HIV and AIDS in Azerbaijan:
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.

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Representative of the Flemish Government
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Foreword

The Azerbaijan national report presented here was prepared with the support of UNESCO and Flanders government, and takes a socio-cultural approach in its analysis of the current status of the HIV epidemic. It was developed within the framework of a project that focuses on the sub-region of Southern Caucasus: Armenia, Azerbaijan, and Georgia. This sub-regional approach makes sense because these republics share many of the same traditions, have a similar outlook on life, and also experience similar social and economic problems. The main distinction between Azerbaijan and Georgia/Armenia is religion: Azerbaijan is mainly Islamic, while Christianity is dominant in Armenia and Georgia.

Military conflicts have left one out of every eight people in Azerbaijan an internally displaced person (IDP) or refugee, and a significant sector of the population works either as a seasonal labour migrant or has permanently emigrated. Both groups play a key role in how the HIV epidemic has developed in Azerbaijan.

As of 1 January 2005, there were 721 registered HIV cases in the country. Of those, 65 developed into AIDS, and there were 63 AIDS-related deaths. However, the more realistic number of people living with HIV in Azerbaijan – according to local and international experts – is ten times higher than the official number.

Azerbaijan is currently facing a ‘concentrated’ HIV epidemic; it is (mainly) confined to distinctive social groups – IDUs, CSWs and MSM – that are marginalized by society and rejected by religious figures for what is seen as their ‘non-conformity’ with the rest of the country.

Since 1996, the Azerbaijani government has had in place a ‘National Strategic Programme on HIV/AIDS Prevention,’ which officially places HIV and AIDS at the top of the state’s priorities. In 2002, the inter-ministerial ‘National Commission on Prevention of HIV/AIDS’ was established. Azerbaijan is also a signatory to the UN Declaration ‘Global Crisis - Global Actions,’ as well as the Programme of Urgent Actions of Members of the Newly Independent States. Unfortunately though, due to social and economic difficulties and ongoing conflict situations, Azerbaijan’s HIV and AIDS-related programmes do not receive sufficient funding.

The Azerbaijan AIDS Center focuses its attention on the education of teenagers, students, key populations at particular risk to HIV, and finally, the general population. To reinforce the promotion of public health, in 1997 and 2002, all administrative areas (regions and cities) established 24-hour anonymous counselling services, with pre- and post-test counselling. In addition, every Azerbaijan citizen, irrespective of where they live, is eligible to receive anonymous and free HIV testing.

Since 1997, the Azerbaijan AIDS Center, in conjunction with World AIDS Day, has devoted the first ten days of December to a series of HIV-awareness events, including concerts held under the slogan ‘Azerbaijani Stars against AIDS’ that are attended by official representatives, the media, and youth. Every year the Center publishes hundreds of articles, gives interviews, assists local newspapers with journalistic research, issues quarterly press releases, and conducts competitions for ‘the best article’ related to the AIDS issue. It also runs awareness-raising campaigns in bazaars, railway stations, metro stations, and prisons, and educates people through innovative approaches like its ‘Journalists against AIDS,’ and ‘Cartoonists and Humor against AIDS’ competitions. The Center also has a mobile team for HIV testing.

In their research, the Azerbaijan expert group that drafted this country report touched on some important cultural issues that deserve further consideration. I'm sure that in the future it will be possible to devote more attention to each aspect.

Dr Galib M. Aliyev
Director of the National Center in Response to AIDS
Azerbaijan

Preface

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

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

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

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

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

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

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

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

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

different disciplines: sociology, epidemiology, drug-related treatment and care, psychology, etc.

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

This publication presents the full-length review of the current situation of the epidemic in Azerbaijan from a socio-cultural perspective.

The full-length reviews for Armenia and Georgia, as well as summary reports for all three countries and a comparative analysis, are available in separate publications.

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

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

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

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

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
CBO	Community-based organisation
CDC	Center for Disease Control (USA)
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
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
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IDP	Internally Displaced Person/People/Population
IEC	Information Education Communication
IGO	Inter-Governmental Organization
IOM	International Organization for Migration
IRC	International Rescue Committee
MSM	Men who have Sex with Men
MTCT	Mother-To-Child-Transmission
NGO	Non-Governmental Organization
PLHIV	People/Persons Living with HIV
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VC(C)T	Voluntary (and Confidential) Counselling and Testing
WB	World Bank
WHO	World Health Organization
WV(I)	World Vision (International)

Map of Azerbaijan

HIV and AIDS in Azerbaijan: A Socio-Cultural Approach

T. Magerramov, L. Ismayilova, T. Faradov

PART I: HIV and AIDS overview in Azerbaijan

I.1 HIV prevalence and major trends

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[1]; of this group, 109 people have developed AIDS and 66 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, Aliyev, Imanov, Sadigova, Magerramov, Mahmudova, 2003).

Main modes of transmission
Azerbaijan is currently facing a 'concentrated'[2] 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 reported 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 1% of cases; mother to child transmission (MTCT), 1.3%; and via blood transmission, 0.1%. It is worth noting that in 26% of the cases, the source of infection is unknown[3] (National AIDS Center, 2004).

Table 1: Main Modes of HIV Transmission

HIV transmission	%
Injecting drug use	47
Unprotected sexual practices (Heterosexual)	26
MTCT	1.3
Unprotected sexual practices (MSM)	0.4
Blood transfusion	0.1
Unknown	26

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.

[1] Due to objective circumstances (the status couldn't be confirmed because the tested individuals did not come back for follow-up testing) demographic statistics of 485 positive ELISA test result cases from 1997 through to 2004 could not be obtained. Also HIV cases disclosed during first epidemiological in 2003 and behavioural surveillance in Azerbaijan were included.

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

[3] 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.

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. In fact, current data and behavioural and social trends indicate a very high probability for further growth of the HIV epidemic; its evolvement might be explosive (UNAIDS/WHO, 2004).

For the general public, HIV and AIDS are associated with 'immoral' behaviour. Therefore, the majority of people, although aware of the illness, do not acknowledge a personal risk of HIV infection or practice preventive healthy life skills. During the first few years of the epidemic in Azerbaijan, it seemed at the surface as though HIV affected only certain key populations (IDUs, CSWs, and MSM; all marginalized social groups). However, with time, reported HIV cases among children and other individuals who are not part of these marginalized populations proved to the public that risk to HIV is not restrictive to these key populations.

In 1997, the UN conducted an analysis of the situation in order to determine the main factors that are driving the spread of HIV in Azerbaijan. This analysis demonstrated that the existing low level of HIV prevalence – without critical measures to prevent it – might significantly increase. One of the recommended measures is strengthening the National Blood Bank to ensure the prevention of HIV transmission through blood transfusions.

If one only looks at official statistics, one can make false conclusion that the current rate of HIV-infection in Azerbaijan is low. With strong confidence, we can say that the number of disclosed cases of HIV-infection is only a small part of the real number. Despite this, there is still a possibility to slow down the HIV epidemic with a complex response that involves prophylactics, treatment, and social, economic, and legal steps.

I.2 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. In seven families, both parents and a child are HIV-positive; in forty families, the husband and wife are; in 104 families, only the husband is; and in eight families, only the wife is HIV-positive.

Ninety-two percent (92%) of PLHIV are of working age. 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; see Table 2) (National AIDS Center, 2004).

Table 2: HIV prevalence according to age groups (National AIDS Center, 2004)

Age range	% of PLHIV
0-7	1.3 %
15-19	1.6%
20-24	10.94%
25-29	22.26%
30-39	43.1%
40-49	13.2%
50-59	1.6%
60-69	0.9%
>70	0.3%
unknown	4.8%

76.4% 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 unprotected heterosexual sexual contact, primarily from their drug injecting or migrant life partner (National AIDS Center).

Cases of HIV infection have been identified in all administrative regional districts of Azerbaijan; 44.4% of all PLHIV live in the capital city of Baku. However, Baku is the largest city in the country (estimated 2.5 million residents; about 30% of total population of Azerbaijan) and some cities in the south close to Iranian border (Lenkaran) have formed epidemic centres. In Baku the highest prevalence districts are Yasamal and Sabunchi. According to national experts, it is important to work in the zone of potentially 'high risk,' such as the Sumgayit, Gandga, and Lenkaran (these are the largest cities; they are more industrially developed and have high rates of drug use).

I.3 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. Not surprisingly, the policy change 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 elevated risk for HIV and STIs. Out of the 960,000 tests conducted between 1997 and 2004, 695 new HIV cases were registered (about a 100-fold rate increase; National AIDS Center, 2005).

In 1997, due to a lack of financial resources, it was decided to discontinue widespread testing and focus more on key populations (at higher risk) who were tested voluntarily and free of charge (pregnant women, all IDUs in prisons, TB patients, people diagnosed with STIs are urged to undergo HIV testing, but not mandatory). Although mandatory testing only applies to blood donors, testing is recommended (often resulting in HIV testing) to registered IDUs, IDUs seeking treatment, those testing positive for STIs, and prisoners.

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.

I.4 Socio-economic factors

Azerbaijan is geographically located at the shore of Caspian Sea in the eastern part of South Caucasus. It shares borders with Iran, Armenia, Russia, Turkey, Georgia, and a seashore with Turkmenistan and Kazakhstan.

The Great Silk Road passes directly through Azerbaijan, whose location in the eastern part of South Caucasus, has historically made it one of the main transport corridors between Asia and Europe. The rise of substance abuse and commercial sex work, 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 country temporarily to help build the BTC oil pipeline (Baku, Azerbaijan – Tbilisi, Georgia – Ceyhan, Turkey) and the Baku, Azerbaijan –Arzurum, Turkey gas pipeline.

I.5 Key populations vulnerable to HIV

In general, there are not enough empirical materials in Azerbaijan on the status and dynamics of the HIV epidemic among key populations. Nevertheless, the National AIDS Center, with the support of WHO, has conducted the first HIV epidemiological and behavioural surveillance survey of IDUs and CSWs. The location of research was Baku and Lenkoran – the leading cities for HIV-infection. The research was anonymous and anyone who wanted to know their HIV-status was given a special code. Test participants could then contact a 24-hour consulting service and find out the results. Thanks to this surveillance survey, the HIV epidemic was found concentrated in certain social groups at particular risk to HIV.

I.5.1 Injecting drug users

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 reported HIV cases.

According to the Republic Drug (Narcology) Dispensary[4], 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 clinics[5] or police (Abdullayev & Nasibov, 2004). Therefore, it is thought that the real number of drug users in Azerbaijan is even higher (UNAIDS/WHO, 2004).

IDUs receive free treatment from state drug clinics and anonymous substance abuse treatment rooms at polyclinics. Seeking treatment does not lead to legal punishment. Medical and psychological treatment and rehabilitation are available at the clinics.

Despite the fact that official statistics do not reflect the real situation, they still show that the vast majority of drug users are in Baku and in the south of country, in Lenkoran. Widespread use of drugs in Baku (total population of the city is over 2.5 million, as per unofficial statistics) and in Lenkoran, can be explained due to it's the borders with Iran.

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 possibility to accessing drugs, have led to an increase in injecting drug use and consequently, a heightened risk of HIV.

Unemployed people – 76% of IDUs (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.

[4] The Narcology Dispensaries (or Drug Clinics) in Azerbaijan are state agencies.
[5] 'Narcology clinic' is a regional term referring to health institutions that provide drug-related treatment and care.

Drug use is much lower among women (5%, Abdullayev & Nasibov, 2004) than among men, is due to strong traditional gender roles as well as the bigger stigma associated with female drug use. Unfortunately, as a whole, there is not enough research on Azerbaijan youth to get an accurate picture of this group's use of injecting drugs.

Drug consumption is growing widely in the regions of Azerbaijan. In analysing the results of a 2001 survey among drug users ('Anti-Narcotism' International Scientific and Analytical Center), 15.3% of respondents who use drugs said they were unaware of the harms of drug addiction; 26.4% said they were influenced to use drugs by their friends; 30.6% said they were just interested in it; 27.7% mentioned difficulties in their lives.

44.7% of drug users acknowledged that drug use goes against national traditions, and 3% did not see something wrong with this. The most-often cited reasons for the growth of the narcotics industry were: the complexity of the social-economic condition, unemployment and poverty (49.7%); the chance to increase income (30.1%); the weakness of the government's fight against drug use (12.7%); and the expansion of links with other countries (9.3%). Asked who is at fault for the observed rates of drug use, 33% of participants singled out the indifference of parents to the fact that young people became drug users; 36.1% (40.2% among youth) lay the blame on sellers and drug distributors, and 19.8% (16.1% among youth) blame friends who persuaded them to consume drugs.

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.

Young people are more vulnerable to narcotics because they are more easily influenced by peers. In recent years, narcotic use has acquired a small amount of social prestige and authority, and it has become very 'modern' to use drugs. Young people often start using drugs out of fear of otherwise 'falling out' of a particular social 'circle.' In the environment of the group, the use of an individual syringe might seem inappropriate. More than that, in cities and especially in rural areas since the beginning of the 1990s, the number of sport and hobby clubs has significantly decreased. But in recent years there have been observable and substantial positive changes in youth involvement in out-of-school activities.

The first case of HIV among IDUs was registered in 1995. WHO provided financial and methodological support for an epidemiological and behavioural surveillance survey 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) (Kasumov et al., 2003).

Following analysis of HIV tests of 200 IDUs in Baku revealed 13% (26) were HIV-positive, 52% (105 individuals) tested positive only to hepatitis C, and 11% (22) had a 'mix-infection' (HIV and hepatitis C). A similar test of 200 IDUs in Lenkoran revealed HIV infection in 19.5% (39), out of which 92.3% (36) of them had the antibodies to the hepatitis C virus. 57% (114 out of the total 200) were infected only with 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 the 200 IDUs used drugs when alone, and only 17% used sterilized syringes. Although almost all 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 percent (77%) of those IDUs

surveyed who are HIV-positive report sharing syringes and needles. Syringes are quite cheap (0.04 USD per syringe) and are available at any pharmacy.

The prevalence of HIV is twelve times higher among the so-called 'street IDUs' than among IDUs who have registered with narcology centres, indicating that the main part of the 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 and less practice in sharing needles. 53% of all IDUs (and 38.5% of HIV-positive IDUs) are, or were at some point, migrants living outside the country for a significant length of time within the five years previous to their diagnosis.

