issues could help considerably in the effective development and implementation of HIV prevention and support programmes for the general population, key population groups, and PLHIV:
 - Key factors influencing risky behaviour patterns among various age and social groups;
 - More information on social issues that are closely associated with HIV (poverty, migration, drug use) and demographic and social data about key populations;
 - Assessment of quality of life and living standards of PLHIV (including protection of their rights);
 - Collect more empirical information about cultural, family, and religious norms (factors) playing a role in the spread of HIV and HIV prevention, care, support, and treatment;
 - Assessment of economic, and legal factors complicating the efforts directed toward awareness raising, education, prevention, care, and support.

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Chapter 4. Georgia

HIV and AIDS in Georgia: a socio-cultural approach

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Introduction

At 0.13%, the prevalence of HIV in Georgia is relatively low. Despite this, there is a high potential for the rapid spread of the HIV epidemic and the low prevalence is actually a factor in the low level of awareness about the disease among the Georgian population. Stigma against, and fear of discrimination among, people living with HIV (PLHIV) has led many to conceal their HIV-positive status. Since the majority of HIV-positive individuals are former or current injecting drug users, commercial sex workers, or other marginalized members of society, there is additional stigma associated with an HIV infection.

The public's understanding of, and attitude toward, HIV and AIDS reflects the lack of available information about the virus and risks of transmission. Only a few studies have been done, focussing on HIV/AIDS epidemiology and behaviour, and how local culture has influenced the course of the epidemic. Areas of research that are particularly under-examined include how gender, religious, cultural, and traditional roles influence the effectiveness of HIV prevention programmes. In many cases, the response to HIV and AIDS is modelled on the experiences of other countries, which have cultures that are very different than Georgia's. In addition to determining the most common methods of transmission and structure of the health care system, Georgian cultural specificities and traditions play a key role in effective responses to HIV and AIDS.

As of 1 November 2004, Georgia had a total of 597 registered cases of HIV infection, according to the National AIDS Center. From this group, 193 individuals developed AIDS, and 111 died. The World Health Organization (WHO) estimates that there are 3,000 PLHIV in Georgia, with the highest number of registered cases in the capital, Tbilisi, and in the country's Black Sea regions, Ajara and Samegrelo. The first HIV case was registered in 1989 in Sukhumi, Abkhazia, Western Georgia, three years after a decree from the USSR's Minister of Health established the Georgian AIDS Control Service. The decree mandated mass screening of the population for the purposes of case identification and strict epidemiological control. In Georgia, every person who visited an outpatient clinic or a hospital was required to undergo mandatory HIV testing. During the late 1980s, about 500,000 people, or about one-tenth of the total population – mostly pregnant women and people who visited health care facilities for various treatments – underwent mandatory HIV testing.

Surveillance

The largest set of Georgian seroprevalence data comes from HIV testing carried out between 1985 and 1992, a period when more than 1.4 million individuals were tested for HIV and ten

were found to be HIV-positive. In 1995, all hospital patients in the country were tested for HIV. Out of 400,000 persons tested, twenty were HIV-positive. In 1996, out of a total of 30,505 HIV tests performed, eight people tested positive.

HIV/AIDS prevention and case control policy changed substantially after independence and through the early transition period, as the country began to build a democratic state. In 1993, Georgia joined the Riga Declaration and started shifting the emphasis from mandatory HIV testing to wide scale prevention activities. It also put a new focus on human rights and made public education and community involvement a priority. All mandatory testing was discontinued, except for blood donors. Consequently, the number of HIV tests performed annually in Georgia dropped sharply, with counselling and testing of key populations, such as IDUs, CSWs, MSM, STI and TB patients, receiving priority. Currently, confidential HIV testing and counselling is available at the National AIDS Center and 54 regional counselling centres, and patients who wish to remain anonymous may do so.

The most common mode of HIV transmission in Georgia is through injecting drug use. The second most common mode is sexual contact with an infected partner, which occurs mainly between heterosexuals. Injecting drug users (IDUs) account for 64.7% of registered HIV-positive individuals; of that group, 27% contracted the virus through unprotected heterosexual contacts and 3.2% are men who have sex with men (MSM). The highest rates of HIV infection are among people aged 15-24 and 25-34. The majority of HIV infected individuals are male (the ratio to female is 6:1) and urban-dwelling (60%). Ninety-three per cent are Georgian citizens, and include a small number of Internally Displaced Persons (4%).

At the beginning of the epidemic, cultural attitudes toward HIV and AIDS in Georgia reflected the global trend to treat the disease as a problem unique to MSM and commercial sex workers (CSWs). In the early 1990s, HIV was spread in Georgia mainly through unsafe sex between heterosexual and same-sex partners, which strengthened these perceptions and fuelled stigma and discrimination. From 1996-97, an increase in the number of IDUs made contaminated needles the primary mode of HIV transmission (69% of registered cases).

