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Labor Migration and STI/HIV Risks in Armenia: Assessing Prevention Needs and Designing Effective Interventions

Analytical Report

Prepared by

Victor Agadjanian, PhD
Karine Markosyan, PhD
CRRC-Armenia Team

The Caucasus Research Resource Center – Armenia

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TABLE OF CONTENTS

LIST OF ACRONYMS	4
ACKNOWLEDGEMENTS.....	6
EXECUTIVE SUMMARY	7
1. INTRODUCTION	10
2. METHODOLOGY.....	11
2.1 Desk study	11
2.2. Quantitative component	11
2.3. Qualitative component: in-depth interviews	12
2.4. HIV and STI testing component	12
2.5. Expert interviews	13
3. RESULTS	13
3.1. Desk study	13
3.1.1. The history and current state of the HIV epidemic in Armenia.....	13
3.1.2 Overview of cross-national evidence of the connections between migration and HIV, with a focus on Eurasia.....	16
3.1.3 Labor migration from Armenia and vulnerability of Armenian labor migrants and their partners to HIV	18
3.1.4 Analysis of current HIV- and migrant-related policies at the country and bilateral/multilateral levels (international agreements)	23
Armenian National Policy on HIV/AIDS.....	23
<i>Legislative Framework</i>	23
<i>Coordination, management and financing of the National HIV/AIDS Program</i>	24
<i>Targeting migrants in the National AIDS Program (NAP)</i>	25
Armenia state regulation of migration and bilateral/multilateral agreements	25
HIV and health related policies in the Russian Federation	28
3.1.5 Mapping of existing migrant HIV projects/programs in Armenia.....	29
3.2 Findings from the survey of migrant and non-migrant households.....	34
3.2.1 The demographic profile of the survey sample	34
3.2.2 Perceptions of STI/HIV risks.....	36
3.2.3 Strategies to avoid STI/HIV infections	36
3.2.4 HIV risk factors.....	37
Drug use	37
3.2.5 Spousal communication about STI risks and condom use within marriage	40
3.2.6 Access to and use of HIV counseling and testing services.....	41
3.2.7 Exposure to HIV/AIDS information and programs	42

3.2.8 Understanding of HIV/STI infection risks	44
3.2.9 Tolerance toward persons living with HIV/AIDS (PLWHA)	45
3.3 Insights from in-depth interviews.....	46
3.3.1 Household health-related decision making.....	47
3.3.2 Gender issues and the role of men and women in the family.....	48
3.3.3. Reproductive health.....	50
3.3.4 Sexually transmitted infections	51
3.3.5 HIV/AIDS awareness and sources of information	52
3.3.6 Attitude towards people with HIV	56
3.3.7 Migration and HIV	57
3.3.8 Experience of HIV testing	58
3.3.9 Access to and utilization of VCT centers	59
3.3.10 Health services and HIV testing in destination countries.....	60
3.3.11 Summary of in-depth interview findings.....	61
3.4. HIV testing	61
3.5 Findings of expert interviews: Existing problems and their possible solutions.....	63
3.5.1 Specific HIV and STI risks of Armenian migrants and their family members and recommendations on how to reduce these risks.....	63
3.5.2. Limitations to the principle of universal access to HIV counseling and testing: Recommendations on how to increase the access and utilization of VCT	66
4. CONCLUSIONS AND RECOMMENDATIONS.....	69
4.1 Strengthening research on HIV risks and prevention among migrants	69
4.2 Awareness raising	69
4.3 Increasing migrants' access to and utilization of VCT services.....	70
4.4 Improving HIV prevention interventions targeting migrants.....	71
4.5 Optimizing migration policies and cross border cooperation for HIV/AIDS prevention.....	72
4.6 Optimal package of services for migrants and their spouses.....	73
BIBLIOGRAPHY	74
ANNEXES: LABOR MIGRATION AND STI/HIV RISKS IN ARMENIA SURVEY INSTRUMENTS	78
A1. Title page of the Survey Questionnaire (for female and male).....	78
A2. Survey Questionnaire for Female.....	78
A3. Survey Questionnaire for Male	78
A4. Expert interview Guide	78
A5. In-depth interview guide	78

LIST OF ACRONYMS

ADP – area development program
AIDS – Acquired immune deficiency syndrome
ANAF – Armenian National AIDS Foundation
AYF – Armenian Youth Foundation
ART – antiretroviral therapy
BBP – Basic Benefit Package
BCC – Behavior Change Communication
BBS – behavioural and biological HIV surveillance
CCM – Country Coordinating Mechanisms
CHV – Community Health Volunteer
CIS – Commonwealth of Independent States
CRRC – Caucasus Research Resource Centers
FGD- focus group discussion
FSW / CSW – female sex worker / commercial sex worker
GFATM – Global Fund to fight AIDS, TB and Malaria
GO – government organization
HIV – Human immunodeficiency virus
HTC – HIV testing and counseling
IDU – injecting drug use or injecting drug user
IO – international organization
IOM – International Organization for Migration
MARP – most at risk populations (in terms of HIV transmission)
ME – Mission East
MMT – Mobile Medical Team
MoT – mode of HIV transmission
MSM – men who have sex with men
NAP – National AIDS Program
NCA – Norwegian Church Aid
NCAP – National Center for AIDS Prevention, Armenia
NGO – non-governmental organization
NSA – non-state actor
PHC – primary health care
PITC – provider Initiated HIV Counseling and Testing

PLHIV / PLWHA – people living with HIV / people living with HIV & AIDS
PSA – Public social advertisement
RA – Republic of Armenia
RCC – Rolling Continuation Channel
SAMSA – Scientific Association of Medical Students of Armenia
SHA – State Health Agency
STD – sexually transmitted infection disease
STI – sexually transmitted infection
TB – tuberculosis
UFC – user friendly clinic
UMCOR – United Methodist Committee on Relief
UNAIDS – the Joint United Nations Program on HIV/AIDS
UNDP – United Nations Development Program
UNESCO – United Nations Education, Scientific and Cultural Organization
UNFPA – United Nations Population Fund
UNGASS – United Nations General Assembly Special Session
VCT – Voluntary Counseling and Testing
WHO – World Health Organization
WV – World Vision

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As part of its committed efforts to address the complex issues surrounding HIV/AIDS and STIs in Armenia, the Global Fund to fight AIDS, TB and Malaria, along with its partner Mission East-Armenia, conceived and initiated the following report that addresses the HIV/AIDS and STI risks of Armenian migrants and their families.

The Caucasus Research Resource Centers-Armenia (CRRC) of the Eurasia Partnership Foundation was contracted as the implementing partner for the project. CRRC was responsible for conducting the survey and coordinating the project in close co-operation with Mission East - Armenia staff.

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EXECUTIVE SUMMARY

Recent evidence has shown that migration has become a major driving force of the HIV epidemic in the Republic of Armenia (RA). Taking this into account, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other funding agencies have considerably increased the amount of funding allocated for HIV prevention activities among migrants and their spouses. However, the HIV prevention strategies targeted at migrants and their spouses and the package of services for them are not well defined, which is at least partly due to a shortage of comprehensive studies that focus specifically on HIV among labor migrants in Armenia.

To address these growing concerns about the HIV vulnerabilities surrounding labor migration, the Caucasus Research Resource Center of Eurasia Partnership Foundation in Armenia (CRRC-Armenia), with financial support from Mission East - Armenia and technical assistance from the National Center for AIDS Prevention and Medical Scientific Center of Dermatology and STIs, designed and implemented a nationally representative study on labor migration and HIV/AIDS and STIs in Armenia. The aim of this study was to examine STI/HIV risks among labor migrants and their marital partners; to assess the scope, scale and quality of current regulations and activities on HIV prevention among this population segment; and to produce recommendations for comprehensive, evidence-based, culturally-grounded, and cost-effective interventions for expanding and optimizing these regulations and activities.

The study, implemented between November 2012 and March 2013, consisted of five main components: a desk study; a nationally representative standardized survey of migrants and non-migrant households; in-depth interviews with selected migrants and their partners; free, confidential, and anonymous HIV and STI testing for the study participants; and expert interviews with policymakers and health professionals.

The desk study supplied ample evidence of elevated HIV/AIDS and STI vulnerabilities associated with labor migration globally and in the context of the RA, in particular. The desk study also identified considerable shortcomings in the current legislation, policies, and activities aimed at increasing the public awareness of HIV/AIDS and STI risks stemming from labor migrations and at reducing these risks through effective education, counseling, and prevention.

The analyses of the collected field data point to serious gaps in the public's understanding and awareness of HIV and STI risks. Although the study participants were well aware of the main modes of HIV and STI transmission and the main protective behaviors, misconceptions about HIV and STI transmission remain widespread. Alarming, most study participants demonstrated little concern about their own risks of HIV and STI infection. The survey and qualitative interviews also illustrated a strong stigma regarding especially HIV/AIDS and widespread intolerance toward persons living with HIV/AIDS. The study also found low levels of communication about HIV and STI risks. The lack of communication coupled with low rates of condom use among marital partners raises particular concerns about the HIV and STI risks of the marital partners of migrants.

The survey demonstrated that male migrants were much more likely to engage in risky behaviors (sex with extramarital partners, use of commercial sex services, and low levels of both consistent condom use and refusal to engage in unprotected sex) than their non-migrant counterparts.

At the same time, the study found that migrant men were much more likely than non-migrant men to know where one could be tested for HIV and to have ever been tested for HIV. This

difference was mostly due to testing required for legal employment in the Russian Federation. However, because evidence supplied by the desk study shows that migrants tend to contract HIV in the countries of destination, HIV testing prior to entry into those countries does little to detect possible infection and to alert migrants to potential risks. It is therefore critical that migrants get tested upon returning from migration.