The major risks associated with injecting drug use are the usage of shared syringes and needles as well as the use of substances (drugs) contaminated with HIV during the preparation process. Drug users usually use amateurish prepared drugs in the form of a solution (the main injecting drug is heroin). The low educational level of most drug users, as well as their sexual behaviour patterns, may further facilitate the spread of HIV among drug users and the spread of the HIV epidemic in general, as these two factors may lead to continuous practice of non-preventive and risky behaviour in the preparation of and the usage of narcotics.

Not all IDUs are aware of the modes of HIV transmission and that it is possible to prevent HIV. The majority of IDUs (79.7%) consider it impossible to avoid infection. This is related to inadequate information on HIV and AIDS. HIV- and AIDS-related awareness-raising campaigns targeted at IDUs are few in number and non-systematic, organized by some local NGOs (see below).

Drug and alcohol use is closely linked to unsafe sexual behaviour, and this in turn, increases the risk that IDUs 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 survey showed that only 8% of IDUs had used condoms during a recent week and only 12% had used a sterile syringe during their last injection.

Even though condoms are available in drug stores, the low number of purchased condoms is mostly related to moral obstacles; people feel shameful buying condoms in drug stores. For IDUs this is a more critical problem.

Over half (61.5%) of HIV-positive IDUs have sexual partners; 44.5% of those 61.5% report having regular sexual partners, while the remaining report having casual sexual partners, or partners involved in commercial sex work, regardless of their marital status. 170 out of 200 know that condom use can prevent HIV. However, only 2-7% reported using them with their regular or life partners or when with a sex worker. The usage of condoms is lower in the regions. Thus, not only IDUs, but also their sexual partners, including wives, are at a very high risk of HIV. 69.5% of IDUs have never undergone a medical examination. 13.2% of those IDUs who did seek medical counselling were diagnosed with tuberculosis (47%), HIV (11.3%), STI (34 %) and hepatitis 19.5% (Abdullayev & Nasibov, 2004).

As a whole, 45.8% of surveyed IDUs have some information on HIV and AIDS (drug users from Baku are comparatively better informed, 68%). But 24% of all IDU have false or insufficient information on HIV-transmission methods. The majority got their information from peers, medical personnel or the mass-media (Abdullayev and Nasibov, 2004).

Individual risk behaviour factors are accompanied by the risk associated with the public attitude toward substance abuse and especially toward drug users. 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' in the clinic and police[6] discourages users from visiting medical facilities, leads to distrust of doctors, and reduces their access to treatment and prevention methods. (In accordance with current legislation, any drug user who enters a medical institution is urged to undergo voluntary HIV testing.)

Due to fear of possible rejection by society after disclosing their drug use, the majority of IDUs do not apply to medical clinics and tend to receive anonymous treatment. Furthermore, HIV testing is very low among patients who receive anonymous drug treatment, especially in the regions.

All of these factors increase the risk related to drug use and promote absence of comprehensive information on drug situation in the country. Therefore, it becomes very hard to maintain statistics and monitor the spread of infections such as HIV, hepatitis, and STIs, especially in the regions.

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 only two local NGOs – the Anti-Narcotism International Scientific and Analytical Center and the Azerbaijan Association of Public Health, funded by the Open Society Institute/Soros Foundation (OSI) – have been running needle exchange programmes as a part of broader harm reduction programmes**.**

However, the implementation of harm reduction programmes is complicated by the current legislation. Because of fear of being exposed and undergoing HIV testing, many do not try to get medical assistance in drug-related treatment clinics and thus remain unaware of their HIV (and general immune system) status. This increases the risk of infection to sexual partners and people who practice drug use in groups. Nevertheless, the existing number of programmes and organisations working on drug and HIV prevention is insufficient to respond to 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.

The high prevalence of HIV and hepatitis C among IDUs enable us to envisage the trends and scales of HIV spread in Azerbaijan. The fast rate of infection among drug users will continue if certain preventive measures are not implemented.

Support programmes for treatment of dependency, psychological and social assistance and adaptation of people suffering from addiction are still not wide spread in the country. The lack of effective treatment and rehabilitation programmes further limits their access to services. In cases where drug users receive medical treatment, psychological treatment services are often also unavailable (due to lack of funding and insufficiency of trained staff).

Also, there are not sufficient awareness programmes for IDUs aimed at increasing their level of knowledge, and most importantly programmes aimed at helping IDUs make behavioural changes.

[6] All IDUs who requested treatment from the State Drug Dispensary are not registered by police; only those who were charged with a crime – drug sale – are registered by police.

Due to financial difficulties, the majority of IDUs are not able to get quality treatment and rehabilitate themselves.

In addition, it is necessary to continue researching behavioural characteristics of IDUs with the aim of better determining the social factors and conditions that promote the spread of HIV infection. This is a necessary step in the design of effective responses.

I.5.2 Commercial sex workers

Poor economic conditions and a lack of well-paid jobs or alternative employment opportunities, especially for women, are undermining the local traditional values and family relations. Desperate conditions have forced an increasing number of people to seek alternative sources 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.

When studying the epidemic situation on HIV infection in Azerbaijan, it is necessary to more thoroughly determine the main trends, behavioural aspects, and leading factors of HIV infection among sex workers (mainly women). The ratio of HIV-infected men to women in Azerbaijan is 4:1. This low indicator of exposure among women does not reflect the reality, however, because there is no mechanism to test CSWs. Currently, only patients with STIs who apply to state medical institutions are (voluntary) tested for HIV. Patients of private skin and venereal disease clinics are not tested for HIV, further complicating the collection of reliable data on the HIV epidemic and other STIs. The private sector, as a rule, is not reporting to the Republican Skin and Venereal Diseases Dispensary.

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 were between the ages of 20 and 30 (64.5%; 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%). Usually their ex-husbands are in prison, unemployed or use drugs.

Out of the 200 CSWs surveyed, 17 (8.5%) were HIV-positive and 146 (74%) had other STIs – syphilis (9%) and Chlamydia (63%) (Kasumov et al., 2003). 86% had never used condoms during sexual contacts and none of the surveyed 17 HIV-positive CSWs used condoms during their most recent sexual contacts. 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.’ Exposure to HIV infection among ‘street sex workers’ is 35% higher than CSWs working in pubs, cafys and saunas.

Out of 17 HIV-positive sex workers (women), 16 had symptoms of other STIs. These women do not seek out venereologists or other forms of treatment, and therefore increase the possibility of transmitting the infection to their clients.

In Azerbaijan, especially in rural areas, the majority of women are expected to provide domestic care to their families and are financially supported by their husbands. 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 earning money.

The influx of a considerable number of well-paid foreign workers (2,500 according to the State Statistical Committee, 2004) 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.

There are many complications when it comes to prevention and care activities with CSWs, which not only makes any access to this group very difficult for researchers, for preventive work, but also creates difficulties with their access to adequate medical aid.

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. It is also important to mention the low level of trust that CSWs have of specialists (medical personnel).

Another consequence of the impoverished conditions has been a rise in human trafficking. According to the International Organization for Migration (IOM, 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 other former Soviet countries (Russia, Ukraine, and Uzbekistan) are usually trafficked to Turkey and the United Arab Emirates.

The plethora of advertisements in Azerbaijan offering well-paid jobs for women abroad has raised serious concern within official institutions in the country, as well as international organisations such as IOM, emphasising the need for the coordination of activities by various agencies for an organized fight against trafficking and human trade.

I.5.3 Men who have sex with men

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 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.

There exist no surveys regarding MSM and HIV and AIDS that offer information on behavioural patterns of this key population. There is also no information on any particular activities to specifically reach out to this group.

I.5.4 Prisoners

Of all the current registered cases of PLHIV in Azerbaijan, 72% have a history of imprisonment (National AIDS Center, 2004). During the last two years, 4,000 prisoners (primarily IDUs) have been voluntarily tested for HIV after discussions on HIV prevention.[7]

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 and using of common syringes for injecting drugs, coercive or voluntary same-sex sexual relationships, tattooing).

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

Effective prevention and care activities usually mean working in difficult situations and conditions such as unsanitary living conditions and inadequate medical. 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 in prisons: HIV prevention and harm reduction programmes and distribution of condoms, peer education for IDUs, HIV counselling and testing, training of administration and personnel, and if needed, where possible, supply institutions with sterile needles or sterilisation substances.

I.5.5 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% 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 group for HIV and AIDS prevention, treatment, support, and care programmes.

In the current difficult social circumstances, many young adults assume the responsibility 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 youth in Azerbaijan are 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 risk behaviour varies. These differences have to be considered in the development of prevention programmes for youth.

Most youth in Azerbaijan have been raised in traditional families and grown up in quite a conservative social environment. Their behaviour is controlled by family members and other social institutions (relatives, neighbours, public opinion, etc.) who consider this close monitoring 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 behaviour that may put them at risk for 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 of HIV. In reality, however, fewer prejudices encourage openness to knowledge about HIV and AIDS, which in turn may reduce the risk of infection.

I.5.6 Migrants

The insufficient number of employment opportunities, and the traditional expectation that a man should provide for his family, is the main factor why a very large number of men temporarily migrate to neighbouring countries (Russia, Ukraine, and Turkey) in search of jobs (Thouth, 2004). The majority of them are men aged 20-40 who live abroad or are constantly looking for employment for several months – some, even several years.

Currently, the migrant population constitutes a substantial part of all registered PLHIV in Azerbaijan – 43%, or 299 people (National AIDS Center, 2005); more than half of women living with HIV in Azerbaijan were infected by their migrant husbands (National AIDS Center, 2004).

Living abroad for months or even years at a time, and being away from their families and social networks, 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, they increase the risk of transmission to their sexual partners. Many unmarried young people who go abroad to find work and improve their financial status, return to their native country to get married, which increases the possibility that if HIV-positive they will transmit HIV to their future partners.

The situation is complicated by the fact that, due to deep-rooted perception and false shame neither women (fiancyes, wives) nor their families ask future husbands who have been working abroad for an HIV test and/or confirmation of their HIV status. Moreover, there are no compulsory mechanisms for submission of papers that declare the HIV status of people living for a long period abroad who would like to get married.

In addition, people involved in ‘pendulum’ migration – people who go abroad for two or three months at a time, and have casual, short-term relations before returning to their families in Azerbaijan – are more at risk of passing on transmitting HIV to their original partners than people who establish stable, ‘second families’ abroad, and send back money to their first families but don’t necessarily return for long periods of time.

Despite financial difficulties and rampant unemployment, the general consensus is that men are solely responsible for the economic welfare of their families; this is an additional reason for men to search for alternative sources of income and leave the country to try and earn money abroad, often accompanied with a lack of concern about their own sexual health.

I.5.7 *Refugees and Internally Displaced People*

As with any group of people living in very difficult and unfavourable socio-economic and psychological conditions, refugees and IDPs (about 1 million, or 13% of the total population; UNDP Human Development Report, 2003) are very vulnerable to different infectious deceases, including HIV. The 17-year-long Armenia-Azerbaijan conflict over the Nagorno Karabakh region continues to have a significant effect on the socio-economic and psychological conditions of Azerbaijan’s people.

Even though the current HIV prevalence among refugees and IDPs is relatively low (fifteen 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 elevate their vulnerability to HIV. All these factors and the difficult living conditions stand to have a serious effect on the future evolution of the epidemic among this population.

Firstly, the existence of about 1 million refugees and IDPs sharpened the problem of unemployment and competitiveness in the workplace in the regions where they are temporarily settled, especially among men (UNDP, 2003). With a high unemployment rate, refugees and IDPs are engaged to a large extent in labour migration (ibid). Male refugees and IDPs constitute the greatest number of unemployed and therefore form the majority of labour migrants.

Furthermore, refugees and IDPs have mostly settled in regions that are unprepared for such a large population influx, and regions that have an undeveloped social infrastructure. 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). Despite these steps, proper access to quality social and medical services, and in particular access to HIV prevention and care, remains low.

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 organisations, have been conducting HIV education programmes and running contraception-awareness campaigns in refugee communities for the last few years. Even though 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 never heard of HIV or AIDS (CDC, 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.

Also, national programmes to disseminate information about: HIV and AIDS; prevention and treatment methods; other HIV and AIDS-related programmes; and emergency situation responses, were not very well developed and as a result, information on HIV and AIDS was either lacking or not included at all.

Undoubtedly, the large number of refugees and IDPs is catalysing the process of HIV spread. In the ongoing efforts to prevent HIV it is necessary to consider the whole complex of objective difficulties that arose due to the Armenian-Azerbaijani conflict: difficult socio-economic conditions, the constant search for means of subsistence, and social and cultural discomfort has made this category of people very vulnerable to different negative phenomena indirectly related with their vulnerability to HIV. Experts have repeatedly underlined that while the million of refugees and IDPs (many of whom are still living in camps and temporary settlements in inappropriate socio-economic and sanitary conditions) still remains, it will be impossible for relevant organisations to respond to HIV and AIDS.

Below is an interesting excerpt from **an interview with the director of one of the NGOs directly working with refugees and Internally Displaced People**:

'I personally heard about HIV spread in our country 3 years ago. Being a citizen of this country, I was worried that there are people infected with HIV in Azerbaijan. I think that

we need to conduct education work both with women and men so that they know how this disease is transmitted which may have lethal outcome, and how people can protect themselves. Surely, this education work should be realized very carefully, considering our psychology and mentality. There are difficulties – they won't understand properly, they won't accept it. We need to determine some specific methods to deliver the facts about this human immunodeficiency virus.

There are different opinions about how HIV is now spread. A weak economic condition in the republic leads to the situation when some part of male population leaves the country to go to Russia, for example. There, without having any knowledge about [HIV], they […] become a risk group. […]

The community should take appropriate measures regarding this problem. Assume we – women – are trying to carry out education work in the city, in the regions where we mainly work, in the refugee camps. There are many state structures in the country, such as non-governmental organisations seriously dealing with this problem. I know that [some have] done this work with non-governmental organisations under the UNDP. Also I heard about [the International Federation of Red Cross and Red Crescent Societies], which work mainly with young people [and other international organisations]. However, to be honest, some programmes cover a very limited circle of people. It would be more beneficial if non-governmental organisations, which work in communities, carry out this education work there. […] And there is no high-quality medical service in small villages with small populations. It means there is no information on HIV and AIDS in these villages.

The fact that the refugees and Internally Displaced People are at [or below] the poverty line is also [an additional risk to] infection. I mentioned non-governmental organisations conducting more or less active work, but I think that all non-governmental organisations working in medicine, civil society and youth should get involved in this process. […]

Education programmes for women are necessary. Main and special programmes are also needed. So, if an education programme exists, women groups may prevent the risk of infection through the knowledge they will obtain. As a support to people with HIV there are actions, concerts and other events, even special movement among youth.