The perceived confinement of HIV and AIDS to specific, key populations – IDUs, CSWs and MSM – and the low prevalence of HIV even among these groups, feeds the misconception among the wider population that they are not at risk for contracting HIV. This belief is expressed in declarations such as: ‘I don’t use injecting drugs, and I am not a sex worker, therefore AIDS is never going to be my problem.’ If in the early 1990s the common public attitude toward HIV and AIDS was that it was a problem for Africa and the United States, the rise of HIV infection rates in the Ukraine and Russia changed this perception, albeit minimally; the Georgian population still believes that, as a whole, Georgia is not at risk for an acute HIV epidemic.

Relevant Characteristics of Georgian Culture

and should be considered when building an effective response to HIV and AIDS in Georgia. Collectivism, expressed in small groups (extended family, relatives, friends, neighbours and others), is one of the defining characteristics of Georgian social culture. This baseline determines the following trends:

1. The values shared by small groups take precedence over ‘abstract’ values, such as laws, moral perceptions, the rules of ‘rational thought,’ the ‘right way of life,’ and so on;

2. Interpersonal relations are considered to be the highest priority, compared to other interests like careers;
3. The psychological horizons of space and time are quite narrow – space is limited by small group(s) and time is mainly focused on the present moment;
4. Daily behaviour and practices that affect the future are rarely practiced, because their usefulness is not immediately apparent. Healthcare prophylactics, which protect against various infections, including HIV, are used infrequently.

Because of the high cost of treatment at official medical centres, some people turn to traditional healers, and receive affordable herbal medicines. Sufferers of incurable diseases often seek alternative treatments from traditional healers, some of whom claim to have successfully cured AIDS. A few years ago an article appeared in a local magazine about a person with AIDS who claimed to have been cured by practicing yoga. Indeed, the demand for traditional medicine and alternative treatments has been driven by the lack of anti-retroviral (ARV) treatment in Georgia. That situation is expected to change with universal access to ARV treatment for all AIDS patients through the GFATM project.

Drug use and related high-risk behaviour in Georgia

During the 1990s, Georgia weathered numerous social, political and economic crises. Since the collapse of the Soviet Union, a number of factors have contributed to the rise of injecting drug use in the country: the collapse of government efforts to control illegal substances; uncontrolled borders; an increase in crime; worsening corruption; a crisis of social values; social pessimism; social-economic collapse; escalating unemployment; and the long-term effects of conflicts in Abkhazia and South Ossetia – territories that are nominally parts of Georgia but de facto are out of Georgian jurisdiction.

Georgia's geopolitical location at the crossroads of Asia and Europe further complicates the situation. The country has become a key link in drug routes from Afghanistan and Central Asia (Janashia, 2002; Shelley, nd.), and the availability of illegal substances – primarily opiates and cannabis – has increased throughout the country. Despite a recent gradual improvement of the economy and a decrease in crime rates, the usage and trafficking of injecting drugs has continued to rise.

Unfortunately, at the same time, Georgia's budget deficit has hindered the implementation of appropriate state responses like drug prevention and treatment programmes. The absence of state-sponsored solutions is compounded by a lack of popular public interest in the issue and relevant legislation.

Drugs are more readily available and more often used in the country's cities, but they can also be found in small towns and villages. Drug use occurs among all social classes, from the uneducated and poor to high-ranking government officials. According to research data, approximately 150,000 people regularly use illegal substances in Georgia, and around 60,000 of those are IDUs (Annual Report on Drug Situation in Georgia, 2003). Since 1999 the most common drug has been heroin, followed by homemade cocktails of raw opium or 'poppy straws.' Recently, the average age, geographic origins, and social class of drug users has changed. Now drug users can be found among all age groups, but the highest number of users is between 21 to 40 years old.

Although drug use by women runs counter to cultural and traditional norms – and is not as significant as in some other areas (e.g. Russia and the Ukraine) – experts say drug use among women and young girls has increased in recent years.

Current behaviour trends among IDUs are influenced by patterns that emerged in the 1960s, when drug use in Georgia became more widespread among young people in elite classes, rather than among marginalized social groups. A 2002 survey of IDUs in Tbilisi indicated that almost 70% of IDUs had either graduated from a university or had started but not completed their university studies. Even today, drug use does not indicate social exclusion.

Since the 1970s – i.e. before the emergence of HIV and AIDS – hepatitis C was also widely transmitted through shared needles. As a result, IDUs in Georgia became informed about the risks of needle-sharing, and became more careful about such practices. This may be the main reason why cases of HIV among drug users in Georgia remain relatively low. According to some studies the prevalence of HIV among IDUs is less than 1%.