With regard to HIV testing, the study demonstrated that offering an HIV test free of charge at a local clinic is not a strong enough incentive. Although male migrant study participants were more likely to request an HIV test than their non-migrant counterparts, even among them only 7.0% did so.

Although one-third of all survey respondents knew where to get information about HIV/AIDS and STIs, only 1.5% of migrants and some 3% of migrants' marital partners had ever been involved in HIV/AIDS awareness campaigns. The study participants identified television, followed by print media, as the best channel for disseminating information on HIV risks and prevention. All participants, regardless of migration status, overwhelmingly supported the idea of making educational information on HIV and STIs available to school students (7-11 grades) of both sexes.

The following recommendations were developed to address the gaps in migrants' knowledge and awareness of HIV and STI risks and in their access to and utilization of especially HIV/AIDS counseling, testing, and treatment:

Awareness and Knowledge

- Design information and educational programs as well as public social advertisements (PSAs) and broadcast them regularly on TV and in other media.
- Develop special informational and educational materials related to migration-specific HIV risks and HIV/AIDS prevention for migrants and their family members. Make these materials available at health facilities and other locales frequented by migrants and their family members and disseminate these materials to migrants at their homes by outreach workers.
- Provide HIV/STI-related information in various forms (video, printed materials, etc.) at the airport, inside airplanes, at the air tickets booking offices, and at the land border posts.
- Disseminate HIV/STI- and migrant-related information through the Internet and SMS.
- Conduct special awareness-raising events (e.g., community meetings, lectures).

Access

- Revise the national HIV/STI-related regulations and policies to ensure universal access to and maximal utilization of HIV/STI counseling and testing services by migrants and their families.
- Ensure full coverage from the state budget of all costs connected with providing HIV counseling and testing, especially for migrants and their spouses.
- Include HIV/STI-related treatment and counseling for migrants in the job descriptions of both primary healthcare center and family physicians.
- Raise awareness among migrants of the availability of HIV/STI counseling and testing services locally, throughout Armenia, and in destination countries and cities.
- Create new and improve existing capacity for providing quality HIV/STI pre- and post-test counseling at the primary healthcare centers and women's consultation facilities.
- Ensure uninterrupted procurement and supply of HIV test kits and supply rapid HIV tests to all primary health care units and women consultation facilities.
- Ensure uninterrupted supply of rapid HIV tests to NGOs working with migrants in cooperation with the healthcare centers.

- Establish a health unit at the customs stations at the airport to provide voluntary counseling and testing (VCT), syndromic management of STIs, and other non-sexual health-related services.
- Utilize mobile medical teams for providing HIV counseling and testing services.

1. INTRODUCTION

Despite considerable advancement in prevention and treatment, HIV/AIDS remains a major public health concern globally. While in several parts of the world the efforts to contain the epidemic have led to a stabilization of HIV prevalence levels, in transitional societies of post-Soviet Eurasia, the epidemic continues to expand. As in other parts of the world, population mobility may play a non-trivial role in shaping the HIV/AIDS epidemic in the region. Given the high level of international labor migration out of the RA and the rising HIV prevalence in the countries of Armenian migrants' primary destination (the Russian Federation, Ukraine), potential risks of Armenian labor migrants and their marital partners require a careful assessment in order to develop and deploy effective measures to minimize these risks.

The report is based on the results of a nationally representative study carried out in Armenia in November 2012 - March 2013. Designed by Victor Agadjanian, PhD (PI) and Karine Markosyan, PhD (co-PI) and implemented by the Caucasus Research Resource Center – Armenia (directed by Heggine Manasyan, PhD) in collaboration with the Armenian National Center for AIDS Prevention, and the Medical-Scientific Center of Dermatology and STIs and under a grant contract from Mission East–Armenia, the study aimed at identifying unique vulnerabilities to HIV/AIDS and STIs of labor migrants and their marital partners and devising recommendations for HIV/AIDS and STI education and prevention tailored to their needs.

This report starts with a general overview of the study's methodology, including a description of the types of data collected, the sampling design and procedure, and the content of the study instruments. It then describes the results of the five main components of the study:

1. A desk study that involved an exhaustive review of the extant legislation and regulations regarding the provision of HIV/AIDS-related services in Armenia in general and to labor migrants and their families in particular. The desk study also includes a review of cross-national evidence on possible connections between migration and HIV risks.
2. A nationally representative standardized survey of HIV/AIDS and STI-related knowledge, attitudes, and behavior among migrant and non-migrant households.
3. Semi-structured in-depth interviews conducted with a subsample of the survey respondents with the purpose of highlighting complexities and contingencies of migrants' HIV/AIDS and STI risks.
4. Voluntary HIV and STI counseling and testing of the study participants; and
5. Interviews with health professionals and policy experts in the area of HIV/AIDS and STIs mitigation.

The study concludes with a set of detailed and specific recommendations aimed at raising the awareness of migrants and their partners about HIV/AIDS and STIs risks; expanding their knowledge or HIV/AIDS prevention; and enhancing their access to HIV/AIDS counseling, testing, and treatment services.

2. METHODOLOGY

The study consisted of five major components: a desk study; a quantitative component; a qualitative component; HIV and STI testing; and expert interviews.

2.1 Desk study

The desk study included an exhaustive review of existing data, legislative documents, and literature on HIV and its possible connections with migration in Armenia as well as a detailed review of cross-national evidence on the migration-HIV links.

2.2. Quantitative component

The quantitative component was a nationally representative household survey. The survey was conducted in January-February 2013 through face-to-face interviews using a standardized questionnaire.

The survey target population was households of migrants and of non-migrants in Armenia. In this study, the definition of a “household of migrant” is a household with a married couple of reproductive age (women aged 15 to 49 and their spouses or partners) with a partner who worked abroad at least once between 2007 and the time of the survey.

For the sampling of households, the following subgroups/subsamples of the target population were defined:

- a. Migrant men or women
- b. Migrants’ spouses or partners
- c. Non-migrant men
- d. Non-migrant women

The above four subgroups formed a sample of 2,490 respondents (see the composition of the sample by marz in the table 2.2.1), with the following quotas for each subgroup:

- Subsample a. 830 respondents
- Subsample b. 830 respondents
- Subsample c. 415 respondents
- Subsample d. 415 respondents

The study used a multistage stratified cluster sampling methodology. Clusters within each stratum and households within each cluster were selected randomly. A list of electricity network customers in each survey cluster served as the basis for the random selection of households. The size of each sampled cluster is 30 respondents, which is further divided proportionally into groups of 10:10:5:5 to match the aforementioned four subgroups.

Table 2.2.1 Survey sample design by: strata and marz

Marzes/Strata	Ararat	Vayots Dzor	Aragatsotn	Armavir	Kotayk	Tavush	Gegharkunik	Lori	Shirak	Syunik	Yerevan	Total by strata	Grand Total
Capital	-	-	-	-	-	-	-	-	-	-	810	810	2,490
Other Urban	60	30	30	60	120	30	60	120	120	60	-	690	
Rural	180	30	90	150	120	60	120	90	90	60	-	990	

Because of the restrictions for selecting the target population (i.e. respondents' age and migration status within the defined time frame), the main sampling lists were supplemented by a reserve sample of the same size to ensure a sufficient number of respondents. In clusters where both the main and reserve sampling lists were exhausted, snowball sampling was utilized to identify additional migrants and ensure that the required number of migrants is interviewed. In rural clusters, the snowballing was based on the addresses indicated by the municipalities and local medical facilities, whereas in urban areas the snowballing was based on information about migrants living in the area obtained from the interviewed respondents. Table 1 below summarizes the sampling design of the survey component.

Response rates: In total, 6,676 survey interviews were attempted. The final database contains 2,478 completed interviews (37% of all attempts). The remaining 4,198 (63%) attempts were unsuccessful for the following reasons:

- address not found: 304 cases (7%)
- no permanent resident in the address: 640 cases (15%)
- no adult in the household during the entire fieldwork: 39 cases (1%)
- household has no adult member: 30 cases (1%)
- household will not be available during the fieldwork: 738 cases (18%)
- no qualifying respondent among household members: 1,537 cases (37%)
- respondent not available: 126 cases (3%)
- household refusal: 639 cases (15%)
- respondent refusal: 105 cases (3%)
- interview in Armenian language impossible: 40 cases (1%)

Out of the 2,478 completed interviews, 617 (25%) came from the main and reserve samples. The rest of completed interviews (1,861, or 75%) were obtained through the snowball method.

The interview data quality was assured through thorough training of the interviewers, careful observation of planned quotas within clusters, and appropriate ways of administering the study questionnaires that contained highly sensitive questions.

The collected data was processed using the CSPro data entry program. Double entry was used to minimize the number of errors of both interviewers and data entry operators. In addition, the database was put through the standard processes of data checking and data cleaning.

2.3. Qualitative component: in-depth interviews

To complement the standardized survey and further explore the HIV risks faced by migrants and their partners, the study employed qualitative methods, namely semi-structured in-depth interviews. These interviews were conducted with 20 migrants or their spouses/partners from the survey sample. All 20 in-depth interviews were conducted by interviewers with highly relevant qualifications, backgrounds, and sector-specific experience. Out of 20 completed in-depth interviews, 14 were digitally recorded. Six interviewees refused to have their interviews digitally recorded and their answers were written down by interviewers. Upon completion of each interview, the interviewers wrote summaries of that interview (up to 5 pages); these summaries were then compiled into a single analytical summary.