When some of us find out that the ones closed to them are infected with HIV, they break off any contacts with them. I think it is wrong to isolate a person from the society. […]

Trafficking of women is also a factor for the spread of HIV. [L]aws should be developed concerning trafficking and women being forced to travel abroad.

Alcohol use is another reason for HIV spread. […]

Education is important. It is a little difficult in the regions though. However, national non-governmental organisations, local non-governmental organisations should conduct education work, because only local non-governmental organisations can know the specifics of their people and can work out relevant methodological responses."

I.6 Socio-cultural context of HIV and related behaviour

The risk of HIV infection is closely tied to social and cultural norms, traditions, beliefs, values, and stereotypes. In particular, the perceptions of, and reaction to, issues related to sexuality (an issue not spoken widely in public) are related to cultural and societal norms and beliefs.

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 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 tend to hide their HIV status from others.

In Azerbaijan, traditional views on sexual relationship and behaviour prevail. So reticence, a sense of false prudence, and a double standard of 'morality' may show up not only in the family, but also outside it, when talking about intimate relations, which blocks the spread of reliable information on sexually transmitted diseases (and moreover, safe sex negotiation), even more so on HIV.

This also causes difficulties for conducting surveys when people refuse to answer private sensitive questions even if a survey is conducted anonymously.

Only a small part of the population believes that HIV and AIDS is a topic of discussion that can and must be discussed with everyone; moreover, they are convinced that *not* discussing it is the only way to prevent the spread of epidemic.

The current socio-cultural views and norms were formed long time ago and cannot be changed within a short time. In this regard, when designing a programme, special attention must be paid to the local peculiarities. Programmes must not be in conflict with existing norms and values.

For instance, programmes targeting children and teenagers – particularly when they cover sensitive issues and being conducted without consulting their parents – might be interpreted as an interference in the family, private lives, an obtrusion of alien norms of conduct and education, and finally result in the family's negative response towards the programme.

When discussing topics such as HIV and sex education, for example, pre-existing stereotypes influence people's reactions and they begin to think that 'it is too early' for children to know about sex, and 'is it worth to know at all?' This type of bias can be particularly encountered when working with young women.

The main reason for this reaction is that elder members of a family, being respected by others, take an active (some may even say, excessively active) part in the lives of younger members, and in this way restrict the latter's access to certain information, sense of independence, and responsibility for own behaviour. 'Excessive' custody by adults is a factor that impedes the dissemination of knowledge and information. However, not only restricted access to knowledge by adults, but also lack of reliable and accurate knowledge by adults on sexual issues directly relating to HIV is another serious issue that needs to be addressed. Moreover, as issues of sexuality are often considered taboo, adults feel uncomfortable discussing them, not only with children, but also with each other.

Obviously, in light of integration of Azerbaijan into the world community and globalisation processes – as well as progressively, with time and wider international contacts – conservative and traditional social directives, values and stereotypes will be changing with time; in particular, new ways of life and norms of behaviour are often adopted from other cultures. However, this process is very slow and mostly relates to the young generation living in the capital, rather than to the rural population.

Furthermore, certain elements of socio-cultural behaviour can become risk factors for infection. For instance, interfamily marriages (when a husband is a distant relative or cousin

of his wife) can still be encountered 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.[8]

The traditional widespread ritual of circumcision in Azerbaijan slightly reduces the risk of HIV infection (Gray, 2004).[9] However, there is a possibility of infection during performing the circumcision, as it is not uncommon in rural regions that boys are circumcised not by a surgeon in the hospital, but by the "legzi, a traditional master who performs the circumcision, at home in non-sterile conditions. It is also not uncommon that circumcisions of dozens of boys are performed at once in orphanages, using the same cutting instrument.

Thus, it is important to review and rethink some of the traditions that have been carried down through time. Probably, it is crucial to adjust some stereotypical thinking about social and cultural behaviour, to bring it in line with how life has changed, and also, approach some traditions more wisely, in light of the risk of HIV infection.

I.6.1 Family and gender aspects of HIV and AIDS

For Azerbaijanis, the family is a fundamental social institution. The Azerbaijani family is child-oriented, and establishing conditions for children's full upbringing, with respect to the family's home, is a higher priority for a married couple than their own interests.

The current number of HIV-positive men (76%) in Azerbaijan is much greater than the number of HIV-positive 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 'feminisation' of HIV occurring, the number of HIV-infected women in Azerbaijan seems set to rise and may lead to a change in the demographic picture of HIV and AIDS in the country.

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. While women are expected to follow such social principles as matrimonial faithfulness, men on the other hand are treated by the society with greater tolerance when they have premarital and extramarital sexual relations. For example, it is quite acceptable for a man to: start his sexual life early ('boy is not girl, he will not become pregnant'); have premarital sex ('he gains experience'); have extramarital sex; have a long 'service record' of sexual relations ('sign of machismo').

Women, not having the power to negotiate safer sex, are sometimes exposed to HIV from their husbands who, in search of work, leave the families for long periods. Upon return, if infected with HIV or another STI, they become a source of infection to their wives (and possibly their future children).

The culture of condom use also remains at a pretty low level. Frequently, use is determined not by general unawareness, but by different socio-cultural stereotypes (prejudices), norms

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

[9] Even though it has been shown that the cells found on the male foreskin, due to their membrane composition, may facilitate the transmission of HIV, male circumcision does not necessarily imply a means of prevention. If risk behaviour is continued by either circumcised or non-circumcised men, risk to HIV remains present. What may vary is the number of exposures to the virus before transmission occurs.

and conventionalities regulating family relations. Usually the use of condoms depends on a man's decision, whereas women can hardly influence this decision.

According to the National AIDS Center (2004), more than a half of all women living with HIV were not infected from a casual sexual partner or by taking drugs, but from their long-term partner or husband.

The general population often ignores or underestimates this important fact, believing that HIV threatens only those the society considers 'immoral' (CSWs, IDUs, MSM) and that the more traditional 'moral' way of life is the only means of prevention.

According to public opinion, virginity and chastity still play significant roles in the value scale. In Azerbaijan, virginity is still considered an important social measurer; it is an indicator of a girl's 'decency' and is considered a pledge of future marriage. This social attitude contributed to the fact that the majority of women report almost never having had any sexual partner other than their husbands.

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 (ibid). Nevertheless, they do take place as demonstrated in the UNICEF study (1999): 2% out of 200 teenage girls under 18 reported having premarital sex, and young people try to hide this fact in every possible way.

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.

I.6.2 Sexual behaviour and sex education

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 (IRC, 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 'at-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 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 (Akhundov, 2002).

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 shows that 44% of 7,668 female-respondents know how to use and where to buy a condom, however, only 3% confirmed that they use condoms in their sexual lives (CDC, 2001). One of the stereotypes hindering safe sex practices 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. The general idea widespread in the society is that ‘this is shameful,’ ‘indecent,’ ‘improper’ and ‘wrong.’ Discussions of people’s sexual life in public (community, educational institution, a private discussion within or outside the family) are quite restricted and considered unacceptable. Since sexual contacts are a prominent route of HIV transmission, HIV is therefore 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. Socio-cultural and psychological barriers, as well as psychological distance between parents and children, stipulate the existing bans against discussions of these issues in the family circle with parents.

For example, it is considered very ‘trendy’ among wealthy people in Azerbaijan to send their children for education abroad. Informal interviews conducted in the framework of this report with some of such parents revealed that none of them had given such ‘precautionary talks’ to their children about sex; they regarded it as unnecessary and useless.

As stated earlier, this ‘moral’ and psychological atmosphere blocks the dissemination of accurate and reliable factual information on sexually transmitted diseases, in particular on HIV.

There is also a general myth that sex education promotes ‘sexual depravity’ and encourages young people to ‘deviate’ from generally-accepted norms.

However, experts express a different view: that lack of awareness increases susceptibility to infection. People who receive accurate information about human sexuality have the necessary knowledge and tools to act more cautiously toward their sexual life and to practice safe sex.

Hence, such methods and approaches must be developed that, despite a lack of practice in discussing sex and HIV issues, will help parents to talk to their children about these topics. Young people must get knowledge on the issues and use preventive means, such as condoms.

Health protection and safe sex education, voluntary HIV counselling and testing, training people on how to openly carry on discussions of the issues, are all of vital significance in reducing young people’s risk to HIV.

I.6.3 Religion, HIV and AIDS

Azerbaijan is a secular state, but 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 STIs 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 the only means of prevention promoted is a ‘decent’ lifestyle. In interviews and discussions, religious figures have emphasised subsiding morality, breach of morals, dissoluteness and permissiveness as peculiar to the current transitional period. In addition to the negative attitude towards HIV, AIDS and PLHIV, poorly informed religious figures sometimes perpetuate distorted and even biased information.

This is of particular concern as religious figures are much respected in society, and their involvement in HIV prevention programmes and activities can have a significant influence on the level of attention these issues receive and on the formation of a unified public position on this vital problem.

Identification of a role for, and the involvement of, the Muslim community in activities aimed at preventing the spread of HIV can hardly be considered a simple task.

According to experts, religious figures in Azerbaijan have not been actively involved in HIV and AIDS issues so far. Nevertheless, there have been reported isolated events during which religious figures prayed for those who died of AIDS-related illnesses and gave moral support to PLHIV. But the number of organized, centralised and officially sanctioned religious initiatives and programmes related to the issue has not been sufficient.

This, to some extent, testifies to the fact that religious communities and organisations, as well as the society in total, being poorly informed on the disease, retain harmful and incorrect stereotypes and do not have a clear idea of the role of Islam and other religions in this problem.

Bearing in mind the increasing dynamics of the HIV epidemic in Azerbaijan, Islam can and must undertake more active measures, tailor all its efforts, and use all its available resources to help prevent the epidemic’s further spread.

The care of, 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 towards creating a more tolerant public attitude towards PLHIV.

Another important task for religious leaders is to be intensely involved in programmes, especially for youth, on prevention of drug use, alcohol, and by instilling directives on abstinence and faithfulness.

It is worth noting that some religious figures already actively work with drug users in centres for drug-related treatment and rehabilitation.

However, marginalized, key populations particularly vulnerable to HIV (IDUs, CSWs, MSM) may not be easily reached by prevention programmes organized by religious figures, since in most cases these people are not mosque- (or church or synagogue) goers and most likely do not turn to religious figures for advice. All of the above, combined with religion’s view of these groups, makes the work of religious figures with these groups of population complicated. Given the high HIV prevalence, however, among these social groups, especially IDUs, the necessity to reinforce and increase efforts to work with key populations – which often become social outcasts – is evident.

The organisation of HIV and AIDS prevention and education programmes, and activities by religious figures, should not be limited to the Muslim religion but expanded to other religions – Christian, Jewish – to end the stigma and discriminatory attitudes towards those infected and/or affected by HIV.

The first attempts to involve religious figures in HIV- and AIDS-related work 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 and AIDS.’ The project is aimed at involving Muslim and non-Muslim religious figures in HIV prevention activities in Azerbaijan (UNDP, 2004). Two sessions were carried out: a roundtable on ‘Response of religious communities to HIV and AIDS’ and a first stage of trainings on ‘Religious communities respond to HIV and AIDS.’

The training's main objective was to mobilize religious communities in the response to the HIV epidemic in Azerbaijan. Religious figures agreed that the best method is education. On the first day of training, general information on HIV and AIDS was delivered to the participants. The second day was dedicated to putting forward and discussing activities that must be implemented to raise the general population's awareness of HIV and AIDS.

After that, the participants learned how representatives of religious communities could be involved, how they would communicate the issues to their communities, and how Holy Scriptures will be used in HIV-prevention intervention. All participants concurred that religious communities must be involved in HIV and AIDS awareness-raising programmes.

Information on the HIV epidemic globally, its consequences, driving forces and means of prevention were presented to the participants of these two sessions. It was emphasized that religious organisations can and must play an active part in preventing the HIV epidemic. The reasons include their spiritual leadership, their ability to reach thousands of people throughout the country, the trust they are given and the long-term respect they have been shown.

Representatives of religious communities that are officially registered in Azerbaijan participated in these trainings. A similar training was held for representatives of non-Islamic organisations. More workshops were held in other regions of the country: Guba, Gandja, Ismayilli ('Echo' Newspaper, No. *145 (883),* 30 July, 2004*)*

However, although religion is being challenged to play a positive role in promotional and educational work, there are some deeply-held beliefs that must first change. That is why it is necessary to work with religious figures themselves on transforming their fixed beliefs and the stigma they attach to the disease and to PLHIV. Religious figures themselves must be free from stereotypes and prejudices before they can have a positive influence on the general population.

From an interview with one of the leaders of Muslim community of the Caucasus, the Chairman of Supreme Directorate of Caucasus Muslims, who took part in the training sessions mentioned above:

'AIDS is a serious problem both in the whole world as well as in Azerbaijan. If we look at AIDS from Islam point of view, AIDS is a punishment. If we look for the reasons behind AIDS, we will come to the common opinion that AIDS is a punishment for improper, and not pleasing to God, behaviour.

From my side, having an interest and being a participant of this round table, 'Fight against AIDS at school,' organized by Executive Power of Yasamal district, where we have participants from state agencies and police who talked about how this disease comes from illegal actions against the state as well as against religion, such as out-of-wedlock intimate relations and not knowing the basics of religion and the Koran. If more people pay attention to religion and try to learn the Koran, we could have avoided this.

We live in Azerbaijan – a Muslim society – but we have influence [from] Europe as well. I do not mean that if we would like to transform our country into a European state, we should bring to Azerbaijan depravity and walk half-naked. We should bring to Azerbaijan [a] healthy lifestyle and education, which exists in European states, and grab only [the] positive features of Europe. No doubt, that [the] question arises: 'What can we do [about the fact] that some people who pass [into] Azerbaijan's territory are the carriers of these diseases and they bring them into Azerbaijan? What can we do in this regard?' As a religious leader and on behalf of religion, what can I say about [the] spread of [HIV] in Azerbaijan? We religious leaders, including myself, are invited to various TV shows primarily linked to family relations and we give advice on proper family building. If today Azerbaijan people take [a] more serious approach to family building, learn what is 'halal' and 'haram,' then we will be able

to prevent the spread of the epidemic. Fortunately, the majority of Azerbaijan population are believers and they should understand that starting intimate relations with another person without Allah's permission is a sin. Also every Muslim man should start a family with a pure girl who knows her roots. And if he acts the way Allah says, establishes a family and relations […] in accordance with religion, he would then be able to avoid Allah's punishment, such as AIDS. As [a] religious leader I can only urge people and every Muslim to respect religion provisions and comply with them.