There is one particular aspect of drug use in Georgia – compared to Russia and possibly Ukraine – worth noting. In Russia, alcohol and drug users are often strangers to each other, whereas in Georgia, drug users generally create more stable groups. This may be another factor that contributes to the lower rate of HIV transmission.

Although most studies indicate that virtually all IDUs in Georgia have been told about the two main modes of HIV transmission (direct blood contact and unprotected sex), their behaviour has not become significantly less risky (Dershem et al. 2004). Over the last fifteen years there has been a significant decrease in the use of un-sterilized injection paraphernalia, but the practise of sharing injecting equipment remains an issue (in a survey conducted in Tbilisi in 2002, 22.7% of IDUs reported needle sharing between their peer group members).

Studies also indicate a high risk of HIV transmission between IDUs and their sexual partners (Situation Analysis on HIV/AIDS in Georgia, 2001; Dershem L. et al. 2004): habitual low condom use increases the vulnerability of the sexual partners of IDUs (and especially their spouses and other regular partners) to HIV and other infections.

Only a small portion (no more than 5%) of IDUs are regularly tested for HIV because of the traditional lack of concern for personal health, lack of trust in medical care providers and institutions, and fear of being arrested (even though HIV testing is confidential, anonymous, and free for key population members, current laws mandate a fine or imprisonment for drug use). Only IDUs who visit specialized health care institutions – of which there are very few in the country (AIDS Center, Institute on Drug Addiction and the NGOs Bemoni Public Union and New Way) – are tested for HIV on a regular basis. Because the risks of exposure to HIV are especially high among incarcerated IDUs who engage in frequent drug use without access to clean equipment, this population has urgent and unique intervention needs (Karselishvili, 2002).

Stereotypes concerning sexual behaviour in Georgian culture

Despite trends that show that attitude toward sexuality are liberalizing, traditional values in Georgia embrace double standards and unequal gender roles. For example, public opinion is quite tolerant towards men who have sexual experiences before, and outside, marriage. But

women are strongly condemned for the same behaviour, and as a result, are unlikely to reveal their pre- or extra-marital sexual experiences to others, or even in anonymous surveys.

Furthermore, mainstream public opinion holds that a woman's primary function is motherhood, and therefore, a woman should only have sex if she is trying to become pregnant. Any discussion or display of women's sexuality triggers heavy criticism. Of course, these norms greatly influence lifestyle, and sexual contacts between strangers are uncommon in Georgia. Even a man who flirts with a woman in a café or disco and tries to develop a relationship from there will have a hard time. As a rule, girls and women are quite concerned about their public image and feel a strong sense of responsibility toward their parents.

According to sociological data, most Georgian women living in Tbilisi do not have any sexual experience before marriage, and once married, rarely use, or ask their partner to use, contraceptives. According to Georgian cultural norms, premarital sex is an immoral act that reflects negatively on women; the 'tradition of virginity' still dominates (Kachkachishvili, 1999). On the other hand, observed increases in the average age of marriage (Tsuladze et al., 2003: 57) mean that the likelihood of pre-marital sex has increased, which is also a risk factor for HIV infection.

In Georgia, homosexuality is far more stigmatised than women's sexuality. Homosexuals, who are thought of as people who have 'changed their original gender role,' are the object of general hatred and aggression by most of society and by the Georgian Orthodox Church. The result of the predominating homophobia is the fact that homosexuals are deprived of any possibility to openly demonstrate their sexual orientation. As a result, strong ties develop within groups of MSM.

Since the 1990s the poor economic situation has fuelled the increase of commercial sex work. The majority of CSWs define sex work as their primary source of income. At the same time, they say they are only temporarily involved in commercial sex work, and plan to find different employment after they have saved some money.

In this context, HIV- and AIDS-related stigma and discrimination against CSWs and MSM remains much higher than that directed toward the IDU population, despite the higher risk of infection among IDUs. This trend can be attributed to the different social status of these groups: IDUs usually come from wealthy families and have very small, closed networks. Typically, he has a good job, a good car, and a reputation as the 'best' or a really 'smart' guy. Conversely, homosexuality is heavily stigmatised and their behaviour is invisible; public meetings between MSM are virtually impossible. Many MSM get married to female partners and adopt a bisexual life to avoid social scrutiny and discrimination.

Awareness

Although different research data shows that the level of awareness about HIV and AIDS among the population of Georgia can be considered satisfactory (Kachkachishvili, 1999; Goodwin et al., 2003), many people interviewed for this report expressed incorrect views on how HIV is transmitted, including through the air, touching someone living with HIV, or sharing dishes with an infected person. Such lack of awareness about modes of transmission may put people at risk and deepen the isolation and mistreatment of PLHIV, who already face a level of discrimination and stigmatisation similar to that of lepers.