2.4. HIV and STI testing component

This component consisted of free STI/HIV testing of the survey respondents at specified medical/health facilities. Respondents from Yerevan were referred to the Yerevan Medical Scientific Center of Dermatology and STIs, while respondents in areas outside Yerevan could choose between their local facilities and Yerevan Medical Scientific Center of Dermatology and STIs. The blood samples collected at local medical points were stored in special containers and

delivered to the National Centre for AIDS Prevention in Yerevan. All survey respondents were given coupons and leaflets with a contact phone number of the National Centre for AIDS Prevention in Yerevan to call and make enquiries about their test results (upon submission of an anonymous ID number).

All data collection was carried out so as to fully guarantee confidentiality of the study participants. The study was approved by the Institutional Review Board of the National Center for AIDS Prevention (NCAP).

2.5. Expert interviews

Interviews were conducted with 15 experts. Nine of them are high-level stakeholders in Yerevan who are involved in HIV-related decision making, policy development and program implementation for migrants. The remaining 6 expert interviews were carried out with VCT providers outside Yerevan, to evaluate migrants' access to, and utilization of, VCT services.

3. RESULTS

3.1. Desk study

3.1.1. *The history and current state of the HIV epidemic in Armenia*

The first case of HIV was detected in the RA in 1988, and as of January 31, 2013 1,395 cases had been registered with 228 new cases of HIV infection registered during 2012 (NCAP, 2013). The AIDS diagnosis has been made to 713 patients with HIV, of whom 133 were registered during 2012 (NCAP, 2013). The estimated number of people living with HIV (PLHIV) is around 3,500, with an overall HIV prevalence in the general population of 0.1%. The number of HIV cases recorded in 2012 exceeds the number of cases registered annually in the preceding years (148 and 182 in 2010 and 2011, respectively). Based on these statistics, the experts suggest that the HIV epidemic in Armenia started later than in many other countries and has not yet reached its natural peak (Wilson et al, 2012).

The increase in registered HIV cases over the last five years is attributed in part to the scaling-up of laboratory diagnostic capacities, increased accessibility to HIV testing, and the establishment a VCT system in 2004 (Grigoryan et al, 2012). Provider initiated counseling and testing (PITC) services are offered in state-run out-patient medical institutions (antenatal clinics, dermato-venerological, narcological, and tuberculosis (TB) centers, the National Center for AIDS Prevention (NCAP)) through established PITC and VCT sites. The number of sites providing VCT increased from 29 in 2007 to 150 in 2012 (Grigoryan et al, 2012).

As a result of these developments, the number of HIV tests performed has increased from 71,882 in 2010 to 83,827 in 2012 (National HIV Surveillance Data, 2010-2012). Most HIV tests conducted in Armenia are those routinely performed among pregnant women and blood and organ donors (52% and 20% of all HIV tests, respectively in 2012). There were 99 migrants tested for HIV during the year 2012, however, it should be noted that the registration of migrants as a separate group only started in October 2012 (National HIV Surveillance Data, 2012). Geographical location has a substantial impact both on access to HIV testing and on the likelihood of being diagnosed with HIV. Out of all people tested for HIV between 2004 and 2010, 49.6% lived in Yerevan, 31.7% in other cities, and 18.7% in rural areas (International Organization for Migration 2011a). Armenian residents aged 20-29 are currently substantially under-represented in HIV testing compared to the proportion this group represents within the general population of Armenia (International Organization for Migration, 2011a). The increase

in HIV testing is also associated with raising the level of HIV/AIDS-related knowledge among health care workers through relevant trainings provided by NCAP (*United Nations General Assembly Special Session (UNGASS): Country Progress Report Republic of Armenia, 2012; Cunningham, 2011*).

The number of new cases of HIV and AIDS has increased in part because in recent years, more Armenian citizens with HIV diagnosis and clinical symptoms have returned to Armenia from other Commonwealth of Independent States (CIS) countries, particularly the Russian Federation (National HIV Surveillance Data, 2010-2012). Out of an estimated 60,000 labor migrants seeking job in the Russian Federation, only 46 underwent HIV testing and counseling in 2010 and the majority of them applied due to clinical symptoms. The highest HIV detection rate in 2010—42%—was observed exactly in this group. Finally, the increase in registered cases may be explained by improved efficiency of the epidemiological surveillance system.

National HIV surveillance data has been available from the NCAP since 1988. This data contain demographic and clinical information on people diagnosed with HIV, including age; sex; marital status; date of HIV, AIDS, and death diagnoses; location of residence (marz); suspected mode of transmission; place and date of likely transmission; presence of an STI; (antiretroviral therapy) ART use; and t-cell (CD4) count at diagnosis (International Organization for Migration, 2011a). Based on the surveillance data, the pattern of the HIV epidemic in Armenia is as follows:

Males constitute the majority of the total number of HIV cases - 983 (70.5%); there are 412 (29.5%) females infected with HIV; 55.8% of the HIV-infected individuals were 25-39 years old at the moment of the HIV diagnosis. The highest number of HIV registered cases per 100,000 people is in Shirak marz – 51.9, followed by Yerevan, Lori, and Armavir marzes with rates of 47.9, 47.2 and 42.2, respectively (NCAP, February 2013). Between 2001 and 2010, the number of registered HIV cases increased in rural areas by more than 3.5 times and among women by more than 3 times. Between 2001 and 2012, the average age at first HIV positive test increased from 34 to 37.8. During the same period the estimated average age of infection was 29 years old, which means that HIV is detected at late stages in many individuals (National HIV Surveillance Data, 2001 - 2012).

Over the past six years, the major mode of HIV transmission (MoT) in the country has shifted from injection drug use (IDU) to heterosexual intercourse. Transmission through IDU reached a peak of almost 67.0% of registered cases in 2007 and has since decreased to 33.9% in 2012. The proportion of HIV cases attributed to heterosexual intercourse transmission has increased two-fold over the past 12 years, from 27.6% in 2000 to 57.0% in 2012. More women than men were infected via sexual contact, while transmission via IDU occurred predominantly among men (National Strategic Plan on HIV & AIDS, RA, 2012-2016). A significant number of HIV infected people became infected outside Armenia. Between 2007 and 2010 the estimated proportion of women infected outside Armenia has increased almost 300% among HIV cases. During the same period, IDU was the predominant MoT for men infected outside Armenia and heterosexual intercourse was the predominant MoT for men infected in Armenia. The proportion of HIV transmission through IDU among men infected in Armenia increased only slightly between 2007 and 2010 (Grigoryan et al. 2012).

According to the most recent simulation model, if the current conditions persist, it is expected that HIV incidences will continue to increase in Armenia by an estimated 57% annually from 2011 to 2020 (Wilson et al, 2012). However, this prediction may be too optimistic: the real number of new registered HIV cases in 2012 (228) far exceeded the most pessimistic projections (172) made in 2010 (Papoyan et al, 2011, p.51, Table 12). Inconsistency between prognoses and reality may be explained by the increasing impacts of migration to the HIV

epidemic in Armenia. According to National HIV Surveillance Data, among the HIV cases registered in Armenia between 2009 and 2012, 55% stated they were infected with HIV outside Armenia, mostly in the Russian Federation and Ukraine. Out of the 228 HIV cases registered in Armenia in 2012, 141 persons (62%) were infected outside Armenia (including 126 who were infected in the Russian Federation) and 45 (20%) who were sexual partners of those infected outside Armenia (National HIV Surveillance Data, 2009-2012). This data suggests that recently migration has become a major driving force for the spread of HIV in Armenia.

The Armenian national HIV/AIDS strategic planning is guided by the latest evidence on effectiveness of interventions and global best practice. The original data for strategic planning is provided by behavioral and biological HIV surveillance (BBS) studies. The formulation of the plan for 2012 through 2016 took into consideration the results of 2010-2011 BBS (HIV BBS, 2011). In accordance with the guidelines of the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS), the biological surveillance, aimed to assess the HIV prevalence, was conducted only among the most-at-risk populations (MARPs), IDUs, female sex workers (FSWs) and men who have sex with men (MSM). Behavioral HIV surveillance, aimed to identify behaviors driving HIV transmission and to assess the level of knowledge of HIV prevention, was conducted in groups of population vulnerable to HIV, including migrants. According to the data from biological surveillance, HIV prevalence among IDUs was 6.5%, among FSWs - <1%, and among MSM - 3.4% (HIV BBS, 2011). Based on the prevalence data, the experts classified the HIV epidemic in Armenia as a concentrated epidemic driven by MARPs (Cunningham, 2011; Papoyan et al, 2011; International Organization for Migration, 2011a). Accordingly, the HIV prevention strategies within the National AIDS Program (NAP) for 2012-2016 have focused predominately on reaching MARPs (National Strategic Plan on HIV & AIDS, RA, 2012-2016).

Another study that guided the strategic planning was the *HIV Situation and Response Analysis* (2011). Among the conclusions of the study were the following: “HIV prevention resources should be aligned to those population groups in which new HIV infections are occurring” and “The needs of the labor migrants in HIV prevention, access to HIV testing, treatment and care should be addressed”. Based in part on the conclusions of this study, GFATM-supported AIDS Program allocated €269,000 for HIV prevention activities among migrants, which is much more than amounts allocated for the same population in the previous programs. The program for 2013-2015 also suggested that out of estimated 60,000 labor migrants in Armenia (Papoyan et al, 2011), 50,000 will be covered by prevention services by the year 2015. However, the program doesn't clearly define what prevention strategies should be utilized and what services should be provided. One possible reason for that is that the populations of migrants and their spouses are understudied and therefore their risk profiles are not clearly defined. To understand the impact migration has on the HIV epidemic in Armenia, sufficient financial resources should be allocated to research and monitoring studies among migrants and their family members.