From our side, we try, and with help of the government, to assist in the resolution of AIDS problems. For example, there is a religious institute functioning in Azerbaijan and we invite people to utilize the graduates of that institute. We also suggest to open religious chair at the universities with the purpose of explaining [to] people [the] basics of Islam [….]

After studying at these chairs and in further employment, these people will stick to what was taught […] and will avoid casual relations and therefore we could stop [the] invasion of this disease. Thus, we take preventive measures in advance […].

It is important to connect kids to religion aimed to prevention of drug use. Very often kids are not listening to parents, but they might listen and pay attention to the words written in the Koran. For example, [if a boy knew] that smoking is a sin, he would not use drugs.'

Future activities targeted at religious figures should focus on issues of tolerance, acceptance and care for those infected and/or affected by HIV.

I.6.4 Public awareness of HIV and AIDS

The general population's insufficient level awareness about HIV and AIDS is one of the factors that may facilitate the rapid spread of the epidemic in Azerbaijan.

Overall, the general public mainly perceives of HIV and AIDS as a problem much more urgent for other countries (mainly the USA and Russia) than for Azerbaijan. The general population of Azerbaijan believes that in their country the prevalence of the disease is at a low level and that on the whole the situation in Azerbaijan is relatively secure and an acute HIV epidemic is not a likely scenario 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, 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 and 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.

The majority of the general public still consider HIV and AIDS as a 'punishment' for dissoluteness in sexual behaviour, drug addiction and commercial sex. This common belief that HIV is restricted to 'immoral' groups and/or particular social groups that are often marginalized by society is not reflected upon the observed prevalence. Therefore, the combination of believing that not being a member of these social groups eliminates any risk to HIV and not being familiar with, or not using, available means of HIV prevention, puts people at risk.

A wide-ranging reproductive health survey (CDC, 2001) conducted among 7,668 women aged 15 to 44 showed that the majority of respondents (74%) have heard about HIV and AIDS (i.e. 26% have never heard about HIV and AIDS) and 61% do not see any risk to HIV. The actual depth of knowledge varied, depending on the social and demographic characteristics of respondents – the lowest level of knowledge was among respondents under twenty (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.

The following factors seem to have the biggest effect on people's awareness of HIV and AIDS issues: the level of education achieved, where one lives, and personal socio-economic status. The subsequent conclusion is that education programmes are particularly significant for women living in rural areas, women with primary (or incomplete secondary) education, and those with low economic status.

Based on the same survey, only every fifth respondent (21%) was aware of the fact that the HIV disease does not have any specific symptoms. This is especially important, as people have the false belief that physical appearance may demonstrate one's HIV status.

Despite broad education programmes, current research shows that only a few out of 7,668 females aged 15 to 44 could correctly answer that HIV cannot be transmitted through: handshake (32%), public toilet (17%), manicure and coiffure in beauty salons (16%), public goods that have been touched by an infected person (16%), a mosquito bite (14%), a kiss (13%), and visiting a dentist (5%).

It is noteworthy that only 16% of respondents said that they know where they can take an HIV test, including those 3% of respondents who had already done it before. This index was identical to results of the research conducted by UNICEF (Ministry of Health/Ministry of Education/UNICEF, 2002), where the proportion of respondents who knew where they can pass the test was far less among females living outside Baku, those under twenty (20), women with secondary (or incomplete secondary) education and unfavourable economic status, and women who were never married. Difference between women-refugees and IDPs and other women was insignificant.

According to the same survey (CDC, 2001), unprotected sexual practices between men who have sex with men were the top answer (58%) among the least-known HIV transmission routes. Then followed infant breast-feeding transmission (48%), heterosexual contact (44%), the use of non-sterile needles (37%) and mother-to-child prenatal transmission (43%). The most known transmission route was blood transfusion (37%).

It was also important to reveal the depth of women's awareness on means of HIV prevention. The respondents to the survey mentioned the following factors preventing HIV transmission: monogamy and reduction of the number of sexual partners (67%), use of sterile syringes and avoidance of syringe sharing (68%), avoidance of unsafe sex (67%), asking partner to take an HIV test (59%), (it is noteworthy that this index was much higher among females living in Baku, 76%, compared to women from the southern, rural regions, 44%), avoidance of blood transfusion and injections (44%), use of condoms (40%), and sexual abstinence/restraint (35%).

On the whole, a high level of misunderstanding and incorrect ideas about HIV and AIDS stipulate the necessity for special education programmes focusing mostly on means of HIV transmission and prevention. Women are at a higher risk of HIV for many reasons (resulting in less access to, and lower awareness on, issues of sex education and sexual health), which means more focused education programmes for women and girls that give precise information, accurate data on HIV and sexual health in general are needed.

A survey conducted by the Caucasus Research Resource Center-Azerbaijan (CRRC-Azerbaijan, 2004) among 1,500 people, also demonstrated an average level of general public awareness of HIV; the overwhelming majority of respondents knew that HIV can be transmitted sexually (95%), and that 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.

Approximately one-third of all participants in a recent public opinion poll (CRRC, 2004) stated that HIV can be transmitted via using the same bath, towel, and or toilet (32%), sharing dishes (30%), mosquito bites (31%), and handshakes (24%). More than a half of respondents (53%) think that HIV can be contracted by a kiss. Only every fourth (24%) person believes the opposite. Remarkably, a similar number of respondents (23%) found it difficult to answer anything to the question. These results are evidence of the insufficient level of HIV and AIDS awareness among a certain part of the general public.

As stated above, there is a large difference in levels of awareness between the urban and rural population. Whereas in the capital and other large cities the volume of accessible and reliable information is much higher and the number of HIV prevention activities is greater, in rural areas there is much less activity. Moreover, in rural areas, the dissemination of various published documents, e.g. newspapers or magazines, is limited, let alone IEC materials on HIV and AIDS.

Rural areas pose more difficulties in the implementation of HIV-related programmes due to the fact that there it is much more complicated to overcome existing psychological barriers and traditional stereotypes. The non-governmental organisations working there, which can communicate reliable information on HIV and AIDS to the regional communities, do not seem to be effective as these programmes, oriented toward rural populations, are not especially adapted for this population and do not reflect on the local conditions and circumstances.

Research conducted by the International Medical Corps (IMC, 2002) was aimed at the identification of awareness of, attitude toward and practices in relation to, HIV and AIDS and other STIs among contractors working on the project of, and people living in communities located near, the oil pipeline BTC. It was revealed that the respondents had very insufficient knowledge on HIV and AIDS, their attitude showed high levels of stigmatisation towards PLHIV, and they did not take any prevention measures. When asked about the use of condoms, the majority of workers said they did not use them.

Many experts emphasize the extremely low and unsatisfactory level of awareness of the problem among children and youth. This statement is backed up by empirical evidence. Results of the survey carried on by Institute for Social Action and Renewal in Eurasia (ISAR)-Azerbaijan several years ago among pupils in forms 8-11 in fifteen schools in the Qakh and Zaqatala regions revealed that 11.5% of respondents were not aware of a single HIV transmission route. Interestingly, the same survey also revealed that 80.9% of schoolteachers and 64.5% of pupils of those schools draw information on the disease from television and radio broadcasts. The number of local, informative television programmes on HIV and AIDS is much lower than the number of entertainment programmes.

Experts who participated in different interviews for this report repeatedly stressed the necessity of more information and awareness-raising campaigns in schools, colleges and universities and of more open and easy-to-understand discussions on sexual issues and safe sex. Nonetheless, they qualified those recommendations by saying that ‘this must be in line with cultural and moral norms.’

A low level of awareness among youth also correlates with the rural vs. urban environment, although both settings show low awareness levels. The picture in remote rural regional schools not visited by trainers, representatives of youth organisations, or doctors, is even worse.

Probably the only exception is UNICEF's initiative on establishing Youth Friendly Clinic attached to municipal hospitals in ten rural regions of the country. Raising sufficient awareness of HIV and AIDS among young people was one of the Centres' objectives. However, since it was a pilot project, these activities covered only the largest regional centres, and were unable to spread out to remote areas.

Available employment in regions is especially important and relevant to the spread of HIV. Usually, high school upperclassmen leaving regional schools, who do not enter an institute of higher education or find a good job in the region, tend to move to the capital. And in the course of time, they may join the ranks of labour migrants heading to Russia and other countries in search for a job.

Contrary to the general population, members of some key social groups marginalized by society, who live in extremely difficult conditions and are particularly vulnerable to HIV (CSW, street children), seem to have a higher level of HIV- and AIDS-related awareness. For instance, the UNICEF (1995) survey among street children in Baku showed that 92.5% of young sex workers are aware of HIV and AIDS, sexually-transmitted diseases (97.5%), and safe sex (97.5%).

The increasingly more frequent promotion of condom use by celebrities (popular singers) has been interpreted by many local experts as a positive sign, and although it is understood that this is mainly determined by commercial reasons, at the same time it can be regarded as a significant step towards the openness of the general psychological atmosphere around the issue.

I.6.5 Public perception of HIV and AIDS

Generally it is necessary to note that at present in Azerbaijan there are not enough concrete empirical materials about the state and dynamics of public opinion on HIV and AIDS. There is little sociological data about the level of knowledge and public awareness, about attitudes and orientations of public perception regarding the problem. Nevertheless, research carried out during the last years allows for a rough picture of the public opinion about HIV and AIDS.

Currently the topic of HIV and AIDS is in the centre of constant and undiverted attention for only a particular circle of experts and specialists, several NGOs and some international organisations, and for those infected and/or affected by HIV.

In general, and on the whole, this serious social (medical, psychological) problem has not become a subject of wide discussions and public debates. As it was noted by one of the interviewed experts 'there is an impression that our society lives in itself, and this problem exists of itself.'

The general perception and attitude to HIV and AIDS is characterized by a lack of detailed, comprehensive information about the disease.

The perceived risk of HIV infection of such key groups such as IDUs, CSWs and MSM, and the reasonably low prevalence of HIV even among these 'risk behaviour groups' supports the

formation and strengthening of false ideas, beliefs (even convictions) among broad masses; that they are beyond the danger of being infected with HIV.

These prevailing attitudes are expressed in statements such as, ‘I do not use injecting drugs, and I am not a sex worker, therefore AIDS will never become my personal problem.’ On the basis of conversations and interviews with people (conducted in the framework of this report) it became clear that the public perception of HIV and AIDS is that this problem is for other countries and continents (Africa, the USA, Russia, Ukraine, etc.), but not for Azerbaijan.

Currently, IDUs, CSWs, MSM and prisoners remain the key populations with the highest HIV prevalence and thus are most vulnerable to HIV. Even though, statistical data in Azerbaijan shows HIV prevalence among all social groups, categories and professions, the general public does not accept the fact that key populations such as women, youth, people with low income, seasonal migrants, refugees, IDP and prisoners may also be at risk.

Many Azerbaijani experts interviewed for this report said that it is necessary to combat the complacent, weakened position of society concerning this illness very soon, and to fully realize the approaching danger and make a maximum effort to mobilise all of society; all resources (financial, public, informational, intellectual, socio-cultural) for an effective response to the HIV epidemic.

Such a response should be systematic, with specific priorities, directions and targets. For this purpose, it is necessary to actively engage the mass-media, and to organise more actions targeting specific groups, while considering their particular needs and interests.

Generally, according to various sources (interviews, observations, communications with experts, etc.), it is possible to draw a conclusion that there is a low awareness level, lack of knowledge, and basic non-understanding of the actual problem among the Azerbaijan population on issues of ways of transmission, preventive measures, available testing, etc.

Knowledge of HIV and AIDS, and HIV modes of transmission are basically reduced to the idea that it is a terrible, fatal illness, ‘that it is incurable.’ Not everyone has a precise idea about the difference between HIV and AIDS.

It is especially applicable for adults who have a more limited access to various modern information sources (the Internet, educational programmes) and have much stronger stereotypes and biases that block them from receiving such information.

Moreover, even if part of the population is aware of safe sex practices, the actual, real number of those who do practice safer sex is much lower. For example, in one of research projects (IMC, 2001) adult men felt ashamed, and were concerned when asked about condoms; they told researchers that they never use condoms.

As a whole, attitudes toward personal health is an important factor affecting the spread of HIV. Azerbaijani people wait a long time before consulting a doctor. Avoidance and procrastination of treatment is common. As one expert said, in an interview: ‘People are not excited [by] health problems; as always they consult a doctor at the last minute; it is a very national feature’.

As many people do not demand that their dentists and hairdressers/barbers to sterilise the tools they use, booklets on HIV and AIDS (issued and provided by USAID, and the International Relief and Development, Inc.) are available in some places.

It is clear from conversations that people either do not know, or have little information on, how and where one can get tested for HIV. Besides, there is no culture, or habit, of asking

one's partner about his/her HIV status. Only a very extreme situation can force someone to go for an HIV test. There are a lot of reasons, including fear of a positive answer, and ignorance about the opportunity for anonymous VCT. The unavailability of ARV treatment medication is also a factor.

In the framework of an anonymous survey among PLHIV for the purpose of studying the influence of the socially psychological, moral, legal, material and other factors that put people at risk and led to an eventual HIV infection, the results of questioning have shown that about 90% of respondents had no idea about the methods of HIV transmission before their own diagnosis.

Promoting a sense of strengthening one's healthy way of life and encouraging a more serious, careful attitude among people towards their own health may serve as a more effective approach to HIV prevention.

I.6.6 HIV and AIDS 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- and 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 skilled trainers has created a degree of public resistance, even prejudice, which prevents people from absorbing and using the information they receive.

It is hard to say what prevails: indifference to these issues or unawareness. As a whole, it is important to note that the level of sex education is very low in the country, particularly in the regions (rural areas).

Very few discussions, consultations, or lectures by doctors, specialists, and professionals are held. Therefore, dissemination of information on these topics is done not by competent specialists and professionals, but by untrained people (friends, acquaintances). This often leads to the perpetuation of prejudice, rumours and gossip.

At the same time there is an opinion that the low level of awareness among youth on HIV is due to the low number and level of lectures, seminars, and other activities on HIV and AIDS matters. These types of informational events are usually timed to certain dates only once a year, such as the UN's World AIDS Day.