According to a study of 360 school children and students, 56% of those surveyed acquire information about illegal substances on the street, 34% get it from mass media, and only 10% find information in popular educational literature. Efforts to include sex education in secondary school curricula are continually and effectively blocked by certain interest groups – often headed by religious leaders – who wield considerable cultural influence and power.

Migration

Experts estimate that approximately one million individuals are currently living abroad for employment or education purposes (Tsuladze et al., 2003: 161). The majority of emigrating males travel to Russia and Ukraine – countries with higher HIV prevalence than Georgia – as well as Greece and Western Europe, while women emigrants mainly travel to Turkey, Greece, the United States, Germany, and France, where many find work as domestic caregivers. The highest level of emigration is from the regions of Samegrelo and Javakheti. In contrast, very few people immigrate to Georgia, and those who do primarily come from Russia and Azerbaijan, and usually find employment on farms.

HIV testing and screening

The first laboratory for HIV testing opened in 1986 and today, there are about 60 HIV diagnostic laboratories throughout the country. All conduct voluntary HIV testing and blood screening, and confirm their diagnoses with Western Blot and PCR methods. The tests are conducted at the Lab of Serology and Virology in Tbilisi's Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC). Approximately 18,000-20,000 persons, representing key HIV populations, undergo voluntarily testing annually. In addition, roughly 28,000 blood donors are subject to mandatory testing through the 'Safe Blood' programme. The National Programme on Blood Safety has been operating since 1997 with the goal of ensuring that the nation's donated blood supply is free of HIV, HCV, HBV, and syphilis. Due to limited funding, the programme only tests an estimated 80% of blood donors, although this number is growing through the Global Fund to Fight AIDS, TB and Malaria (GFATM) project. Although HIV testing is fully confidential, anonymous and voluntary counselling and testing (VCT) is provided at only five of the existing HIV diagnostic sites. GFATM project support during the next five years will increase the number of VCT centres to around 40, and special centres will be opened for key populations (IDUs, CSWs, MSM and youth).

In its current condition, the health care system lacks the infrastructure and resources to address the special needs of individual members of key populations and other vulnerable groups, such as IDUs, CSWs, MSM, IDPs, and youth. There are a limited number of institutions that operate without the burden of stigma and are able to provide quality services to these constituencies in a respectful, user-friendly and confidential atmosphere. In 2001, several centres were opened with the support of various international donor organizations, including USAID and Doctors without Borders (Greece). All the centres are located in urban areas, but offer outreach services to rural areas.

Unlike the NGO sector, many state facilities continue to treat key populations in a discriminatory manner, with forced diagnostic and treatment. In addition, state facilities have a limited ability to provide free services. In addition to stigma and discrimination, the cost of

care is one of the main issues influencing health care access for marginalized groups; it drives them to seek alternate care elsewhere.

As many as 95% of registered PLHIV in Georgia are unemployed and extremely poor (National AIDS Center), and their needs extend beyond HIV or AIDS treatment and care. Psychosocial support is an essential need for PLHIV. This sub-population is becoming more organized in an effort to protect its rights and obtain higher-quality care and treatment. Many of these needs, including access to Highly Active Antiretroviral Treatment (HAART), will be at least partly met through national programmes and support from the GFATM. Currently, only HIV-positive persons who develop AIDS are entitled to receive HAART at no cost. Until the GFATM project is put into place, only four PLHIV are currently being treated through state support and 22 people are paying for ARV drugs themselves. ARV treatment is available only at the National AIDS Center and the two regional AIDS treatment centers in Ajara and Samegrelo.

The lack of social support and care, including palliative care, requires an immediate response. The responsibility for palliative care is left up to the families of terminally ill AIDS patients – an enormous burden that falls on the family's female members, who are the primary caregivers in Georgia.

Prevention and Support

Before 1996, only specialized governmental institutions, namely the National AIDS Center (IDACIRC) and its branch offices, were working on HIV prevention in Georgia. Since UNICEF became involved in 1997, the situation has dramatically improved. UNICEF, along with other members of the UNAIDS theme group (including UNDP, UNFPA, WHO, and World Bank), has led the country's national strategic planning for HIV and AIDS control. The group's efforts include the situational and response analysis of HIV/AIDS that was finalized in 2002, and the development of the National Strategic Plan of Action on HIV/AIDS for 2003-2007 (UNICEF Georgia, 2004).

Along with UN organizations, several other international and bilateral organizations have gotten involved in HIV prevention activities in Georgia. From 2002-2004, USAID provided 1.5 million USD in grant funds to address HIV prevention among IDUs and CSWs in Tbilisi, and in Ajara, in Western Georgia – regions selected on the basis of current HIV surveillance data and geographical location (main ports of Georgia).