In preparation for the next round of strategic planning, international experts were invited to conduct a study aimed to estimate what it would take, in terms of targeted program implementation and associated financial resources, first to reverse the increasing trend of HIV incidence in Armenia and then to achieve the goal of zero new infections, defined by the WHO's elimination threshold (Wilson et al, 2012). Through reassessment of the modes of HIV transmission in Armenia, evaluating the relationships between investments, program implementation and impact, coupled with insights from experiences from comparable countries, epidemic trajectories associated with different prevention strategies were projected. The study estimated that currently, approximately half of all new HIV infections in Armenia occur in the general population, including migrants and partners of MARPs. However, despite these findings, migrants are not mentioned in any of strategies that the authors suggest. Based on the fact that Armenia has limited financial resources for designing and implementing effective

programs, the authors suggest: "...combinations of ART and basic prevention programs can feasibly reverse HIV epidemics towards stabilization. The most cost-effective combination of programs has been identified for various levels of available funding and generally involves targeting funding towards MARPs in alignment with risk profiles and epidemiological trends" (Wilson et al, 2012). Thus, if the next NAP takes into consideration these recommendations, the needs of migrants and their spouses in HIV prevention services will most likely not be met.

3.1.2 Overview of cross-national evidence of the connections between migration and HIV, with a focus on Eurasia

A large body of cross-national literature points to elevated risks of STI and HIV among migrants. Research on the association between migration and HIV/AIDS, one of the most often studied STIs, has long looked at migration as a link between high and low HIV prevalence regions, tracking the transmission of HIV infection from areas of migrant labor concentration to migrant labor reserve areas (Hunt, 1989; Quinn, 1994). However, studies have also suggested that geographic connectivity alone cannot explain the spread of HIV epidemic. Regardless of specific foci and emphases, a general view shared by this literature is that migrants, removed from the checks and controls of their usual social environment and often separated from their permanent sexual partners, are more likely to engage in high risky behavior, such as commercial sex, multiple partnerships, or injecting drug use than are non-migrants (Anarfi, 1993; Brockerhoff and Biddlecom, 1999; Lagarde et al., 2003; Li et al., 2004; Yang, 2004; Coffee et al., 2005; He et al., 2005; Liu et al., 2005; Mtika, 2007; Yang, Derlega, and Luo, 2007; Agadjanian and Avogo, 2008; Yang and Xia, 2008; El-Bassel et al. , 2011). In addition, migrants' marginalization in places of destination may hinder their access to health services and information and tools that these services might offer.

The factors linking population mobility and increased vulnerability to HIV are varied in different social and cultural settings. In the context of this study, it is particularly important to look at the factors that are specific to Eurasia, and particularly to the countries of the former Soviet Union. The study conducted by the European Center for Disease Prevention and Control in 2008 (ECDC, 2008) found that the following factors prevented migrants from accessing health services: policies and laws, service delivery, migrant communities themselves, and wider society. Policies to disperse migrants within countries were reported to limit access to prevention and treatment services. Illegal status and the accompanying lack of residence permit and health insurance — were mentioned most often as barriers to HIV treatment, especially by respondents from the new EU member states. Lack of culturally sensitive information in relevant languages, suitably trained professionals, and services tailored to the specific needs of migrants were all also mentioned as barriers. Within migrant communities, culture, religion, fear of discrimination, and limited knowledge of available services were reported to prevent access to services. Within the host society, stigma and discrimination towards migrants impairs migrants' access to prevention and care services. (ECDC, 2008). Similar factors are mentioned also in the following publication (Jizn s VICH v stranakh Vostochnoj Evropi i SNG, 2008.).

Besides the already mentioned evaluations, original studies describing the vulnerability of migrants within the countries of the former Soviet Union are also useful to review. The study by Weine et al. (2008) examines the HIV/AIDS risks of Tajik male migrant workers in Moscow, focusing on their protective knowledge, attitudes, and behaviors. The research is based on 16 individual interviews and focus group discussions with 14 Tajik male labor migrants. The respondents were asked about their work and living conditions in Moscow, family in Tajikistan, HIV risk behaviors, HIV risk awareness and prevention skills, spousal communication, and alcohol and drug use. The study revealed that, "migrants' behaviors and attitudes regarding HIV

risk and protection was being framed by the harsh conditions of labor migration”. Although engaging in high HIV risk behaviors (unprotected sex with commercial sex workers (CSW), often accompanied by alcohol and drug use), Tajik migrants, especially younger ones, had little or no knowledge of HIV and AIDS. Most respondents did not think that HIV/AIDS presented a serious threat for them or they were unaware of the high prevalence of HIV in Moscow, believing that it was a big issue in Africa, but not in their receiving country. The problem was aggravated by the illegal status of most Tajik migrants in the Russian Federation. Being unprotected by law, they could not access the Russian health care system, HIV prevention services, or even receive information through HIV prevention programs. In addition, most male migrants did not get tested or discuss HIV with their spouses in Tajikistan (Weine et al, 2008).

Amirkhanian et al. (2011) carried out a study about HIV risk behavioral levels, contextual factors and prevention needs of male labor migrants from Central Asia (mainly Tajikistan and Uzbekistan) and Eastern Europe (Ukraine, Moldova, and Belarus) working in the Russian Federation. The study revealed that Eastern European migrants had more partners, both casual and permanent; more frequent intercourse; and lower condom use than migrants from Central Asia. This result may be explained by their greater assimilation and social connectedness in the Russian Federation and, consequently, more opportunities for risky sex (Amirkhanian et al, 2011).

The study carried out in the Republic of Moldova (Terzioglo et al, 2010) found that migrants had an increased risk of HIV and STD infection by means of sexual contact, with a twice as many persons having occasional sexual partners than the general population. Another finding was that a large number of migrants have incorrect understandings about HIV transmission. The authors suggest that the observed high level of intolerance towards persons with HIV comes in large part from these misconceptions of HIV transmission. Further, the research suggests that migration involves a number of risks for the health and psycho-emotional integrity of migrants. Emotions and stress related to the separation from family and children, especially among illegal migrants, can cause a state of depression; difficulties in concentration, sleep, and communication; migraines, and the development of chronic diseases (Terzioglo et al, 2010).

Given that migration flows are significant between the Russian Federation (as the destination country) and all three countries of the Southern Caucasus (as the countries of origin), and that the factors linking migration and HIV in these three countries are similar, the qualitative study carried out within the framework of “Cross-border Cooperation for HIV/AIDS Prevention and Impact Mitigation in Southern Caucasus and the Russian Federation” Project (Talakvadze, 2013) is also relevant for the present study. Within the scope of the study, focus group discussions (FGDs) were carried out with different stakeholders. The factors preventing access to HIV related healthcare most often referred to during the FGDs were language barriers, marginalization and social exclusion, and legal obstacles. Cultural stereotypes, religious beliefs, fear of discrimination, limited awareness of HIV within migrant communities, negative social attitudes towards migrants, and poverty were highlighted as factors that increase vulnerability. Many of the inequalities that drive the spread of HIV are amplified during the migration process. Migration policies and procedures that restrict the possibility to work or obstruct access to services for undocumented migrants were among the specific policy and legal factors mentioned by the participants of FGDs that increase the risk of HIV transmission among migrants.

The study also found that the migrants lack information about where and how to receive an HIV test as well as where and how to access treatment (or funding for the treatment). Migrants do not possess sufficient information on HIV transmission, its manifestations, treatment

possibilities, or outcomes. Most of those interviewed did not have information on the legal rights of HIV patients or the rights of migrants to access health services (Talakovadze, 2013).

Despite a growing body of literature on the connections between migration and STI/HIV risks, relatively little is known about migrants' partners in the country of origin. The nature of the partners' vulnerabilities and the direction of the spread of STIs and HIV between migrants and their partners (i.e., from migrants to their non-migrating partners or vice versa) are still being debated. While Kishamawe et al. (2006) identified more sexual risk behavior and higher HIV prevalence in women who have long-term mobile partners compared to women with resident or short-term mobile partners; another study in South Africa showed no significant association between women's HIV status and their partners' migration (Lurie et al., 2002). Coffee, Lurie, and Garnett (2007) modeled the impact of migration on the HIV epidemic in South Africa and came to the conclusion that migration increases prevalence of HIV by increased high-risk sexual behavior among both migrants and their non-migrant partners.

These findings add an interesting nuance to the debate on the association between STI/HIV risks, the gendered division of power and resources, as well as the issues of sexual negotiation between migrant men and their left-behind partners. Women's STI/HIV risks are often increased due to an unequal gender division of labor and power. Studies have found that women often are not able to negotiate safe sex practices or to refuse having sexual intercourse with high STI/HIV-risk partners because they depend on them economically and socially or are physically abused by them (Gupta, 2000; Weiss, Whelan, and Gupta, 2000; Wingood and DiClemente, 2000). The gendered division of labor and power can be even stronger among couples with a migrant male partner. Hughes, Hoyo, and Puoane (2006) found that women married to migrants in South Africa had higher risks of STIs as a result of reduced power for sexual negotiation, especially in cases of long separation. In their study, women who saw their husbands less frequently were less likely to communicate with them about STIs, HIV/ AIDS, and contraception.

Although these studies show that women with migrant husbands have increased risks of STIs/HIV, more research is needed to understand the mechanisms through which men's migration affects the spread of STIs among their non-migrant partners.