The non-regular and non-systemized nature and sequence of these events also contributes to the low level of inculcation of received information.

But there is another opinion: that failed awareness programmes have led to the lack of information. When organizing these types of events, dedicated to such a delicate and sensitive topic, one should consider social and cultural factors and nuances, the specifics of audience and target groups. For example, many young men might feel uncomfortable during seminars, conducted by female teachers or medical personnel.

Effective campaigns on prevention measures should consider the existing relations in the society, values and social-economic conditions. Young people need to participate actively in these campaigns, and be involved in decision-making processes that affect their lives. Their positive aspirations should be assessed, taken into account and included in the design of programmes in response to HIV and AIDS.

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 extend 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.

One idea is to involve young people in discussions in a more casual, less formal, environment – such as at an Internet cafy, or through the Internet itself.

It is vital to have serious, systematic and continual (not periodic or spontaneous) information and explanations in order to deliver precise, non-biased and truthful knowledge to people on the ways of transmission of HIV-infection, ways to protect and prevent, norms and rules of safe sex and safe sexual behaviour.

I.6.7 People living with HIV

In Azerbaijan, 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.

Despite the fact that PLHIV are eligible for disability status and receive certain social benefits (including pension) financial security is still a major concern. The majority of PLHIV in Azerbaijan are unemployed and live in poverty. According to information from the National AIDS Center, 98% of PLHIV are unemployed and live in poverty. For example, some labour migrants, who used to have decent income, now live in poverty because of their health condition (and sometimes because of narcotics). Their social life is also affected.

At the Prague senior-level meeting in 1994, the governments of forty-two countries announced that the wider participation of people living with HIV is at the core of the response to epidemic.

The greater involvement of PLHIV at all stages of designing and implementing responses to the HIV epidemic has been called for by UNAIDS and other UN agencies, and has been emphasized by the Secretary General of the United Nations, Kofi Annan, in his speech to the XV International AIDS Conference in Bangkok, July 2004.

It is important to note that people affected by HIV and AIDS are not a separate group or category of individuals, but form a more inclusive spectrum of the population: starting from people living with HIV, and including HIV-negative partners, family members, and close friends.

Despite all of the above calls for the greater involvement of PLHIV, the number of activities and programmes involving PLHIV remains very small.

I.6.8 Public attitude toward PLHIV

Generally speaking, public opinion shows an intolerance to those living with HIV, which is a very alarming indicator.

In 2002, UNICEF did a study of youth and teenagers on their awareness and attitude towards HIV and AIDS, measuring the level of stigmatisation and negative behaviour towards people living with HIV (PLHIV). 72% of youth between the ages of 15-25 think that PLHIV should not be allowed to work as teachers, and 80% responded that they would not buy products from a shop where an HIV-positive person works (Ministry of Health/Ministry of Education/UNICEF, 2002).

It is interesting to find out the level of intolerance of Baku residents towards HIV-positive people. Responses to the question: ‘Could you or would you like to be friends/communicate, cooperate/work with, or be a neighbour of a person with HIV?’ enable us to establish the level of stigmatisation and intolerance. From those who responded to this question, only very small number of participants (5% would be friends, 8.9% would work with, 13% be a neighbour)

gave a positive answer. The majority (respectively, 83%, 78% and 71%) responded negatively.

A high percentage of people (83%) are not willing to count a PLHIV among their friends. The same case is seen when people are asked about having a PLHIV as a business colleague (78%). The most surprising response was that 71% of responders would not like to have an HIV-positive neighbour. All the above are very high indicators for the otherwise traditionally tolerant Azerbaijan society (based on the result of many studies, the level of inter-ethnic and inter-confession tolerance is very high; CRRC, 2004).

The high level of intolerance towards PLHIV obviously correlates with false, anomalous impressions on how infection is transmitted. If there is no precise information and knowledge, there is obviously fear and reluctance to have any contacts with PLHIV. All of these complicate the organisation of sensitisation, awareness and prevention events.

In addition, if the level of tolerance towards PLHIV is so low, it reduces the probability of people finding out their own HIV status.

Another important impeding factor in the fight against stigma is that many confuse HIV with AIDS. Thus, it is important to deliver the information to the broader public that living with HIV does not mean that one cannot lead a healthy and productive life.

HIV-positive people have all rights, as stipulated by legislation in the Azerbaijan Republic. In theory, they can be employed and study. However, in practice, there is not enough information on whether the rights of PLHIV are always honoured.

As a whole, there are negative stereotypes and prejudice towards PLHIV. Many people think of PLHIV as lepers and people who set themselves apart from the rest of society, yet who are a potential threat to even their closest friends, and to society as a whole. This opinion usually discourages people (especially those from ‘risk groups’) from applying for testing, and complicates monitoring and care for those infected and/or affected by HIV.

If an HIV-positive person makes his/her HIV-status known during some event, one can observe a strong negative reaction among the surrounding people, which has an oppressive effect on the mentality of the HIV-positive person. Infection leads to a series of emotional and social consequences, changes in behaviour of the PLHIV, and affects his/her family and access to one’s legal rights.

Links to family and relatives are very strong in Azerbaijan. Respondents to a survey conducted for the purpose of this report said that they would care for a PLHIV if she/he was close to them. In general, relatives expressed a readiness to take care of people with AIDS, but sometimes it was considered more of an obligation.

Obviously, the psychological environment is more heavy and tense when the infected person is a family member. This means additional expenses for treatment and a special regime of nutrition and rest. In some cases, it leads to conflicts, even divorce.

When PLHIV don’t participate in social activities, it aggravates the psychological and moral consequences of the disease, and impedes positive changes in their mentality and psychology. It is important to create incentives to involve PLHIV in social life, as integration to society could also contribute to significant strengthening of their optimistic and positive thinking.

It is very possible that many people live without knowing that they are HIV-positive, either due to lack of information on this particular disease, or to people’s unwillingness to determine

their status, which is purely connected to their fear of being marginalised, stigmatised and isolated from their social networks.

In order to eliminate the marginalisation and prejudice in society towards HIV-positive citizens, it is important to first inform people about the epidemic and means of transmission and prevention.

PART II: Institutional Assessment

II.1 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 of Azerbaijan (MHA)[10] 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 (tuberculosis, malaria, etc). Substantial financial, technical, and methodological support for this effort has been provided by international organisations, including the World Bank, WHO, and UNICEF.

In tangent with those health services that are subsidized by the state, and available free of charge, a system of private health services, accessible only by a limited group of people, is emerging (WHO, 2001).

Nowadays in Azerbaijan significant efforts have been made to establish an efficient system for HIV and AIDS prevention, detection and treatment. A considerable legislative base has been put in place and judicial mechanisms currently regulate the work of all parties involved in the issues. The New National Strategic Plan for 2002-2006 approved by the Cabinet of Ministers is oriented on a multi-sectoral approach to the response to HIV and AIDS, and provides for the cooperation of different ministries, departments, non-governmental and international organisations, making them all partners in the joint activities.

II.2 Legislative basis

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 organisational mechanisms for the prevention and treatment of HIV and AIDS.

Guided by the goal of coordinating activities on performing such functions as organisation and education, treatment and prevention, the National AIDS Center was established in 1990 by the Ministry of Health of Azerbaijan.

In 1996 the law on the 'Prevention of the spread of the disease (AIDS) caused by HIV' was adopted.[11] Instruction No. 424 on this was signed off by the President of Azerbaijan on 17 September 1996 – it provided the strengthening of material and technical basis of the [HIV/]AIDS Prevention Service, the National Program's adoption, as well as the social support to PLHIV.

Articles 10-15 and 18 of the current law provide legislative guarantees of non-discriminatory approach to all groups vulnerable to HIV, consistent with item 20 of Dublin Declaration on 'Partnership against HIV and AIDS in Europe and Central Asia,' adopted on 24 February 2004.

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[10] http://www.mednet.az
[11] HIV and AIDS Resource Center, http://www.undpaids.az/respaz.html

According to Decree No. 157, dated 23 October 1997 and issued by the Ministry of Health of Azerbaijan, pregnant women, women who are having an abortion, women in childbirth, IDUs, people infected by malaria, hepatitis B, C and D, people who had sexual contacts with PLHIV, people with STIs, foreign students, military personnel, homeless people, long-distance drivers, and blood product recipients are recommended to voluntarily undergo HIV testing. It is significant that ARV treatment in Azerbaijan is not available, so it is impossible to provide preventive drug treatment to pregnant women in order to prevent HIV mother-to-child transmission. HIV-positive mothers do not have an access to breast-milk substitutes to feed their newborn children, nor does the Center have enough funds to purchase infant formula.

The law includes legislative guarantees that take a non-discriminatory approach to all PLHIV and their families.[12] To guarantee the safety of blood supply, two other decrees, 'On Donor Blood Testing for HIV, Syphilis and Hepatitis' (No. 109) and 'On Safe Blood and Its Components Supply' (No. 64) 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 (No. 155). According to the current legislation, PLHIV are eligible for disability status and pensions. The present decree allows all citizens, anonymously and free of charge, to take an HIV test, receive pre- and post-consultation, and find out the results. Prior to this decree anonymous HIV counselling was conducted in accordance with WHO regulations.

By the decree No. 210S of 20 October 1997 issued by the Cabinet of Ministers, the 'National Strategic Plan for Preventing the Spread of HIV and AIDS in the Country' was approved.

On 16 August 2002, the Cabinet of Ministers (decree No. 164) established the National Commission on Prevention of HIV and AIDS and approved its members – deputy ministers of all ministers, the head of the National AIDS Center as commission secretary, and the minister of health, Mr. Ali Insanov, as chairman. The Commission prepared a new National Strategic Plan (NSP) on AIDS prevention for the period 2002-2006 that was approved by the Cabinet of Ministries (decree No. 205S dated 25 September 2002). NSP promotes the multisectoral (multidisciplinary) approach and cooperation between various ministries and state departments, non-governmental organisations, and international organisations as partners in the implementation of the planned actions in nine priority areas:
1. development of a national policy on HIV prevention;
2. ensuring safety of donated blood and other blood products, and medical interventions;
3. prevention of HIV among youth;
4. prevention of MTCT transmission;
5. prevention of HIV transmission among IDUs and their sexual partners;
6. prevention of HIV transmission among migrants, refugees and IDPs;
7. prevention of HIV transmission through sexual practices;
8. medical care and social protection of PLHIV and their family members;
9. improvement of an epidemiological surveillance and state control over HIV and AIDS.

Also in 2002, Azerbaijan joined the UN Declaration 'Global Crisis – Global Actions' as well as the Programme of Actions of members of the Commonwealth of Independent States (CIS).

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.

[12] HIV/AIDS Resource Center: http://www.undpaids.az/respaz.html

People with HIV receive disability pensions to improve their financial position. Within the framework of NSP, the Center and the Central Administration of Employment concluded a mutual agreement to offer people with HIV employment.

The priorities in combating the HIV epidemic and minimizing its consequences are defined in the National Strategic Plan and incorporated in the Poverty Reduction and Economic Sustainability Program. Guidelines for establishing the legislative base for cooperation of governmental institutions, non-governmental organisations and private sector in the implementation of an HIV epidemic prevention strategy are being drafted.

The final versions of legal regulations, which will provide implementation of HIV prevention programmes particularly for key populations and socially vulnerable groups, are yet to be drafted and adopted.

II.3 Governmental response to HIV and AIDS

The Ministry of Health of Azerbaijan carried on a significant work in the field of HIV identification, surveillance, safe blood supply, conducting prevention programmes in medical and counselling institutions, as well as raising awareness among the general population of the country. The key provisions determined by the NSP adopted back in 1997 were realized to the extent of the Ministry's capabilities. The National Intersectoral Coordinating Council, founded by the Cabinet of Ministers, is granted administration and coordination functions for the NSP.

The national budget was not envisioned being the only funding source for the NSP – various international organisations were expected to contribute to the Plan's realization, as today Azerbaijan does not have enough funding resources to cover all planned activities financially.

Unfortunately, neither the state budget nor international organisations were able to fully fund the NSP. An application submitted to the Global AIDS and Health Fund has been only recently approved. The World Bank and other UNAIDS donors, as well as international and humanitarian organisations (except for the WHO) did not provide any support to the country for HIV- and AIDS-related programmes. This factor complicates the functioning of the public health system in the country and the Center, in particular.

The National AIDS Center was established in 1990 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 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 organisational and technical support to the country's rural areas on HIV prevention issues. According to Decree No. 424 of 17 September 1996, signed by the President of Azerbaijan, 'On Preventing the AIDS Epidemic,' the National Center of AIDS was granted a separate three-story building within the premises of the capital's medical camp and it is maintained with modern HIV testing equipment and laboratories.

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.

With the purpose of establishing Interdepartmental Councils on preventing HIV and other sexually transmitted diseases, the National Center on AIDS has shared its experiences with all chief executives and public health institution officials by providing documents and general information, booklets, results of anonymous polls, leaflets containing the Center's appeal to parents, student-oriented programme on HIV prevention and fighting methods, as well as a press release on the epidemiological situation in the country.

The Center has also developed an educational programme providing sessions on 'Save Yourself from AIDS!', which was designed for students of universities and colleges, as well as for upperclassmen (grades 6 to 11) of secondary schools. This programme was introduced into all secondary schools, institutions of higher education and high schools of Azerbaijan.

The Center has carried out or is planning to carry out the following activities in connection with the NSP:

- Introduced counselling in medical organisations for all groups of population, including key populations vulnerable to HIV. Participation in working out teaching and learning materials for each key population (2003-2004);
- Participation in drafting methodological recommendations and carrying on pre- and post-natal counselling of women, training of respective staff for this purpose, as well as consulting in breastfeeding and infant feeding methods alternative to breastfeeding (2004-2006);
- Participation in drafting methodological recommendations on drug users' counselling and respective consultations;
- Rendering consultative and psychological support to people living with HIV and members of their families.

With the purpose of raising awareness among the general public and more efficient distribution of pictorial presentation materials related to HIV and AIDS issues, the Center organized a Caricaturists Contest under the motto, 'Azerbaijani Caricaturists Are Against AIDS!' In addition, in the framework of the World AIDS Day campaigns, the Center conducted the contest, 'Fight AIDS Smiling,' under the motto 'Do Not Let AIDS Horrify You!'