A project implemented by Save the Children and its partner NGOs Tanadgoma and Bemoni is providing HIV/STI-related outreach activities and quality counselling, testing, diagnosis and treatment services for IDUs and CSWs in specific locations. In 2002, a baseline Behaviour and Biomarker Survey (BBS) was conducted within the project to assess the prevalence of high-risk behaviour among these two core groups. A follow-up survey was planned for late 2004 to assess the effectiveness of the prevention interventions. Tanadgoma and Bemoni apply a mainly socio-cultural approach to enhance the effectiveness of HIV prevention interventions in the two target key populations.

The NGO World Vision International is using a large grant from British Petroleum to implement an HIV/STI prevention project in regions of Georgia along the Baku-Jeikhan pipeline. The project is aimed at educating local communities and foreign workers on issues

related to HIV prevention and the promotion of safe sexual behaviour. All workers participate in training, and multi-lingual communication is provided to meet the needs of these diverse communities.

Two local NGOs – HIV/AIDS Patients Support Foundation and Georgian + Group – are very active in the protection of rights for PLHIV, and also provide much-needed psychosocial assistance. With the support of UNAIDS/UNICEF the two groups are developing a PLHIV network that can be expanded across the country within the framework of the GFATM project.

The National AIDS Center has joined forces with several NGOs to work with youth on prevention education; methods include VCT, peer education programmes, cultural-educational events, distribution of IEC materials, and condom promotion. Currently, there are no official school health programmes in Georgia, although some small health education programmes do exist. For example, the Teachers Postgraduate Education Institute has been working on Life Skills Building Programme with UNICEF/GFATM support since 2001. A teachers' manual for use with students during the first eight years of school has been developed, but has not been adopted by the Ministry of Education.

The development of an HIV, STI and drug use prevention education programme has been continuing within the framework of the GFATM project. A group of local experts (e.g. teachers, psychologists, specialists on HIV and drug use prevention) are currently developing the curriculum and teachers' manual. Twenty schools will participate in the pilot phase of the project and teachers from these schools will be trained to deliver lessons on HIV and STI prevention, and in how to educate students on avoiding drugs and tobacco products.

Sex education in schools has become a highly politicised issue in Georgia, and some religious leaders and political parties vehemently protest such programmes. In order to avoid triggering similar opposition, a clear distinction must be made between sex education and HIV prevention education. After the pilot phase, the programme will be adopted and gradually widened. The entire IEC package of the programme will be carefully reviewed by a special committee of public representatives – including religious groups, PLHIV and adolescents – to improve the content and language of materials. In consideration of local values and traditions, such as the virginity of women before marriage, and requests by religious leaders, the primary message of these courses will be the promotion of abstinence while providing information on the modes of HIV transmission.

Health Care Structure

Since Georgia gained its independence in 1991, the problems of widespread poverty and unemployment, limited government funding and other economic difficulties have persisted. The effect on the population has been an accumulation of severe health problems – including increased morbidity and mortality. Moreover, for financial reasons, many people choose traditional healers over modern health care, and postpone visits to medical centres until their symptoms or conditions have become severe – a decision that obviously further jeopardises their health (Skarbinski et al, 2002).

The country's first official health care reforms were developed in 1992 and introduced in 1994, with financial and technical support from the World Bank and the Atlanta-Tbilisi

Health Partnership. The first stage of these reforms included the structural reorganization of the entire system, including: a new regulatory and policy development role for the Ministry of Health; the independence of local health authorities; the privatisation of out-patient and dental clinics; and the development of public health departments. The second stage of reforms was aimed at developing a modern primary health care system and restructuring/rehabilitating major hospital clinics.

Since those first reforms, many aspects of the health care system have improved. Some objectives have been fulfilled while others require further work and commitment. For example, there have only been weak attempts to reorganize how the health care system is funded. Despite the creation of the State Medical Insurance Company (SMIC), which allocates 4% of payroll taxes, the company's budget is extremely small. Since 1994, the government's per capita expenditure on health care has increased approximately twenty fold. However, in 2002 this amount only represented 18.35 GEL (9 USD) per person. The government currently covers about 15-20% of all health care costs.

Since the reforms began, more than ten years ago, the Georgian Ministry of Health has taken responsibility for providing universal coverage of a basic benefits package (BBP) that includes public health and essential clinical services. The BBP was established through the SMIC, which pays for the services included in this package. However, the SMIC's limited budget and lack of publicly available information about its benefit packages discourages people from visiting health care providers. The SMIC-funded benefits package prioritises services for children, the poor, IDPs, and the elderly, and as much as possible, addresses the diverse needs of the various regions.

As a part of the health care system reform, the Georgian parliament has adopted a law on health care access. Chapter II of this law addresses 'Citizens Rights on Health Care,' but very few Georgians know their rights. Health care consumers in Georgia are mainly passive consumers, rather than active participants, in the health care system; the phrase, 'quality of care,' is completely abstract in Georgia. Nonetheless, PLHIV are relatively well informed on health care benefit packages and tend to demand a higher quality of care and treatment than the general population.