3.1.3 Labor migration from Armenia and vulnerability of Armenian labor migrants and their partners to HIV

During the last 30 years the cumulative net emigration (number of emigrants minus number of immigrants) in Armenia has constituted more than one million people (United Nations Population Fund (UNFPA)-Armenia, 2013. Migration). Despite the recent stabilization of the national economy, international migration is still a very important issue for the country. In 2011, departures through RA border crossing points exceeded arrivals by around 43.8 thousand. The 2009 United Nations Development Program (UNDP) - *Armenian National Report on Migration* projected that, "between 200,000 and 300,000 Armenians will out-migrate from the Republic in near future." (Jijyan et al, 2009). Similar trends are described in the *2012 Armenia Country Report on the Social Impact of Emigration*. The report states that "the experts foresee in Armenia's future labor resource excesses and that the people will have to search for work outside Armenia" (Manasyan. & Poghosyan, 2012). According to the International Organization of Migration (IOM), the Russian Federation currently hosts close to half a million migrants from Armenia (IOM, 2013, Talakovadze, 2013).

While migration types and patterns have differed over time, the past two decades have featured large seasonal labor migration outflows from Armenia (CRRC-Armenia, Migration and skills,

2012). According to data from sociological surveys, between 60,000 and 80,000 residents of RA are involved in temporary labor migration, constituting 13.1% of economically active men and 1.7% of economically active women. Around half of Armenian labor migrants are between 21-40 years old, while the other half are between 41-60 years old. More than 75% of migrants have completed secondary education, while around 20% have higher education. It is estimated that 93% of all Armenian labor migrants go to the Russian Federation (World Vision-Armenia, 2013).

National HIV surveillance is routinely conducted by the NCAAP. It collects various data on identified HIV and AIDS cases including age, gender, mode of transmission, probable place and time of transmission, relation to a specific population group, geographic area of residence, etc. According to the 2009-2012 National HIV surveillance data on the likely place of HIV infection (when it is known), around 55% of all HIV cases registered in Armenia were infected outside Armenia, mostly in the Russian Federation and Ukraine. Out of the 228 new HIV cases registered in Armenia during 2012, 141 mentioned that they were infected outside Armenia, of which 126 were infected in the Russian Federation (National HIV Surveillance Data, 2013). The combination of high HIV prevalence in host countries and low HIV prevalence in origin countries has been considered a strong factor linking HIV and migration (Hunt, 1989; Quinn, 1994). Given that most migration flows from Armenia are directed toward the Russian Federation and that in Russia HIV prevalence is 1% while in Armenia it is not more than 0.1%, Armenian migrants to Russia have a high risk of HIV infection.

The nationally representative data on other HIV-risk factors of Armenian labor migrants are provided by the BBS studies. The first behavioral surveillance study in Armenia was conducted in 2002 and after that Integrated BBS studies have been conducted four more times (2005, 2007, 2010 and 2012). Migrants were represented in all of the studies since 2005. However, because the biological surveillance has never been conducted among them, the epidemiologic data on migrants is incomplete and HIV prevalence among this group is unknown.

The results of behavioral surveillance studies conducted in 2005, 2007, 2010 and 2012 are presented in Table 3.1.1. The studies indicated major risk factors among this group including insufficient HIV prevention knowledge and inconsistent condom use (Papoyan et al, 2011; the unpublished results of the BBS 2012 were kindly provided by the study consultant Arshak Papoyan).

As it is also shown in Table 3.1.1, the HIV risk factors have increased in recent years. At the same time, the share of migrants who underwent HIV testing increased, which is attributable to enhanced laboratory networks, increased access to HIV testing, establishment of the VCT system, improved capacities at health care facilities, and the introduction of provider-initiated testing and counseling procedures. Nevertheless, the current HIV testing rate among migrants remains low. The participation of migrants in HIV prevention programs is also very low. This data, as well as the epidemiological data showing that in 2012 among all new HIV cases in Armenia, 62% were infected outside Armenia and 20% were infected by partners who were themselves infected abroad (National HIV Surveillance Data, 2013), support the recent conclusion of local and international experts who studied the HIV situation in Armenia that migration is a major factor in driving the HIV epidemic in the country (Papoyan et al, 2011, HIV Data Triangulation for Public Health Actions in the RA, 2011; International Organization for Migration, 2011a).

Table 3.1.1 Selected results of the behavioral surveillance studies conducted among migrants in 2005, 2007, 2010 and 2012

Indicator	2005	2007	2010	2012
Size of the migrant population involved in the study	250	250	550	550
Comprehensive HIV knowledge (%)	44.4	27.6	29.9	28.3
Condom use during last sexual encounter (%)	36.2	37.6	25.8	25.6
Condom use during last sexual encounter with a casual partner (%)	74.1	75.2	62.3	66.3
Consistent condom use with all types of sexual partners (%)	20.3	22.9	13.3	12.6
Drug use experience (%)	9.8	23.6	18.2	12.9
Perceived availability/accessibility to VCT (%)	n/a	31	57.6	45.7
Tested for HIV in the last year (%)	2.8	13.7	26.2	33.5
Participation in HIV prevention programs (%)	N/A	N/A	6.2	4.8

Studies aimed to investigate the STI/HIV risks of Armenian migrants and their families members are scarce; while the search of the literature resulted in only one study targeted at marital partners of migrants, four other studies were identified through expert interviews.

The study conducted by the ANAF, with the financial support of UNDP-Armenia (Grigoryan et al, 2008), aimed to identify the HIV risk behaviors of migrants and assess the HIV prevention needs of migrants and their family members with the ultimate goal of developing effective preventive activities and interventions. The study was conducted in Gegharkunik, Ararat, and Armavir marzes because around 35% of the total estimated number of migrants in Armenia resides in those marzes. The methods of data collection included a review of existing information; a survey with a sample of 90 migrants; as well as interviews and FGDs with a total of 96 migrants, their family members and sexual partners, policy makers, service providers, community leaders, representatives of NGOs, and international organizations.

The study concluded that migrants had low awareness of both HIV prevention methods and migration-related legal issues. These gaps were explained by migrants' limited access to HIV/AIDS-related information both in Armenia and in the host countries; limited geographic coverage of awareness-raising projects targeting migrants in Armenia; as well as by the incomprehensiveness, limited efficiency, and non-sustainability of projects due to limited funds. Another weakness noted by the study is the lack of coordination between projects implemented by different organizations and low engagement of community leaders in HIV/AIDS issues. Further, the study identified that migrants' perceived their risk of HIV infection as low. The authors connect the low awareness and risk perception to the fact that when they are away from their families, migrants often lead irregular sexual life and engage in unsafe behaviors; the combination of the two factors amplifies migrants' risks.

In addition to the other findings, it is worth mentioning the stigma connected with STI/HIV which hinders sufficient utilization of health services, particularly in rural areas. The study also mentions insufficient migration-related legislation and lack of cooperation with migration authorities of destination countries, which may impede effective implementation of interventions among the migrants. Based on the findings, the study proposes a set of measures that can improve the situation. It should be noted however, that so far (five years after the

study), although some steps have been taken to address the problems in the area, the majority of identified weaknesses are still present.

A study conducted by the Real World Real People NGO_aimed to understand and classify barriers and facilitators of VCT service utilization (Mikaelyan, 2012). As part of the study, in-depth interviews were conducted with eight migrants and two spouses of migrants. It was found that the main barriers to VCT utilization were the negative stigma connected with HIV/AIDS as well as with the socially unacceptable behaviors that are associated with HIV/AIDS. The respondents believed that if they went to a VCT, it might become known in their social environment and lead to HIV/AIDS-related stigma and discrimination. Further, they were concerned, that if they went to a VCT, they might be regarded as drug users or be suspected of adultery. There were opinions that even going to a VCT would be met with disapproval from the community. Also, the respondent said that it is particularly unacceptable if a woman visits a VCT site alone (without her husband).

Another major reason for the low utilization of VCT identified in the study was low risk perception, which was explained in part by low awareness on the ways of HIV transmission and prevention among participants. Further, the respondents didn't believe that VCT staff would guarantee the confidentiality of HIV-related information. The respondents also mentioned a major structural barrier for men to utilize VCT: the fact that VCT centers are often located in clinics' gynecology departments, which would deter many men from going. The study also identified a number of attitudes that might hinder participants' willingness to practice safer behaviors. For example, it was assumed that condoms must be used only with sex workers and offering a condom to a permanent partner, particularly to the wife, would be offensive. It was also reported that it is deemed unacceptable for the wife to offer a condom. The study concluded with a set of recommendations on how to overcome the identified barriers (Mikaelyan, 2012).

Another qualitative study was conducted within the framework of Cross-Border Cooperation for HIV/AIDS Prevention and Impact Mitigation in Southern Caucasus and the Russian Federation Project (World Vision – Armenia, 2012).The study utilized FGDs with different stakeholders, including migrants and their family members, PLHIV, and MSM. Also, one and two day workshops were organized with representatives of the corresponding sections of the government, the staff of international organizations and NGOs working with MARPs, and health care providers. Through FGDs, brainstorming, and group work at workshops, a number of problems were identified linking population mobility to increased vulnerability to HIV. They included: limited access to HIV prevention, treatment, and care services in host countries because of administrative barriers, affordability and funding of services, social exclusion and stigma; complications due to illegal residence status and host country policies (e.g. deportation of HIV-infected migrants); lack of integration and linkage between HIV prevention and treatment services; lack of programs targeting migrants; lack of trained health professionals; lack of information about where and how to apply for an HIV test and where/how to access treatment (or money for the treatment); lack of information on HIV transmission, its manifestations, treatment possibilities, and outcomes; lack of information on legal rights of HIV patient and right of migrants to access health services; and poor cooperation amongst health care providers, international agencies, government officials, and persons living with HIV/AIDS (PLHA) on the level where prevention projects are planned and implemented. Based on the findings, recommendations were developed for advocacy actions.