The Center renders medical, psychological, social, legal and moral support to anyone who is HIV infected. The Center's doctors also work with PLHIV on helping them maintain their health (as ARV treatment medication is not available). The Center cooperates with some local non-governmental organisations (Imdad, Shafa, Nur, etc.). However, it faces major challenges in working with PLHIV, as many PLHIV do not want to work with the Center out of fear of social discrimination. Moreover, many of the PLHIV are presently are outside the country.

A mobile team on anonymous counselling and testing was formed by the Center. A shuttle conveys passengers free of charge around the city and in the course of the journey a team of doctors conducts awareness-raising work by means of audio-visual equipment. The team demonstrates various video-clips on prevention, informs the population on the different transmission routes and prevention means. Some of the visitors agree to undergo voluntary HIV testing. All this work is carried on in Azeri, Russian, and English.

The Center has also organized a number of workshops on 'AIDS Does Not Have Boundaries' for teachers and pupils of Azerbaijani schools; in the course of these workshops booklets and posters containing information on HIV transmission and prevention have been distributed. While designing these booklets and posters, cultural, national and religious traditions and ethical norms were considered.

There are however objective and subjective factors impeding the complete realisation of the National Strategic Plan. Nevertheless, the decisiveness of the country's leadership in the response to the HIV pandemic gives hope that the adopted plan and assumed obligations will be fulfilled comprehensively and entirely.

II.4 Efforts of international agencies and non-governmental organisations

A number of international agencies and local non-governmental organisations 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 organisations. NGOs, which 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 greatly under-represented in outlying regions and rural areas.

«Imdad-SOS» - Azerbaijan non-governmental association of PLHIV
Imdad-SOS, the country's only PLHIV NGO, was established in 1998, with the active support of the National AIDS Center, to provide social, financial, psychological, and legal assistance to PLHIV. It currently unites around 200 PLHIV and their close relatives, as well as lawyers, psychologists, sociologists, teachers, and medical specialists. The title itself, 'Imdad,' means a call for help, i.e., SOS.

PLHIV in Azerbaijan, whose number grows every day, are faced with a very difficult situation. It is hard for them to sustain their families, especially as ARV treatment is not currently widely available. Thus, Imdad organizes various events for fund raising. For example, in April 1999 the association organized a charity concert, 'Azerbaijan against AIDS' in cooperation with the National Center to which over two thousand youth participated. Collected funds were given directly to PLHIV and their relatives in need.

The association 'Imdad-SOS' also works impressively on providing versatile assistance and support to PLHIV and people with AIDS. For example, following the intervention of 'Imdad-SOS,' three PLHIV convicted and imprisoned were released from custody ahead of time. Under the initiative of 'Imdad-SOS,' the issue of social rehabilitation of PLHIV and people with AIDS was raised with the government.

'Imdad-SOS' implemented several projects on increasing awareness on HIV and AIDS among school children and students in various regions of Azerbaijan. Some PLHIV and their relatives also took part in these events.

For the first time in the country's history, a 'Global day of memory of AIDS victims' was commemorated in the beginning of May 2000 with the participation of the mass media and clerical representatives. Members of 'Imdad-SOS' designed a patchwork quilt as a token of remembrance of those who died of AIDS-related illnesses, and whose names were written on the quilt.

The association is also planning to implement a number of projects on HIV prevention in Azerbaijan, but the implementation of these projects requires significant financial and

technical resources, which the Association does not possess. PLHIV are appealing to all interested parties to contribute (financial or moral assistance) so they can realise the projects.

The HIV/AIDS Resource Center

The HIV/AIDS Resource Center[13] 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 and AIDS.

The goals of the Resource Center are to:

- Provide access to information for NGOs with a specialized library;
- Train active members and volunteers from NGOs in the methods of working with various groups and categories of population;
- Conduct seminars and training courses aimed at teaching the planning and creation of programmes on prevention;
- Prepare information materials with the involvement of international experts;
- Create and/or adapt existing information material, and make them accessible, in local languages.

Training programmes developed by the Resource Center are aimed at providing knowledge and practical skills on HIV and AIDS that are necessary for prevention, care and support on the community level. Training is primarily directed to regional organisations, which have closer social ties with local communities, but are less informed about their vulnerability to HIV.

The Resource Center conducts training courses on HIV and AIDS for local non-governmental organisations in various cities and regions of Azerbaijan – Baku, Mingachevir, Lenkoran, Guba, Ismayilli and others. The theoretical part of the programme includes basic information on HIV and AIDS, the consequences of the epidemic, risk factors and vulnerability.

With the purpose of reducing the level of vulnerability of communities to HIV, the Resource Center published a series of publications called, ‘Mobilisation of communities’ that consists of several brochures: ‘Communities and AIDS,’ ‘Youth and AIDS,’ ‘Gender and AIDS,’ ‘Drug Addiction and AIDS,’ ‘Migration and AIDS,’ and ‘Refugees and AIDS.’ This series not only aims at enlarging people’s knowledge of HIV, AIDS and prevention, but also attempts to increase the psychological readiness of people in receiving and assimilating information on HIV and AIDS.

The practical part of the training courses is targeting changing behavioural patterns towards HIV and AIDS. This is built on interactive communication, role games, watching and discussing audio-visual materials; including IEC materials, published by the Resource Center (from the series ‘Risky behaviour,’ ‘Men and AIDS,’ ‘Women and AIDS,’ and ‘Drug Addiction and AIDS’).

The Resource Center also developed effective programmes for taxi drivers and CSWs (‘Be Aware, don’t give a chance to AIDS!’, ‘A lot depends on Man’, and the brochure, ‘Poverty and AIDS - destructive symbiosis’). This brochure addresses the close ties between AIDS and poverty.

During recent years there have been various events organized by the Resource Center. Most notably, on 3 December 2002, a round table entitled ‘Human Rights and HIV and AIDS’ was

[13] http://www.un-az.org/undp/aids.php

conducted in Baku. Its goal was to consider the HIV epidemic within the context of human rights as well as to discuss response measures to prevent stigma and discrimination. Representatives of governmental, non-governmental, and international organisations as well as the UN and mass media, participated in the round table. Also, on 1 December 2003, the first round table on 'Civil Society in response measures against HIV and AIDS' was organized in order to discuss an inter-agency approach and the role of civil society in a national response to the epidemic.

The Center has also organized a charitable event at the 'Respublika' Palace. The televised event and concert were in the country's biggest hall and dedicated to World AIDS Day, with the participation of famous actors and singers and the distribution of awareness materials. The first essay competition on the topic of HIV and AIDS was organised between 47 schoolchildren from nine schools – the winners were awarded during the ceremony in the Respublika Palace. Another interesting event was interactive meeting with students to discuss 'Poverty and AIDS' at Khazar University.

The Resource Center runs seminars on HIV and AIDS for: volunteers from other NGOs and community based organisations (CBOs) and volunteers from key populations vulnerable to HIV (CSWs, MSM or IDUs).

Special attention by the Resource Center is given to the formation of skills: selection of target groups and identification of methodology for prevention work in accordance with the priorities of NGOs; conducting informational, educational and advisory work on HIV and AIDS in target groups, communities; development, planning and implementation of HIV prevention projects that take into consideration local cultural and ethnic values; partnership with other non-governmental and governmental organisations on effective response measures.

The Center provides prevention education for key populations at risk to HIV. For this purpose, people are provided with information on: sexual health, HIV and AIDS and STIs, vulnerability to HIV and AIDS and risky behaviour, and safe sexual behaviour.

A specialised library is also available at the Resource Center, which uses the resources of the NGO 'Ikhlas' (see below). The library has over 700 titles covering forty thematic areas, which include resources, documents, videotapes and CDs. A bibliographic database has also been established. The primary users of the library are representatives of NGOs and CBOs mass-media, medical personnel, and students. Users can get assistance to adapt materials if needed. Some materials have a brief explanation, which has been translated into the Azeri language.

Association 'Ikhlas'

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

Examples of Ikhlas' activities include the organisation of a photo and essay competition for the best journalist work on HIV/AIDS, and financial prizes for the winners. A competition on the best journalist work, 'Poverty and AIDS,' was conducted in 2001. This event was widely presented in mass media and attracted considerable public attention.

'Anti-Narcotism' International Scientific and Analytical Center

The Anti-Narcotism International Scientific and Analytical Center carries out a number of HIV-related projects for drug users, including needle exchanges, similar to other programmes that have been successfully implemented in other countries, to reduce the risk of HIV transmission among IDUs. The current programme proposes changes in the paragraph 6 of Article 226 of the Azerbaijan Republic Criminal Code, regarding the criminal charges towards drug users.

Other NGOs and Public Organisations

- Medical Students Association (running training on HIV and AIDS issues for medical students and young physicians, 'Medical personnel against AIDS');
- Association of Azerbaijan Scouts ('Teenager to teenager', prevention of HIV among teenagers);
- Children Organization of Azerbaijan ('I want to live' performance on HIV and AIDS for children);
- Initiative Group of Youth attached to Women Jewish Organization ('AIDS: glance from XXI century');
- The humanitarian organisation 'Savab' ('Prevention of HIV among internally displaced people');
- Society of Women Rights Protection ('Prevention of HIV and AIDS among sexual female workers');
- Association of Health of Azerbaijan, Social Union for Civil Rights 'Clean World' (report on victims of illegal trafficking);
- The international association 'Family and Society' ('Men's rights and responsibilities').

NGOs role: an overview
It is obvious that implementation of effective awareness and prevention work on HIV and AIDS requires close cooperation of governmental and non-governmental, public organisations. In this context strengthening the role of civil society, NGOs and public organisations is one of the key directions of activities.

Experts consider that the role of NGOs and public organisations in HIV/AIDS prevention and awareness is very important, and already there are several specialized organisations making valuable contribution to this area. In perspective, activities undertaken by NGOs and civil society will be able to take a substantial share of the responsibility in the response to HIV and AIDS in Azerbaijan.

Some experts have noted that the set of activities undertaken by the civil society in Azerbaijan is limited to occasional uncoordinated actions of various separate NGOs, which do not have a systematic approach to the problem.

The reason for this is probably that currently, civil society in Azerbaijan lacks a strategy and general understanding of their role in the implementation of sensitisation, awareness and prevention projects. Moreover, their own perception of civil society's potential impact on overcoming the consequences of the spread of HIV to various social groups and categories is not developed sufficiently.

The disconnectedness of the various groups in civil society, the weakness of its links with government structures, the absence of joint discussions on complex questions like prevention and the social, psychological and socio-cultural aspects of HIV and AIDS, the absence of coordination and planning of precise activities on local and national level, all complicate the realisation and effectiveness of any activity in response to the HIV epidemic as a collective effort of various individuals of civil society, making it less able to overcome the consequences of HIV and AIDS.

It is important to note that NGOs who work with socially stigmatised and marginalized key populations are not likely to cooperate with government organisations.

As NGOs are more private than state organisations, projects such as ‘peer-to-peer educators’ might have a certain effect: links with key populations are being built up, and activists and volunteers are recruited/identified who will undergo training so they can later train others.

International Organisations

A number of international agencies and local non-governmental organisations have been working in the area of HIV prevention and advocacy and also provide legal and psychological services to people living with HIV.

UN agencies

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. In 1998, these UN agencies jointly contributed a total of 500,000 USD to combat the spread of HIV through the goals mentioned above.

UNHCR is addressing needs in reproductive health, family planning, safe motherhood, breast-feeding promotion, and STI and HIV awareness. Medical kits and hygiene products are distributed, gynaecological services are provided through a network of clinics, and health personnel are trained in family planning practices.

UNFPA works with the Ministry of Health to improve access to reproductive health and family planning services through procurement of contraceptives, medical equipment, and essential medication. UNFPA is also establishing family planning clinics in six pilot districts and providing training to health service providers to update their knowledge of contraceptive technology and reproductive health care.

International Medical Corps

The International Medical Corps (IMC), with the financial support of British Petroleum (BP), has implemented a programme to prevent the spread of STIs and HIV among BTC oil pipeline construction workers and people living in the regions along the pipeline. IMC’s partner organization was responsible for the HIV and AIDS training of medical personnel working in the twenty targeted communities around the BTC/SCP work camps, and will help link the local health services to the regional HIV testing centres and prevention/counselling services.

Interview with a representative of IMC:

“*Immediately after opening its office in Azerbaijan (August, 2000), IMC was engaged in activities on HIV prevention in Azerbaijan, which [showed to us] the significance of the problem. A KAP-survey was conducted within the framework of these activities. Detecting the level of awareness of HIV and AIDS among the general public was the key objective of that survey. One of the questions asked was: ‘Which diseases can be transmitted sexually?’*

Recorded answers [showed] that knowledge of HIV and AIDS was insufficient, [people’s] attitude was close to stigmatisation. Respondents said that AIDS is something indecent. [When] asked about condoms, respondent were confused and emphasized that they had never used them.

That is why our organisation was trying to incorporate education activities in all projects. BTC (Baku-Tbilisi-Ceyhan) Company financed our programme in this field. Organisation of children festivals (at least, once a year, dated for 1 June, the International Children’s Day) is one of the activities provided by the programme. Together with other health-oriented activities, [HIV] AIDS problems are also covered in the programme. Training

teachers, which then will describe [the] advantages of healthy lifestyle, reproductive health to children studying in six regions of the country (Sabirabad, Saatli, Imishli, Beylagan, Bilasuvar, Fizuli), is another activity provided by the programme.

Similar education is provided for the general population of these regions – men, women and youth. The programme covers 42 villages (120,000 people). About twenty (20) young people in each village are trained to become volunteer trainers who then themselves will conduct awareness campaigns on HIV prevention. These volunteers are trained during four to five (4-5) days and provided with special-purpose books and training materials. In addition, Baku-Tbilisi-Ceyhan Company's workers and contractors being trained on HIV prevention issues. In total, 2,500 people will be trained in the course of the programme (1,000 people have already attended the trainings within first four months of the programme).

A survey conducted among the workers revealed that the majority of them have not ever seen condoms at all! Hence, they never used it and never thought of prophylactics. Answering the question: 'Where would you prefer to get condoms from?' many of respondents stated that the best option is to get condoms in WC rooms (because it is more confidential).

Work in the above-mentioned regions happens at different levels. First we have meetings with the chief executives of the region, then with heads of public health, education and youth departments, religious figures. The authorities recognise the high importance of the programme and perceive it in light of the general population's health issues. They actively support and cooperate in the course of this programme not only by 'giving permissions,' but also by granting premises for trainings and assisting in gathering people.