Legislation

Georgia was one of the first countries of the former Soviet Union to adopt a law on HIV prevention. The 1995 law is aimed at:

- Raising awareness and responsibility of the government to control HIV and AIDS;
 - Creating an effective state leadership base and coordinating activities in many sectors of society;
 - Ensuring social protection, legal rights and responsibilities of PLHIV;
 - Ensuring juridical and social protection of medical personnel;
 - Minimizing the impact of HIV and AIDS at the state, society and individual levels.
- (The National HIV/AIDS Prevention Programme, Parliament of Georgia, March 1995).

Major provisions of the Law on HIV/AIDS (as of 2000) are as follows:

- Responsibilities (policymaking, capacity building and financing) of the government in response to HIV and AIDS, and policy development at the governmental, regional, and local levels;
- Principles of epidemiological surveillance;

- Voluntary HIV testing of citizens;
- Protection of rights and interests of PLHIV, ensuring confidentiality, freedom of choice, respect, safety, and equality;
- Treatment and care of PLHIV and access to healthcare services;
- Social protection of PLHIV and their family members;
- Protection of rights and definition of responsibilities of the medical personnel working on HIV/AIDS, and social protection of the medical staff.

The realities of Georgia's social and cultural climate, and the limited resources for HIV/AIDS prevention and treatment, have made some parts of the law difficult to implement; for example, requesting physicians to assist PLHIV but not giving them a sufficient supply of disposable medical instruments.

The Georgian Law on Drug Addiction was amended in November 2002, and brought about some positive changes, including the partial decriminalisation of IDUs and the legalisation of methadone substitution treatment. Unfortunately, the law still does not allow needle-exchange programmes, even in prisons. Within the GFATM project several advocacy workshops are planned to build public and official support for these exchange programmes. Currently, two pilot projects are running with the verbal permission of local police departments. The organizations of the programme will need to present a strong and persuasive argument to gain public support.

There are no laws in Georgia governing commercial sex work. One paragraph of the Civil Code prohibits it, but there is no mention of the social or economic pressures that may be forcing individuals to pursue this kind of work. This fact further complicates the development and implementation of specific HIV prevention programmes targeted at CSWs. In the absence of such laws, 'sex work' can be interpreted differently by members of the police and by specialised health care institutions.

Governmental Efforts

The Georgian government ranks HIV and AIDS control and prevention among its top priorities in public health. However, due to the very limited resources available for health care, the budgeted allocation for HIV/AIDS prevention and control is minimal.

The first government programme on HIV/AIDS – the National HIV/AIDS Prevention and Control Programme – was introduced in 1994. The main goal of the programme is to control and prevent the HIV epidemic among key populations, as well as throughout the general population, through counselling and testing, education, and promotion of a healthy life style.

In 1997 the government assumed responsibility for ensuring the safety of blood and blood products, with the National Safe Blood Programme, which carries out mandatory testing of all blood donors for HIV, HBV, HCV and syphilis. The programmes are funded with money from the state budget for public health programmes. In 2004, around 170,000 USD was earmarked for HIV/AIDS prevention and control programmes. The budget of the National Safe Blood programme for the year 2004 was approximately 420,000 USD.

Preventing mother-to-child transmission (PMTCT) of HIV during pregnancy is one component of the state programme on HIV/AIDS prevention and treatment. The GFATM project intends to provide HIV testing and counselling to pregnant women throughout Georgia, as well as prophylactic ARV treatment to HIV-positive mothers and their newborns, free of charge.

The National AIDS Control service, established in 1990, is headed by a government commission on HIV/AIDS, STIs, and other infectious diseases. The commission was created in 1996 by then-Prime Minister Avtandil Jorbenadze and is comprised of top-level officials (ministers or deputy ministers) of different ministries and state departments, including: the Ministry of Labour, Health and Social Affairs, the Ministry of Justice, the Ministry of Education, the Ministry of Internal Affairs, the Ministry of Foreign Affairs, the Ministry of the National Security, and the Department of Border Control. The commission is responsible for developing and implementing multi-sector HIV/AIDS prevention and control policy and programmes.

Aware of the limits of existing internal resources, Georgian government officials and national AIDS control groups approached the international donor community about the country's HIV/AIDS problem a few years ago.

In 2002, the country finished a comprehensive strategic plan to address HIV and AIDS during the years 2003-2007, with technical support from UNAIDS and UNICEF. That same year, the Country Coordination Mechanism (CCM) was established, with the goals of involving the NGO sector, PLHIV, and community representatives in HIV/AIDS prevention and control policy development, and raising additional external funds.