While the aforementioned studies mostly focused on male migrants' risks, only one published study addressed the implications of migration for STI/HIV risks of Armenian migrants' marital partners in the communities of origin (Sevoyan & Agadjanian, 2010). The data for this study was collected through a survey of 1240 women in Gegharkunik marz. The authors carried out a multivariate comparison of women married to migrants and women married to non-migrants.

According to the study results, the share of women diagnosed with at least one of STI in the past three years was nearly 2.5 times higher among women married to migrants than among women married to non-migrants. Migrants' wives also reported a higher number of STI symptoms. In general, women's STI and HIV risks often increase because of an unequal gender division of labor and power. The study also found that an increase in a migrants household's income leads to higher risks of STI symptoms for migrants (as a result of greater opportunities for extramarital and commercial sex) and subsequently for their non-migrant partners, whereas in non-migrant households the predicted number of STI symptoms appears to decline with better socio-economic conditions.

Sevoyan further explored the impact of men's migration on their partners' reproductive behavior and sexual health in her doctoral dissertation entitled "The consequences of male seasonal migration for women left behind: the case of rural Armenia" (2011). The data comes from two surveys conducted in Armenia in 2005 and 2007 (the second survey is the same as the Sevoyan and Agadjanian (2010) study is based. Chapter 4, "Seasonal migration and risks of sexually transmitted diseases (STDs) among women left-behind", is particularly interesting for the study on labor migration and STI/HIV risks in Armenia. Sevoyan's research proves that "due to limited health care facilities in the region, lack of knowledge about STDs and stigma associated with them, women are unable or unwilling to go to a health facility to get tested for STDs" (Sevoyan, 2011: 81). The author uses husband's migration status and household economic wellbeing as two main predictors for the number of STD symptoms. The findings suggest that women in migrant households have higher risks of STD/HIV than those from non-migrant households. The correlation between male migration and their partners' STD risks may be also moderated by economic status.

The only study which aimed to assess the effectiveness of a pilot HIV prevention intervention is the evaluation of the intervention implemented by World Vision (WV) - Armenia in five communities in the Stepanavan region within the framework of "Mobility Exacerbated HIV Prevention and Impact mitigation in the Southern Caucasus" Program (World Vision – Armenia, 2011 - see the details of the intervention in Section 3.1.5 on Mapping of implemented projects). The study used a quasi-experimental design with experimental and comparison sites to assess the project's effectiveness (e.g., the progress made towards achieving the project goal, outcomes and outputs). Within the framework of the study, a survey was conducted with a sample (N=438) of adults (221 from experimental and 217 from comparison sites) including male migrants (82% of the sample) and their marital partners (18% of the sample) as well as with 156 high grade students (94 from experimental and 62 from comparison sites). Additionally, FGDs were carried out.

The evaluation demonstrated that in adult participants the project was not able to positively impact or significantly change the HIV knowledge, HIV-risk practices (unsafe sex with casual sex partners), and tolerant attitudes of both male and female respondents towards extra-marital sexual relations of men when they are outside Armenia (the latter may increase the HIV vulnerability of migrants and their marital partners). However, the impact of the project on changing people's negative attitudes towards PLHIV was dramatic. Among schoolchildren, the project had significant impact on both the knowledge and attitudes.

The project was also able to positively impact the level of awareness about VCT services in Armenia (60% in intervention sites compared to 30% in control sites knew where they could get VCT services in Armenia) and in destination countries, as well as the awareness on where people can get information about HIV and AIDS. Unfortunately, awareness of VCT services did not necessarily increase the motivation for HIV testing; the utilization of VCT remained extremely low in both sites, although in the intervention site it was higher than in the control site (16% and 5%, respectively). The reported level of utilization of VCT in host countries was

high in both intervention and control sites (around 60%), which was mainly connected with health examinations (including tests for HIV) required of migrants for a work permit in the Russian Federation.

Finally, the study also identified the project activities that were well accepted and considered as effective by the participants; training sessions with video materials were identified as the most effective methods, while the distributed brochures, booklets were mentioned as the only additional useful materials.

3.1.4 Analysis of current HIV- and migrant-related policies at the country and bilateral/multilateral levels (international agreements)

Armenian National Policy on HIV/AIDS

Legislative Framework

Since the 1990s, the authorities in Armenia have made attempts to address HIV effectively on both the legislative and executive levels through creating national coordination and programming as well as by changing regulative frameworks. The first step to regulating the response to HIV at the legislative level was the Law of the RA on “Prevention of Disease Caused by Human Immunodeficiency Virus”, which was passed in 1997 (The Law on HIV). The law provided for ways of prevention, diagnosis and control of HIV/AIDS. Among the law’s strengths was its orientation to HIV prevention as well as on protection of the rights of people infected with HIV. Recognizing the importance of adequate HIV/AIDS-related legislation to properly address the epidemic, the Inter-Standing/Inter-Fraction Committee Parliamentary Group on HIV/AIDS was established within the National Assembly in June 2002. The group included representatives of all parliamentary committees and was charged with improving the legislation related to HIV/AIDS and exercising control by the legislature over the implementation of the National Program on HIV/AIDS Prevention. The parliamentarian group, in collaboration with other stakeholders, further worked to develop amendments and additions to the HIV/AIDS law with the aim of making it consistent with the commitments undertaken by signing the UNGASS Declarations, to further emphasize the human rights approach, and better address changing the pattern of the HIV epidemic in the country. The amendments and additions were introduced in 2000, 2009, 2011, and 2012 based on the Law of the RA “On Making Amendments and Supplements to the Law of the RA On Prevention of the Disease Caused by the Human Immunodeficiency Virus”.

The revised and amended Law is consistent with existing international guidelines on human rights, especially with regards to condition of entry into Armenia and the prohibition of mandatory HIV testing of targeted groups. According to the Law, an individual infected with HIV cannot have their rights and freedoms limited, excluding cases foreseen by the law. The guiding principle of the HIV/AIDS legislation is “universal access” to HIV/AIDS prevention, treatment, and care including the right of every person to receive voluntary and anonymous HIV counseling and testing. The principle is further detailed in the Standard of “Provision of HIV/AIDS services within the state basic benefit package” (further referred to as “Standard”), which is developed and regularly updated by the Ministry of Health. According to the Standard, approved by the Minister of Health in January, 2012, “... HIV testing was available to everyone who applied for that to VCT site.” Further, the Standard defined some categories of population (including MARPs, persons with clinical symptoms, TB and STI patients, and pregnant women) who were eligible for PITC. Migrants and their partners were not included in this list, which meant that they would receive counseling only if they initiated it themselves. Thus, the Standard did not view migrants and their family members as a vulnerable group in terms of HIV transmission and effectively excluded them from provider-initiated HIV

counseling. Furthermore, the Standard stated: “HIV testing may be provided only after receiving oral informed consent of the person to be tested”. Furthermore, the Standard stated, “All diagnostic investigations for revealing the HIV are free of charge”. Finally, the confidentiality of HIV testing, counseling, and treatment should have been guaranteed and ensured according to a general law requiring confidentiality of any health-related information.

Several other documents that affect accessibility of HIV testing are the ones defining the Basic Benefit Package (BBP) and regulations of the State Health Agency (SHA), which manages the overall state health budget, including salaries of providers, transportation and facility costs, HIV testing-related costs, etc. According to the BBP definition and the SHA regulations, HIV/AIDS is not among the conditions for which BBP covers all connected costs. The groups eligible for free testing under the BBP (for whom the SHA covers all HIV-testing-related costs) include only pregnant women and persons with clinical symptoms. Other groups, including migrants and their family members, are to date not eligible for free HIV counseling and testing under the BBP.

Experts are constantly updating and improving the HIV-related policy to make it consistent with the changing pattern of the HIV epidemic in the country. Thus, taking into account the recent surveillance data demonstrating that migration has become one of the major driving forces of the HIV epidemic in Armenia, the Standard approved in 2013 added migrants and their spouses to the 2013 list of groups eligible for PITC. Also, based on the information from policy-level experts, discussions with SHA to revise their regulations so that other categories of population eligible for PITC (including migrants and their spouses) become eligible for free of charge HIV testing are under way, but no consensus on the issue has been reached so far.

Coordination, management and financing of the National HIV/AIDS Program

All the activities implemented in the field of HIV and AIDS in Armenia are coordinated by the Country Coordination Commission on HIV/AIDS, Tuberculosis and Malaria Issues, which was established in 2002 and reformed in 2011. Country Coordinating Mechanisms (CCM) are central to the commitment of the GFATM to local ownership and participatory decision-making. These country-level multi-stakeholder partnerships develop and submit grant proposals to the GFATM in order to meet evidence-based priority needs at the national level. After a grant approval, they oversee progress during implementation. The CCM is a multi-sectorial commission, which includes representatives of the government (including the Deputy Minister of Territorial Administration), the academic sector, local and international NGOs, faith-based organizations, UN agencies and bilateral development partners, private sector, and also people living with the diseases. The Councils on HIV/AIDS, TB and Malaria within each the marz government (*marzpetarans*) coordinate activities implemented at the regional level.