Aybeniz Ibragimova (responsible for trainings): *'Our experience in conducting education programmes shows that people take the problem very much to heart, ask questions, want to know more and more.*

It is very interesting to watch how their attitude to the problem changes as their knowledge increases. Before the sessions, the knowledge they are guided by is wrong and distorted. They treat people infected by HIV with indignation, believing that they must be isolated from the rest of society, deport them to a remote island or settle them in barracks far from other people. However, as people's knowledge increases by more reliable information, their attitude begins to change step-by-step. This is especially so when they learn that this may happen to any of us or members of our families. […]Once again I would like to stress very enthusiastic participation of rural population in the programme's activities.

The range of IMC activities aimed at HIV prevention is widening: presently, a special training module for gynaecologists and epidemiologists; in total, 300 paramedics in five regions – Mingechevir, Ganja, Tovuz, Yevlakh, and Kurdemir) – will be the focus group. Various prevention activities are conducted, e.g. all those who attend trainings, as well as members of the Center for Reproductive Health get free condoms. There are medical posts in working camps along BTC pipeline, where free condoms are distributed and people obtain their HIV education. […] Our organisation cooperates with local non-governmental organisation 'Inam' (Union of AIDS Fighters). Their organisation has 57 beneficiaries – people infected by HIV – and their doctors are constantly working with them and members of their families. They are also provided with free condoms. NGO 'Hayat' working with the general public in 5 regions is another partner of ours.

As of today, this is the only programme directly addressing HIV prevention. This programme is funded by BP, BTC and CCIC (Consolidated Contractors International Co).

PART III Case Study

III.1 Methodology

The aim of this section is to study the existing experience of educational programmes on HIV prevention through a more in-depth analysis of a specific programme as an example, showing the need to consider cultural specifications of the country when developing such programmes.

Neither professionals nor private citizens currently doubt that awareness and education on HIV- and AIDS-related issues are vital and are one of the most important preventive measures in the response to the epidemic. Many local and international organisations in Azerbaijan report on the lack of, or low quality/inadequacy of current programmes and of Information/Education/Communication (IEC) materials. Although this demonstrates the need to introduce and/or improve educational programmes for young people, the ways of achieving this goal, and improving such components, are not entirely evident.

We hope that the recommendations developed in this research as a result of the analysis of one of the educational programmes will be useful in the development and/or modification of future programmes.

The 'case study' method here attempts to show: why certain decisions were made; how they were applied; and what results were achieved.

The analysis of experience from the introduction of an education (Life Skills) programme for secondary school teachers and students chosen for this part of this report bring up two important questions: *(1) what were the difficulties of conducting such educational programmes in the Azerbaijani environment? and (2) how could the educational programme on HIV and AIDS be (better) adapted to the local context for (more) effective results?*

The educational programme for teenagers was chosen for analysis because currently, educational programmes for teenagers are the most common programmes (initiatives) held by local and international organisations for the prevention of HIV in Azerbaijan. Most of these educational programmes (measures) are directed towards youth (mainly high school students), although this group does not have the highest HIV prevalence in the country (2% of PLHIV, according to official statistics). Work with youth is often justified by the fact that it is easier to work with the young generation, since it is more flexible and open to new information. Another reason is that it is pragmatic: since attending school is obligatory in the country, it is quite easy to reach a wide school audience. Therefore, pending permission from governmental educational institutions, it is possible to develop a single course (programme) and reach a wide audience.

Nevertheless, as mentioned earlier, if one focuses only on the youth generation, the question remains of what will happen to adults who lead sexually active lifestyle and are at risk to HIV.

A few organisations (UNFPA, Open Society Institute, IMC) have recently started to direct their programmes toward the adult, sexually-active population (within the framework of family planning and reproductive health programmes), and social groups at particular risk to HIV (e.g. IDUs, refugees and workers of oil companies). The number of programmes aimed at advocacy and lobbying of PLHIV is quite small, despite calls for greater involvement of PLHIV at all stages of the response to HIV and AIDS and calls for a more intense advocacy addressing the stigma and discrimination faced by PLHIV.

This approach is in stark contrast to the work with CSWs, IDUs (47% of all registered PLHIV), prisoners (70%), migrants (44%), and adults in general (77%) who are more 'rigid' than students, and can decide whether or not to attend a course on HIV prevention, their behaviour is much more likely to impact the HIV situation and prevalence. To conduct work with the above-mentioned groups is a lot more difficult because often they resist the idea of being taught, it's difficult to gain access to these groups, and the sociological structure is more complicated (e.g. issues such as gender inequality come into play).

The case study below was chosen because it represents a programme that, despite the availability of financial support and pre-prepared IEC materials, as well as previous implementation in other countries by local trainers who translated it into the local language, did not successfully develop in Azerbaijan.

In addition to collecting and analysing case materials and documents (project description, programme and reports on seminars and project in general), interviews were conducted with the organizer and programme participants.

III.2 Case/Programme description

The programme of learning on 'HIV and AIDS' is a part of a wider programme 'Learning of Healthy Lifestyle among students of middle school (10-14 years). The project was implemented by international humanitarian organisations working in many countries of Central and Eastern Europe and the former Soviet Union. The project was brought to Azerbaijan in the late 1990s, after the programme, existed in other countries for six years.

The Healthy Education Programme consisted of five main components:

- Nutrition
- Smoking
- Alcohol and Drugs
- Reproductive heath
- HIV and AIDS

Each of these sections had a teacher manual and study materials for the students.

The programme was developed together with governmental institutions (State Board on Education and Teachers Re-training Institute) in order to provide the continuity of the programme. After the manuals were translated into the local language, the trainers from other CIS countries were invited to train the team of 25 teachers, who would hold a full course at schools on the basics of healthy life style.

This case is interesting to analyse, as it is an example of how a programme did not succeed in being adopted at a wide (national) scale, despite the availability of finances, programme study materials in the native language, permission of governmental institutions, availability of school personnel, and people's overall positive impression of the seminar.

III.3 Programme analysis

III.3.1 Programme organisation

Target Group. The programme is aimed at students of middle school (10-15 years) from central schools of Baku. This group is neither an active IDU nor a sexually-active group, and their families are not considered vulnerable to poverty or migration.

Trainers. This project proposed to use existing school resources, to avoid the shortcomings of educational programmes that were previously ran by external specialists. In-house trainers would give short lectures on HIV and AIDS but not provide students with further resources or supplies. Both school psychologists and biology teachers were involved in the project. Biology teachers were chosen because of the relatedness of the subject to what they teach and thus considered more knowledgeable and more comfortable explaining the subject. However, while (some) students may feel uncomfortable asking more (in-depth) questions, at the same time (some other) students may not feel comfortable asking such questions of their regular teacher, as it requires some level of self-openness. Thus, the involvement of school psychologists aimed at bridging the gap, as even though they do not see the students every day, they are always at school and ready to answer additional questions or give advice.

Sustainability of the Programme. Using school resources to carry out educational work may be an economically-advantageous decision, as involvement of school staff lessens the expenses payable to externally invited experts.

A survey (UNICEF, 2002) conducted among teenagers confirms the leading assumption that most prefer to learn about HIV and AIDS from an adult/stranger at school, and not at home. Interviews with the parents within the framework of the same research showed that they would also prefer their kids to learn about HIV and AIDS from specialists, not from them. This is largely because of the incompetence parents feel about this issue and their discomfort in having such conversations with their children. Because of this constraint, children don't feel they have a confident and comfortable source of information.

Therefore, the aim of educational programmes for teenagers and training of adults (teachers, parents) was at establishing open and trusted relationships between the two, rather than simply providing information on HIV and AIDS. In the case of absence of such relationships, teenagers, as well as adults – even in a case of acute need for this information or when a problem (infection) has arisen – will hide, deny or deal with the problem alone. Once a person feels comfortable and open towards this subject, s/he will be able to find enough sources (books, flyers, Internet, doctors) in order to fill in some gaps in knowledge.

III.3.2 Content of the programme and teaching materials

As part of a multi-component programme, this project presents HIV and AIDS as an issue of health directly bound to other aspects of life activities and one's own care. By presenting the topic as just one more part of a school health programme, the stigma is partially removed from HIV and AIDS.

The programme only presents medical information on HIV infection and AIDS (understanding of HIV and AIDS, methods of HIV transmission and prevention). Although the materials were prepared in a simple (schematic) and 'entertaining' way – adapted for children – the local socio-cultural features were not considered.

To avoid giving students the incorrect idea that intimate relationships are something shameful and negative, school psychologists were involved in the programme. School psychologists, unlike doctors and biology teachers, would be able to fill in this gap (sex and sexual relationships) and provide information on relationships and other subjects connected to HIV and AIDS (e.g. gender sensitivity, stigma, and stereotypes).

Despite the fact that the most common mode of HIV transmission in post-Soviet countries is via injecting drug use, the course of the programme was mostly oriented on sexual HIV transmission.

Manuals for the teachers clearly describe goals and plan of each lesson, including an example of practical task on each subject. However, the manual presents a minimum of information on HIV and AIDS and is insufficient for a person who is not familiar with the subject. A significant part of the teachers' manual is dedicated to the description of the importance of working with parents and society, and discussion of setting principles for debate on HIV- and AIDS-related issues (respect and acceptance of different views, etc.). However, how to achieve this goal, how to involve parents and how to set positive atmosphere for the discussions and change the attitude towards the subject, is not described.

Thus, it seems that the manual is aimed at teachers who have basic information on HIV and AIDS, are able to obtain additional materials, and most importantly, have experience holding open discussions in class on similar (sensitive) issues.

Considering the current condition of the secondary education institutions in Azerbaijan, the given manual (without prior training of the teachers on HIV- and AIDS-related issues) will not be sufficient for the teachers, who have just become acquainted with the subject, have their own stereotypes, are unlikely to have had practice with HIV prevention, and are not used to an interactive method of teaching.

This situation demonstrates that at the beginning of teachers' training (or trainers) special attention should be paid to the following:
1. Teachers should have sufficient amount of correct information on HIV and AIDS, be informed of the real situation of the problem in Azerbaijan (risks and vulnerabilities to HIV, real evaluation of drug use prevalence among teenagers or leading a sexually-active lifestyle);
2. Teachers should be taught ways to work with groups, since the aim of these lessons is not just to transfer information, but also to arouse interest, convince and help students to assimilate the information they receive, and translate it into behavioural patterns (and/or behavioural changes).

III.3.3 Training of Trainers

Training of trainers was held during five days – one day for each component of the programme. Trainers were invited from other CIS countries that have successfully applied this programme. Participants and trainers were close to one another in age and spent most of their adult lives in the Soviet Union, which made it easy for them to find a common language and understand why discussions on certain subjects cause discomfort.

The subject of HIV and AIDS was introduced and a discussion on the main contents of the programme, as well as basic information on HIV and AIDS, took place. However, specifics of the training programme, such as ways to start the conversation with school children on this subject, how to present the material, how to explain and talk to the parents, and how to deal with their own discomfort were not discussed. In an environment where discussing intimate questions (such as sexuality and drug use) with kids is a taboo, such subjects are the most hard to address and make the training of *how* to address children even the more important, as they define the success of future trainings.

Teachers selected for this project did not have training prior to the programme, and therefore, had some difficulties. In particular:
- Teachers had strong personal stereotypes of their own and were unable to separate these from the teaching directives:
- They did not have sufficient amount of information in order to answer students' questions;

- They felt themselves awkward and showed an unwillingness in discussions of such subjects even with their colleagues. More difficulties appeared when such discussions had to be held with students;
- They did not have personal experience of discussing similar subjects with their fellow teachers or families, as they came of age in a different era.

Nevertheless, the fact that teachers grew up in conditions when relationships with adults were very formal and discussions on such subjects seemed unacceptable could be a positive point when working with parents. As they can relate to parents, this could help them to understand parents' sometimes reluctant attitude towards new social realities.

Some situations from the training illustrate these assumptions.

Example 1: *One of the seminar topics was human reproductive system. The participants were handed pictures with schematically drawn female and male reproductive organs and it was suggested to name each part. This task resulted in an unexpected reaction from the audience (i.e. teachers). The teachers being trained in this particular seminar were comprised of two men and twenty-five women. The senior male teacher stepped out of the room right away and refused to be present during this task. Some of the female participants refused to even look at the pictures and the trainers could not convince them otherwise. Those female teachers who did look at the pictures could not correctly identify the parts of male reproductive system. What is even more noteworthy, as it was mentioned earlier, almost all of the participants were biology teachers.*

Example 2: *Some contraceptives had to be bought before the beginning of the seminar as visual aids. When one of the organizers of the seminar, prior to the training asked a local drugstore worker on means of HIV prevention while purchasing the condoms, the reply was: 'I don't know, I'm not married.'*

III.3.4 Work with students

This programme popularises the importance of an informal atmosphere in class when discussing these subjects with students, as it puts the students at ease and encourages them to converse, rather than simply listening to lectures on HIV and AIDS. This aspect is very important for Azerbaijan, since in the current school system, students are taught to sit quietly and carefully listen to the teacher. Such an atmosphere does not leave space for questions in class, or for dialogue of different opinions, and moreover does not allow teachers to check how the students perceived and absorbed new material.

This programme suggests that group work with students represents an effective and efficient model of educating a large amount of people. However, in addition to all the advantages of group work –(e.g. exchange of views, removal of prohibition on the subject, etc.) in an environment where social opinion is very important, many students, even the most daring and educated ones, may be afraid or embarrassed to ask more in-depth and intimate questions. That's why it is necessary to offer additional opportunities for individual student consultations, whenever it is convenient for them, in an environment that this particular educational programme did not provide.

Moreover, the programme was not gender sensitive and did not provide for a different session for girls and boys. Given the existing gender relations, the advantages and limitations of holding the class in mixed vs. single-sex groups should also be taken into account when planning the work.

Use of supplementary materials

Audio-visual materials and educational material that contain sketches or cartoons (successfully used in other programmes on HIV and AIDS, for example by Street Kids International) have proven effective in work with children and teenagers for the following reasons:

- Allowing the atmosphere to relax, decrease the tension and not presenting HIV as something scary and awful;
- When a person, and especially a child is presented with a subject verbally, it does not seem convincing. S/he forms the characters her/himself and often her/his views and stereotypes are based on her/his imagination. Observing other people, it is hard to believe that situation is real. So, the video materials can show the realities and try to break the stereotypes;
- Video materials help adults (teachers) in Azerbaijan avoid the necessity of talking about 'hard' subjects and pronouncing embarrassing words;
- Professionally prepared video materials prevent the subject from being influenced by the biased views of the teacher. (Of course, the teacher's views will be revealed when s/he facilitates a discussion of the subject);
- Most of the teachers assign the human reproductive system for homework, as it is mandatory in a school programme. In Azerbaijan, teachers decide on their own whether to talk or not talk about subjects they don't feel comfortable. So the use of video materials may guarantee that students will receive equal, complete, correct and undistorted information.