All the main stakeholders and interested parties are represented in the CCM, which was very successful in developing the national proposal called, 'Strengthening the National Response to HIV/AIDS in Georgia.' This proposal was awarded 12 million USD for the 2003-2007 period by the Global Fund to fight AIDS, TB and Malaria (GFATM) – an amount almost ten times the entire budget of the National HIV/AIDS Prevention and Control Programme. Through GFATM, all HIV-positive individuals in Georgia who are diagnosed with AIDS will receive Highly Active Antiretroviral Therapy (HAART) as well as other services, such as testing for ARV-resistant strains of HIV. ARV treatment costs an estimated \$1600 to \$2000 per patient, annually. As is the case in many countries, the availability of HAART may shift the public perception on HIV and AIDS from a deadly disease to a dangerous, but manageable chronic infection. In turn, more individuals might actively seek VCT services. When ARVs become readily available, a critical component of care, support, and treatment services will then become "treatment education".

Recommendations

- As the prevalence of HIV is low but the risk of spread of the HIV epidemic is relatively high, a key component of HIV prevention interventions in Georgia should be public education and information, and most importantly, education that targets youth. Cultural and age appropriate informational/educational campaigns should be developed, piloted and implemented.
- School-based youth educational programme curricula with relevant educational materials should be developed with wide participation of all main stakeholders: Ministry of Education, Ministry of Health, teacher and parent associations, religious leaders, and the public at large. These materials should be tested in urban and rural school pilot programmes. Finally, parents and teachers should be actively involved in curriculum review processes.

- In order to control the epidemic among key population groups (IDUs, CSWs, MSM) special prevention programmes must be implemented on a wider scale (harm reduction, outreach, IEC interventions, counselling and testing, peer education).
- The state must ensure that medical personnel (physicians and nurses) are adequately trained and educated about HIV and AIDS through postgraduate training courses. (The level of awareness about HIV and AIDS among nurses is quite low; Goodwin et al., 1999.)
- Special attention is required for HIV prevention among migrant populations. Information/education interventions that meet the linguistic needs of targeted populations, such as the distribution of relevant pamphlets and condom promotion campaigns at the country's borders for migrants, are necessary.
- HIV prevention interventions are needed in Georgia's penitentiary system. Such interventions should target inmates who use injecting drugs, and promote needle exchange, information, education, counselling and voluntary testing.
- Advocacy interventions are necessary to create a supportive legislative environment for implementing effective HIV prevention activities targeting key populations. In addition, relevant institutional capacities should be developed.
- Certain cultural beliefs and practices common in contemporary Georgian society present possibilities for innovative interventions. As has been stated here previously, IDUs in Georgia are the most at-risk group. In addition, among some of the Georgian youth, the social image of a drug user is quite attractive, or at least, not an image that is hated or avoided. It may be useful to develop a wide – perhaps a pilot – programme aimed at counteracting this image, in order to de-popularise drug use. Here, the church could have a positive influence.
- Members of the mass media in Georgia should be trained on HIV- and AIDS-related issues, with full consideration of, and respect for, human rights and confidentiality issues. Advocacy is needed to promote interest among the mass media for broadcasting HIV prevention information on a wider scale.

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Annex I: Biography of Authors

Chief Scientific Consultant

Cynthia Buckley received her master's degree in Russian and East European Studies in 1987 and her Ph.D. in sociology in 1991, both from the University of Michigan at Ann Arbor. She is currently an Associate Professor of sociology and a Centennial Fellow at the Institute for Innovation, Creativity and Capital at the University of Texas, Austin where she is also the Associate Chair of the Department of Slavic and Eurasian Studies. Dr. Buckley teaches courses related to social demography, development, and methodology, and her main area of research interest is on issues of population change and adaptation in transition economies. She is a former executive board member of the American Association for the Advancement of Slavic Studies, and currently serves on the Social Science Research Council Eurasia Fellowships Committee and The Caucasus Research Resource Center's International Advisory Board. She is also a member of the editorial boards of *Slavic Review* and *Sociological Research*, and a vice president of the Association for the Study of Nationalities. Her research has appeared in *Slavic Review*, *Population Research and Policy Review*, *International Migration Review*, *Studies in Family Planning: Continuity and Change*, *Central Asian Survey: Women and Aging*, *The Journal of Gerontology*, and several other edited volumes. Dr. Buckley's current research projects include: assessing data quality issues relating to the 2002 Russian census (with Dominique Arel and Valerie Tishkov); directing (with Blair Ruble) a Kennan Institute/U.S. State Department working group on migration issues in Eurasia; and a multi-method investigation of changes in family structure and health in Central Asia. Throughout 2004, Dr. Buckley served as the scientific consultant for a UNESCO/ Flanders FIT project that assessed the social and cultural correlates of HIV/AIDS risk in the countries of the southern Caucasus.