Activities implemented within the framework of the National HIV/AIDS Plan are funded by GFATM, by the state budget, and by other donor organizations. Over the years, the total financial allocations from the state budget to the plan increased from 16.2% in 2007 to 37.0% in 2011 (National Strategic Plan on HIV & AIDS, RA, 2012-2016) while the share of support from GFATM by 2011 decreased to 58%. The support of other donors between 2010-2011 accounted for around 5% (UNGASS *Country Progress Report*, RA, 2010-2011) of the total budget. GFATM implements support for the National HIV Program through Mission East for the NGO response and through the Ministry of Health (MOH) for the government response to the HIV epidemic in Armenia. Currently, Armenia has received funding from the Global Fund, namely the GFATM Rolling Continuation Channel (RCC), to implement HIV-related activities in the country during 2013-2015. Forty percent of the national AIDS spending was allocated to prevention programs, followed by care and treatment (30%), program management and

administration strengthening (13.3%), human resources (13.3%), enabling environment (4.3%), and research (0.4%) (National Strategic Plan on HIV & AIDS, RA, 2012-2016).

Thus, the coordination, management, and financing of the NAP are also consistent with internationally accepted guiding principles of HIV programming based on local ownership, participatory decision-making, and evidence-based priority setting. However, some weaknesses still exist in this sphere. For example, as discovered during an expert interview with a CCM member, the CCM is not able to fully exercise its coordinating role because there is no funding for a CCM secretariat. Imperfections of the financial mechanism and allocation of resources have also been noted by international experts who recently analyzed these issues with the goal to provide information for strategic planning. They came to the conclusion that current HIV prevention efforts are constrained by a number of factors, including non-optimal emphases on programs without strong evidence of effectiveness and limited financial resources to design and implement effective programs. Based on these conclusions, they recommended conducting HIV/AIDS effectiveness evaluation and cost-effectiveness studies, which could provide insights into what HIV investments have been used for, whether interventions averted new infections and AIDS deaths, and if they did, at what cost (Wilson et al, 2012). Hopefully, the next round of the National HIV/AIDS programming will take into consideration these recommendations and will take steps to optimize the allocation of available resources.

Targeting migrants in the National AIDS Program (NAP)

Migrants and their family members have been among the beneficiaries of the NAP of 2002-2006 and 2007-2011. Among the specific objectives within the NAP 2002-2006 were improvement of mobile populations' access to the information on HIV prevention and ways of transmission, access to means of HIV transmission prevention, access to VCT, access to STI syndromic treatment, reduction of vulnerability to HIV, and provision of legal support. Within the framework of NAP 2007-2011, HIV/AIDS prevention activities, implemented among all target groups, including the mobile populations, were expanded and scaled up. NAP 2012-2016 also has some specific objectives targeted at migrants. It plans to improve access to HIV testing and counseling among migrants; initiate community and port-of-entry based prevention and education programs for seasonal migrants' partners and migrants prior to departure and upon return; strengthen overall migration policy, coordination, and management; develop legal framework consistent with international standards that will adequately regulate migration issues in accordance to international principles; and ensure effective cooperation and coordination on HIV/AIDS issues with the host countries' respective authorities.

Thus, migrants and their family members benefited from all three NAPs, covering the period between 2002-2016, and particularly from the current NAP (2012-2016), which allocated more funds for them than the previous NAPs. Nevertheless, there are major weaknesses in the strategies targeted at migrants and their spouses compared to the ones targeted at MARPs. While for MARPs the prevention strategies and the package of services are well defined, for migrants and their spouses all this is still undefined. To develop effective prevention interventions for migrants and their family members, sufficient financial resources should be allocated to research and monitoring studies.

Armenia state regulation of migration and bilateral/multilateral agreements

Given the considerable scale of temporary labor out-migration from Armenia in the past and, according to expert forecasts, its continuation in the near future, it is very important to manage the migration flows at the state level. Proper state management can enhance economic benefits and promote desirable as well as prevent undesirable impacts of migration for the country,

including the spread of the HIV epidemic. Although some steps to regulate issues concerning migration were taken up by the Government of the RA in the past, the state system of migration regulation, and the political approaches and the institutional and administrative mechanisms of migration regulation, have been incapable of effectively addressing problems associated with migration. The state's active involvement in the regulation of migration issues started in 2010 when the Government of Armenia approved the "Concept on the Policy of the State Regulation of Migration in the RA" (Manasyan H. & Poghosyan, 2012). Following that, a government decree on November 10, 2011 (# 1593N) approved the "Action Plan for Implementation of the Policy Concept for the State Regulation of Migration in the RA in 2012-2016" (Ministry of Territorial Administration, State Migration Service, RA). Fourteen outstanding issues related to the migration problem are identified in the Concept. The responsibility for addressing each of those issues is assigned to one of the following agencies:

- The Ministry of Labor and Social Issues (MLSI), Department of Labor and Employment: labor migration.
- The Ministry of Territorial Administration (MTA): developing migration management policy and coordinating its implementation as well as developing state policy on labor migration and its organization.
- The State Migration Service (currently within the structure of the Ministry of Territorial Administration, or MTA): design and implementation of projects aimed at management of migration and refugees issues.
- The Ministry of Foreign Affairs (Legal Department, Consular Department, Migration Desk): visa and passport issuance and relations with Armenians abroad.
- The Ministry of Diaspora: developing and implementing the state policy on development of the Armenia-Diaspora partnership and coordinating the activities of the state bodies in this field.
- Border Guards (National Security Service, reporting to the Prime Minister): border management and control.
- Visa and Passport Department (OVIR), within the structure of the Police, reporting to the Prime Minister: irregular migration, visa issuance at the borders, registration of foreigners in the country, and issuance of exit stamps (passport validation) for RA citizens.
- The Office of the President: granting citizenship.

Effective governance and prevention of irregular migration has been recognized as a target for the RA strategy regarding national security. This signifies that the RA will participate in international programs and activities of reputable international organizations regarding migration, as well as integration processes in this field both in Europe and in the CIS. Some concrete steps have already been taken in this direction: a working group created by the RA Prime Minister has already developed a list of recommendations and presented it to the government. Another working group at the RA National Security Council has been created to develop migration reforms. There are several intergovernmental agreements signed by the Government of Armenia regulating the free movement of labor among the CIS countries (Manasyan H. & Poghosyan, 2012).

Armenia has also tried to tackle migrant issues by negotiating with the European Union regarding the Mobility Partnership program, which would establish joint management of migration flows between members of the program. Proposed activities include the development of an environment facilitating people's mobility and legal migration through improved migration management, awareness raising, and better reintegration and protection of returning migrants. However, more needs to be done to improve the regulation and management of migration. One important problem is that the National Migration Agency does not have a mandate to deal with the whole spectrum of migration issues. Also, there is considerable

overlap between the functions of agencies listed above, and the inter-agency coordination, collaboration, and the regulation of information flows is poor (Manasyan H. & Poghosyan, 2012). Finally, as stated by the representative of the International Organization of Migration during an expert interview, the public health authorities/experts do not participate in the development of intergovernmental agreements or any other documents aimed at coordinating the migration issues between Armenia and destination countries. As a result, health-related issues, including access to health services for Armenian migrants in receiving countries, are not addressed in these documents.

However, HIV vulnerability of Armenian migrants and their families is related not only with imperfections in corresponding policies in Armenia, but also with corresponding policies in receiving countries and with insufficient regulation of these issues between the Armenian government and governments of host countries. As it was stated by one of the interviewed experts:

“The problems of Armenian labor migrants outside Armenia cannot be solved by changing Armenian policies. Moreover, we cannot make the governments of Armenian migrant receiving countries to change their legislations so as to make Armenian migrants less vulnerable. These problems can be solved only by common efforts of the Armenian government and governments of receiving countries through the signing of bi-lateral and multilateral agreements”.

For example, it would be beneficial if Armenia could sign bilateral agreements on circular migration. An ideal model of Armenian circular migration would be for migrants to act collectively as working groups rather than as individuals. In this approach, the circular migration can be conceptualized as a form of organized exportation of the national labor force. Unfortunately, the 2010 migration policy concept of Armenia just envisages the application of the circular migration concept without suggesting concrete steps in this direction (Manasyan H. & Poghosyan, 2012). In the meantime, as a result of the inability of the Armenian government to regulate labor migration and to protect the legal interests of its migrant citizens within official intergovernmental agreements, which would stipulate legislative responsibilities of both sending and receiving countries, Armenian migrants’ rights (including the right to health and access to health services) remain unprotected, which exacerbates their vulnerability to HIV.

In the face of the absence of bi-lateral agreements between governments, migrants’ issues may be at least partly addressed by non-governmental organizations. The “Cross-border cooperation for HIV/AIDS Prevention and Impact Mitigation in Southern Caucasus and the Russian Federation Project”, funded by EU and the World Vision, Germany (Talakovadze, 2013), has an important role to play in this context. The project could contribute to decreasing the vulnerability of migrants by negotiating with partner non-governmental organizations in the receiving country (the Russian Federation) to make the HIV/AIDS prevention, testing, and treatment services accessible to Armenian migrants in the Russian Federation. The partner organizations may also engage in advocacy so that their governments tackle the issue more actively.

Also, it is important that not only Armenia, but the receiving countries as well, particularly the Russian Federation, ratify the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which was signed in 1990 and entered into force in 2003. The Convention aims at guaranteeing equality of treatment as well as the same working conditions for migrants and nationals. The Convention recognizes that legal migrants have the legitimacy to claim more rights than undocumented migrants, but it stresses that undocumented migrants must see their fundamental human rights respected. For migrant donor countries, the Convention is an important vehicle to protect their citizens living abroad;

however, it is useless if the receiving country does not ratify it. As it was stated by one of the interviewed experts:

“Since Russia, Ukraine, and Kazakhstan have not ratified the Convention yet, ratifying it by Armenia would hardly change anything in the vulnerability of Armenian migrants.”