Subjects on HIV and AIDS are often the first time sex-related conversations are discussed for children. And since children don't have any experience of their own, such lectures provoke questions, to which they will not be able to receive a proper answer, as they are uncomfortable with the teacher.

III.3.5 Work with the parents

Despite the fact that the need to work with parents was clearly stated in the manual, there was no information given on ways to do or organize this, either in the manual or during training.

It was noted that the family is the source of support for teenagers and that it is most difficult for parents to find a common language with the teenager at this age; teenagers begin claiming their independence from the family and prefer to communicate more with people of the same age. But how to reach the point where the family creates a bridge for communication with the teenager and is ready to help when help is needed? This is not clear to parents or trainers (teachers). Not only do parents often not know how to behave with children in this situation, they also do not know where to obtain this information or who to consult for advice.

Thus, parents not only appear excluded from the whole process of education, but also deprived of the possibility to: find out about the programme prior to it being held with their kids and ask questions about the programme, express their opinion, make suggestions and give the permission.

Most of parents grew up in a time when there were no such programmes at schools, and as this programme was foreign to them, and unawareness of something may provoke fear. Additionally, ignorance of parents raises suspicions, anxiety and indignation towards such programmes. As the interviews with the parents showed, most of them understand the necessity of their children obtaining HIV prevention knowledge. Often, it is the method and timing of instruction that they do not agree with. According to school programme, students begin to study human anatomy, which includes human reproductive system and reproduction,

in the 8th grade (at 14 years of age). This is the age parents consider correct to start programmes on HIV and AIDS.

Therefore, 'shocked' reactions and resistance may be understandable after taking into account the local cultural norms in a country where parents often do not even allow their children to watch kissing on TV, let alone finding out that their child (especially their daughter) was shown a condom and taught how to use it.

Most parents, when they become aware of the real risks to HIV, are even glad that the school has taken upon itself the responsibility of teaching children methods of health protection. They often understand that they won't be able to prepare their children for this problem, either because of a lack of information, or because of their discomfort with the subject. Nevertheless, they are open to new information to fill in their own knowledge gaps and know how to react to their children's questions.

However, it is important to know that not all parents hold such a reasonable and weighted position. There are cases when parents are convinced that this problem does not threaten their children or themselves. Most often this is due to lack of information, and incorrect and perverted images about HIV and AIDS in general.

Such cases reveal the necessity of first holding these educational programmes for adults, as they are the ones who hold the strongest stereotypes and most often demand the termination of school programmes. It is vital not to blame them for such views, but rather, to understand them. The legitimacy of objections should be taken into account in such situations. Parents should be invited to dialogue and help improve educational programmes for children and youth. The feeling of ownership and involvement in the process will decrease their resistance and give teachers a chance to present more correct information on HIV and AIDS and programme itself.

From an interview with Elmina Kazimzade, the Director of Educational Department of Open Society Institute – Assistance Foundation.

Trainings on 'Health Education' with a part dedicated to HIV and AIDS were held 7 years ago with the financial assistance of Open Society Institute.

How was the programme perceived?
The training was perceived very well, as it bore practical character. Participants, school psychologists, were equally trained of ways of teaching this subject and received knowledge not only on [HIV/]AIDS, but also on working out skills of healthy lifestyle.

Were there any shortcomings in the programme?
[HIV/]AIDS was presented as a separate subject. The school psychologists talked about it, but regular teachers didn't at all. The school psychologists do not have classes at school. I think this subject should be integrated into the educational programme in order to avoid it being presented as something frightening and prohibited. The programme must pursue its aim - to bring knowledge. The choice and social responsibility must be left to students. When people are threatened, it raises an effect of prohibition and society frightened of [HIV/]AIDS becomes aggressive towards the people [living with HIV]; the rate of illness statistically does not change.

Have you tried to adopt the programme to local environment (social and cultural)?
Back then, programmes were not written, they were adopted. Firstly, we considered the terminology meanings, but cultural adoption was not one of the tasks.

How can educational programmes on [HIV/]*AIDS be adapted to the local environment?*

In my opinion the programme should stay within the course framework, but teachers and school psychologists should find their own way to deliver this subject to the audience. Biology and human anatomy teachers should include a subject on [HIV/]AIDS in their course. I would recommend not to separate the class, but to hold it with all the students present. Otherwise gender interaction is lost.

Do you plan to hold more programmes on [HIV/]*AIDS?*
Yes, [… w]e want not only to promote the [HIV/]AIDS subject, but mostly to help teachers effectively deliver the subject, i.e. help with the methodological side. We aim at making the lectures on [HIV/]AIDS [have an impact on moral relationships and values]. Later on, we will develop a package of interactive education and manual with recommendations for the existing biology and anatomy educational programmes.

PART IV. Major Conclusions and Recommendations

IV.I Conclusions

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.

Vital importance must be attached to all key social and cultural factors when implementing purposeful, targeted and effective activities aimed at preventing the further spread of the epidemic and improving the quality of life of PLHIV. These factors must be reviewed while developing and implementing educational, awareness-raising, outreach, medical and other support programmes.

IV.2 Overview of the HIV epidemiological situation

- Currently, the HIV epidemic in Azerbaijan is at a stage of ‘concentrated epidemic’ affecting mainly people in key social groups at particular risk and vulnerability to HIV (IDUs, CSWs and migrants);
- The current concentration among the above-mentioned key populations, despite general awareness of HIV, means that the general population often underestimates the possibility of infection and does not practice safe behaviour (relative to HIV);
- As a result, HIV and AIDS issues are frequently associated with ‘immoral’ conduct (especially with key populations such as CSWs, IDUs and MSM). The stigmatisation and marginalisation of these social groups and negative stereotypes prevent the establishment of an open dialogue;
- Azerbaijani society predominantly adheres to traditional models of such institutions as family, relations between men and women, and sexual behaviour. Public discussions of issues related to the sexual and intimate relations – including STIs and HIV – are not welcome;
- Currently, ARV treatment medication is not widely available.

IV.3 Recommendations

IV.3.1 Policy and Programmes

In recent years, both governmental and non-governmental organisations have contributed significantly to HIV-prevention activities and established legislative and organisational response mechanisms aimed at responding to the HIV epidemic. However, many areas still need improvement.

- Since currently, HIV prevalence remains concentrated among mainly ‘at-risk’ groups, more programmes and services purposely oriented on these groups (and their partners) and other key populations considered at risk to HIV – youth, IDUs, CSWs, MSM, prisoners and migrants – must be designed and implemented (all programmes must be culturally appropriate, age and gender responsive, and fully respective of human rights);

- Activities aimed at solving problems indirectly connected to the spread of HIV must be encouraged and supported. In particular: 1) taking more critical measures focusing at solving

the poverty problem and ensuring economical security for the whole population to reduce the number of migrants and CSW; 2) intensively developing drug prevention-and-care and drug dependency treatment programmes; and 3) ensuring gender equity and equality and increasing 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 made available widely.

IV.3.2 Information, Education, Communication

Many of the existing awareness-raising campaigns focus only on medical information about HIV transmission and prevention, and don't always consider local socio-cultural peculiarities.

ACCESS TO INFORMATION

- At the stage of developing and implementing educational programmes, the equal involvement of all age groups into programmes must be in place. Studies show that the majority of implemented programmes were focused on young people (mainly of school-age), whereas older people – who probably are more exposed to the stereotypes and prejudice around the topic – tended to fall out of the focus groups;
- Special measures must be elaborated and followed up ensuring access to education programmes and other information for certain groups (housewives, middle-age people, unemployed, villagers), which so far were restricted from such information;
- Certain conditions and (human and informational) resources must be established to serve as a database for periodic references (on completion of education programme).

PROMOTION OF DISCUSSION PRACTICE

Due to social norms and values, public discussion on sensitive topics (HIV and sexual life) is not welcome in the Azerbaijani society. As a result, many parents often do not support HIV and AIDS and reproductive health education programmes for their school-age children, and schoolteachers find it very difficult and uncomfortable to conduct lessons on this topic.

Accordingly, in order to reduce the level of the population's resistance to and non-acceptance of discussions on the sensitive topics, there is a need to get the population ready by creating a new approach to the public discussions of such issues. All education and awareness-raising programmes must have a component concerning discussion of stereotypes and norms of behaviour in order to lay the foundation for sessions with purely medical information about HIV transmission and prevention.

Education programmes must:

- be delivered within the framework of discussions about culture and ethics of behaviour in family, which should contain indirect HIV-related messages;
- be aimed at establishing an open and trusting relationship between adults and children;
- establish conditions and encourage openness about the issue;

- be conducted within the framework of local values and show various views on the issue (family, religion);
- HIV education programmes must foster 'student-teacher' interaction, enhance a sense of connectedness and security, and provide access to trusting adults.

PROMOTION OF BEHAVIOURIAL CHANGE

Experience has shown that awareness about HIV does not guarantee use of this knowledge. Thus, some social stereotypes and restrictions, rather than lack of knowledge, prevent people not only from learning the information, but also from efficient use of obtained knowledge. Because some programmes did not consider existing principles and stereotypes, features and peculiarities in family relationship, various social situations that encourage high-risk behaviour and lack of precautions, they were not successfully implemented.

- Education programmes, together with information on HIV and precaution measures, must be aimed at overcoming barriers, discussing stereotypes and changing the directives that prevent healthy lifestyles.

- Early identification and treatment of STI and HIV, voluntary and confidential counselling and testing should also be promoted.

Prevention programmes designed for given local peculiarities, ethical norms of conduct and cultural values drafted and approved, should be aimed at the de-popularisation of conduct that puts individuals at risk, and the encouragement of responsible sexual behaviour, including monogamous marriage.

GENDER SENSITISATION AND RESPONSIVENESS

Even being aware of prevention measures, gender inequalities (and in particular male dominance) in all intimate relations does not allow for negotiation on safer sex and equal rights when deciding what method of prevention to choose.

- Therefore, gender sensitivity must become an important component in drafting prevention and education programmes.

HUMAN RIGHTS APPROACH

Given the stigmatising, discriminatory and negative public opinion toward PLHIV and other key populations that are marginalised by society, efficient strategies on prevention, care, support and treatment of HIV must:

- Be conducted within the framework of human rights;
- Encourage a reassessment and change of views on attitudes to PLHIV; and
- Maintain a non-discriminatory approach to, and equal access for, various groups in the population.

CONSIDERING LOCAL PECULIARITIES

A significant part of work, especially at the start, was done by international organisations, which deepened the prevalent stereotype of 'bringing in the HIV problem from outside' and had the effect of increasing the resistance to HIV-related information by various population groups.

- In order to interest the largest number of people, especially parents, education programmes in Azerbaijan must demonstrate the reality of infection for various population groups and present information on HIV trends in Azerbaijan, rather than citing only global statistics on HIV.

Parents often recognize the importance of education programmes in making their children aware of the problem, but they don't always accept the methods of presentation (for example, condom demonstration and distribution, in particular to schoolgirls).

In order not to trigger resistance to the information, HIV education programmes must be in line with the prevailing cultural values. In particular;

- School teachers and parents believe it is illogical and unacceptable to conduct education programmes among children aged 10-14, but upperclassmen (aged 15-17) are considered to be the appropriate age for education programmes;
- Parents also prefer that their children obtain information on HIV from a professional trainer. Teenagers also find this method more comfortable;
- However, parents must be the part of the process, and be informed on what kind of information, and why, will be presented to their children;
- Programmes where a rural population is the focus group have to be adapted so that they are in line with norms of life particular to the region;
- Many parents cannot accept that their children (particularly daughters) are getting information on sexual life before they are married. In order not to arouse public indignation, especially in rural environments with deep-rooted traditions, a focus group should be given to girls who are getting married.

Special attention should be paid to studying the positive and, in some cases, negative role of the family in activities aimed at the prevention and treatment of HIV and AIDS, and support and care of PLHIV.

- Parents, families and PLHIV themselves, as well as religious figures and young people, must be involved in all stages of developing, planning, implementing and evaluating HIV and AIDS programmes.

- And lastly, if possible, international assistance programmes for refugees and IDPs should include components of HIV and AIDS awareness and sensitisation.

IV.3.3 Training

Strengthening human resources and the national medical and social infrastructure must become priorities. Whereas one part of the society is not ready to perceive HIV-related information adequately and sufficiently, another part (experts, trainers) are not always ready to communicate unbiased knowledge in the best way. Before training children and teenagers, there is a need to first train and prepare adults (teachers and parents).

- A special group of trainers must be staffed, who will be responsible for developing training materials and conducting awareness campaigns that take into consideration local values and the peculiarities of work with various groups (young people, rural population, high-risk behaviour groups).

- Training of experts rendering not only educational services, but also other types of support to high-risk behaviour groups, including palliative care, should be considered.

IV.3.4 Information and research

The majority of HIV and AIDS surveys in Azerbaijan were carried out among the general population and were aimed at determining the level of awareness about HIV and people's attitude toward PLHIV. However, the current number of studies conducted among PLHIV or people at particular risk of infection is insufficient. Thus, a more comprehensive survey of the

following issues could help considerably during the development of HIV-prevention programmes and support programmes for PLHIV:

- Key patterns and factors influencing on risk behaviour among various age brackets and social groups of population, including key social groups vulnerable to HIV;
- More detailed demographic and social data on key populations (e.g. IDUs, CSWs, MSM, migrants, IDPs);
- Reasons why social problems are closely associated with HIV (e.g. drug use, migration, gender issues);
- Review of the range of medical, educational and social programmes and services, their accessibility and usage by the general population and key populations, as well as programmes conducted by the beneficiaries;
- Status and living standards of people living with HIV (main problems they encounter, access to and usage of various services, access to ART, etc.);
- Review of cultural, family, ethical and religious norms (factors) that play a part in epidemic prevention, care, support and treatment of HIV;
- Economic, social, cultural, financial and legal factors complicating efforts to raise awareness and educate about infection prevention, care and support of PLHIV.

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Annex I: Biography of authors

Leyla Ismayilova graduated from Columbia University in New York with a master's degree in social work in 2002. Previously she also received a master’s degree in psychology from Baku State University, Baku in 1999. 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.