Arshak Papoyan received his MD from the Yerevan State Medical Institute, Department of Medical Prevention, in 1999. In 2004 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 department of sociological research at 'ALM-HOLDING LTD.' She also works on the daily information broadcast, 'Press review.' She also provides care and support to PLHIV and she was a co-organizer of research on the project: 'The quality of life of People Living with HIV/AIDS' sponsored by the Real World, Real People NGO/National Center for AIDS Prevention. Her main areas of professional interests are social marketing, public relations, political sociology, human rights, and sociological methodology.

Leyla Ismailova graduated from Columbia University in New York with a master's degree in social work in 1999. She also has a master's degree in psychology from Baku State University, Baku in 2002. She is the head of the Center for Psychological Counselling, which provides psychological and counselling services to adults, children, and their families, and also teaches at Baku State University, in the Department of Social Sciences and Psychology.

Tair Faradov graduated with a master's degree in psychology from Moscow State University (1979) and received his Ph.D. from the Institute of Philosophy and Law at the Azerbaijan Academy of Sciences (1987). He has 25 years of experience working in the fields of sociology, political science, and conflict resolution. He is a senior research fellow in the Department of Democracy and Civil Society Studies and the Department of Peace and Conflict Studies at the International Center for Social Research (ICSR), Baku. Dr. Faradov has completed more than ten research projects and received several research grants and fellowships from the John D. and Catherine T. MacArthur Foundation, Open Society Support Foundation (RSS/OSSF), IREX, NATO, and the United States Information Service. In 1997 he was a visiting scholar at the Center for Near Eastern Studies, University of California at Los Angeles (UCLA) .

Telman Guluoglu Magerramov graduated from Azerbaijan Medical University in 1994. Since that time he has worked as a medical officer at the military hospital in Garabakh, Azerbaijan. In 2000, he joined the National AIDS Center in Baku as head of the epidemiological department. In 2002, Dr. Magerramov co-authored the first epidemiological and behavioural surveillance survey for HIV infection among injecting drug users and (female) sex workers in Azerbaijan, a project overseen by the National AIDS Center, with the support of WHO.

Ketevan (Katie) Stvilia is the Head of the AIDS Prevention Department, Infectious Diseases, AIDS and Clinical Immunology Research Centre (Tbilisi). Dr. Stvilia has a master's degree from the Robert Wagner School of Public Administration, New York University, New York, NY (1998) and was an Edmond Muskie and Freedom Support Act Fellow. Her main areas of interest are HIV/AIDS prevention and control policy, HIV/AIDS behavioural and epidemiological studies, and health care system reform. Her major accomplishments include implementing modern HIV/AIDS prevention methodologies and active involvement in UNAIDS-supported strategic planning on HIV/AIDS in Georgia, including a Situational Analysis. Dr. Stvilia is a co-author of the Global Fund to Fight against HIV/AIDS, Tuberculosis, and Malaria's (GFATM) Georgia country proposal, which received a 12 million USD award from the fund for 2003-2007.

George Nizharadze received his Ph.D. from the Scientific Council of D. Uznadze Institute of Psychology, Georgian Academy of Sciences (1985). He is the head of the Laboratory for the Psychology of Culture at the D. Uznadze Institute of Psychology, Georgian Academy of Sciences (Tbilisi). He is also the head of the research group at the International Centre on Conflict and Negotiation, and a lecturer in social and cross-cultural psychology at the I. Javakhishvili Tbilisi State University, Tbilisi State Polytechnic University, and I. Chavchavadze State University of Foreign Languages and Culture. He has participated in two HIV/AIDS-related international research projects: Social Representation of HIV/AIDS in Central and Eastern Europe (1998-99) and Knowledge of HIV/AIDS: Social Representations of Risk and Sexual Activity Amongst Schoolchildren and Homeless Adolescents in Russia, Georgia, and Ukraine (2001-03).

Khatuna Todadze received her M.D. from Tbilisi State Medical Institute (1989) and her Ph.D. on substance abuse (addictology) from Tbilisi State Medical Academy (1999). She is the Scientific Director of the Georgian Institute on Addiction, and an associate professor of the Chair of Narcology at the State Medical Academy. Dr. Todadze is an expert on drug addiction for the Ministry of Health's National Focal Point on Drug Demand and Coordination. Her main areas of interest are epidemiological studies on substance abuse and related harm, psycho-social aspects of drug addiction in Georgia, implementation of modern methods of prevention, and treatment of drug addiction. Dr. Todadze has participated in several projects concerning HIV/AIDS epidemiology and prevention, including a Situational and Response Analyses on HIV/AIDS in Georgia (2000-2002). Since 2005 she has been the coordinator of the first substitution therapy programme in the country under the framework of the HIV prevention project of the GFATM.

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