Another expert noted:

“Although the UNGASS Declarations don’t have real power, if a country signs the Declaration, it assumes some commitments. I am glad that the 2011 UNGASS Declaration on HIV/AIDS addresses the vulnerability of migrants to HIV and reinforces the commitment to support their access to HIV prevention, treatment, care and support. The fact that Russia and other migrant receiving countries have signed the Declaration will in some way make them to comply with recommended actions and address the vulnerability of migrants to HIV”

All the aforementioned steps, if implemented, may result in some positive changes in the future. However, so far Armenian migrants remain unprotected due to inadequate HIV and migration-related policies in the host countries.

HIV and health related policies in the Russian Federation

Because the main labor migration flows from Armenia is to Russia, it is important to analyze the migration and HIV-related policies in Russia to see if these policies may contribute to HIV vulnerability of Armenian migrants. Officially, Russia has signed international charters and declarations aimed at handling HIV vulnerability among mobile populations as well as establishing effective and accessible healthcare services for migrants (Russian Federation – Concept for effective handling of migration – President’s decree). However, these regulations have not been fully implemented, particularly in the areas of proactive workable policies, law reform, and non-discriminative labor environment (Talakvadze, 2013).

Furthermore, the review of available documents shows that links and integration between migration and HIV-related policies in the Russian Federation are poor (Talakvadze, 2013). To some degree migration and HIV are both important national issues in the Russian Federation. However, there is no direct reference to HIV/AIDS in the country’s migration policy documents and migration is not reflected in the policy documents as a contributing factor to the rise of HIV/AIDS. Migration is mostly viewed as a security or national interest issue, while the public health impacts are ignored. In general, the risks between mobility/migration and HIV are not explored and addressed. It is evident that migration and HIV policies exist and function independently and there is little synergy between them, which restrains the effectiveness of HIV related efforts and limits the ability of HIV supportive programming to reach migrant populations.

Furthermore, there is no consistent legal framework for migrants’ rights relating to HIV or general healthcare. While in general, the legislation of the Russian Federation promotes good human rights standards, some specific regulations do not comply with these standards (e.g., mandatory testing while entering Russia, denial of entry on the basis of the HIV-positive status, obligation to submit personal data while receiving benefits of federal programs, barriers for granting the legal status, etc.). Moreover, although the Russian Federation declares universal access to HIV prevention, treatment, and care services, this is not so when it comes to migrants. Access to health care is offered mostly to documented international migrants. Though in some areas non-government healthcare services cover those with undocumented status, the majority of these services are not provided on a sustainable basis because of their dependence on external

funding. Complications due to illegal residence status, migration policies, and international policies (e.g. deportation or fining of undocumented migrants, embargo, or cross-country tensions) undermine migrants' access to health care. Furthermore, negative developments are observed between larger organizations, including the legislative, programming, and service provider domains. While NGOs and non-formal associations are distinguished by better adaptation to the needs than larger organizations and bodies, they lack the effective leverages to create systemic change and therefore cannot be relied on as the only effective actors in the area. (Talakvadze, 2013).

3.1.5 Mapping of existing migrant HIV projects/programs in Armenia

Since 2003 various HIV preventive activities have been designed and delivered for migrants within the framework of the National Program on Response to HIV. These activities have aimed to raise their awareness on HIV/AIDS and change their HIV risk behavior. Some of the activities implemented before 2008 are summarized in the study conducted by the Armenian AIDS Foundation in 2008 (Grigoryan et al, 2012).

An objective of both the NAP 2002-2006 and NAP 2007-2011 was to reduce the spread of HIV/AIDS among migrants and refugees. The activities included: ensuring and improving access to the information on HIV prevention and ways of transmission, access to HIV prevention methods, access to VCT, access to STI syndromic treatment, reduction of vulnerability to HIV, and legal support. By the end of 2011, the HIV Counseling and Testing System was in place in Armenia and had been mostly integrated into the existing health care system. The laboratories providing HIV testing have been appropriately equipped and provided with high-quality test kits (UNGASS *Country Progress Report*, RA, 2010-2011). Health care providers with various backgrounds, including gynecologists, family physicians, pediatricians, psychologists, dermato-venerologists, urologists, sexopathologists and narcologists were trained in VCT. Additionally, prevention information, educational materials, and condoms were made available at the entry and exit gates of the national airport (National Strategic Plan on HIV & AIDS, RA, 2012-2016). Prevention programs for HIV in migrant populations have been commenced with training of key staff and awareness campaigns in rural and urban areas. Bilateral cooperation has been sought out with CIS countries to ensure implementation of HIV response activities among mobile populations (National Strategic Plan on HIV & AIDS, RA, 2012-2016).

In this section we will provide a description of migrant-related projects implemented by UMCOR-Armenia, World-Vision-Armenia and Armenia Youth Foundation (AYF)/ Scientific Association of Medical Students of Armenia (SAMSA) consortium between 2005 and present.

One of the first organizations to initiate work with migrants and their family members was the Armenia country office of the United Methodist Committee on Relief (UMCOR-Armenia). Since 2004, with the financial support of the Norwegian Church Aid (NCA) and the Norwegian Ministry of Foreign Affairs (as well as UMCOR's own funds), UMCOR-Armenia has been implementing the Prevention and Control of HIV/AIDS, STIs, and TB project. By February 2013, 154 rural communities of Gegharkunik, Armavir, Kotayk, Ararat, Aragatsotn, and Lori marzes were covered by the project activities. The activities included:

- a. Training and 3-day public health education sessions for Community Health Volunteers (CHV) and peer educators on HIV/AIDS, STIs and TB conducted by experienced trainers. The training utilized interactive methodologies including discussions and watching special educational films. Overall, 2021 CHVs have been trained to conduct peer education and information dissemination among other community members. In total, 55,614 community members have received messages and information materials from CHVs. In all targeted

- communities, special seminars were conducted for pregnant women on STI/HIV prevention.
- b. Informational materials have been produced including posters, materials to be used during the trainings (e.g., power point, film) as well as printed materials. Printed materials are to be distributed to participants of training sessions so that they may further share them with their peers.
 - c. The Mobile Medical Team (MMT) (comprised of three doctors: STI, TB and laboratory specialists) provided free services (VCT and STI management) in target rural communities. While the services of the MMT were provided at a local health facility, the local staff did not participate in providing services. The MMT services included: voluntary and confidential (anonymous if requested) HIV pre-test counseling, drawing the blood for the test and organizing HIV testing at NCAP, post-test counseling for HIV negative cases (the ones who tested positive were connected with the NCAP for further counseling and treatment). The scope of services provided by the MMT during the project period is as follows: 7,000 patients at risk of having HIV and 5,297 patients with STIs were served; 4,473 patients received voluntary counseling on HIV/AIDS, including 1,415 (32%) who tested for HIV (3 HIV positive cases were revealed); and 32,800 condoms were distributed to people at risk of STI/HIV.
 - d. The project also helped in capacity building. Local primary health care (PHC) providers (n=84) were trained on VCT for HIV, STI management, TB case detection, and follow-up of TB patients' treatment.

In the beginning, the project was targeted at the general population and it didn't focus on migrant issues. However, since the burden of migration in target communities was, and still is very high, the project staff gradually came to the conclusion that they had to pay special attention at migrant issues. With this purpose fundraising was initiated and three projects were implemented specifically targeting male migrants. The projects were as follows:

- 2005 – 2006: A one-year project funded by NCA, implemented in 7 rural communities of Armavir marz, reached 100 male migrants;
- 2009 – 2010: A 16-month project funded by NCA, implemented in 18 communities of Ararat and Kotaik marzes, reached 218 male migrants;
- 2012- present: A one-year project funded by UMCOR, implemented in 23 communities of Ararat , Armavir, Aragatsotn and Lori marzes, reached 270 male migrants.

Within the framework of projects targeted at male migrants, an experienced trainer provided one-day awareness-raising sessions. The sessions covered the ways of HIV transmission, HIV prevention methods, the vulnerability of migrants, etc. All participants were informed about availability of MMT and that they could be tested there for HIV free of charge. Out of total 588 male migrants participating in awareness raising sessions, 225 (338) received VC and 90 (15% of all and 40% of those counseled) were tested.

Also, since the beneficiaries of the main project were mostly women (with considerable yet unmeasured representation of wives of migrant workers) and since the project staff recognized that due to traditional Armenian mentality and gender roles, women could not effectively communicate with their husbands about their own and their husbands' vulnerability to HIV/AIDS, a special training on HIV and gender was added to the main training curriculum of CHVs. In 2005-2010, 531 CHVs from 52 villages of Ararat, Armavir and Kotayk marzes participated in one-day training on gender issues conducted within the framework of NCAP funded project by the trainer invited from UNFPA. The training covered interpersonal communication, concept of gender, gender stereotypes, as well as gender and HIV/AIDS. All participants received information materials on gender issues developed by UNFPA.

Another migrant-related focus of the UMCOR activities is anti-trafficking. We consider this as migrant-related activity because many victims of trafficking are people who initially intend to find a job abroad. Many of the female victims of trafficking are sex workers and they are extremely vulnerable to HIV, both in their home country and especially in destination countries (mostly Turkey and Arab Emirates), where they are not protected by legislation and are less empowered to insist on safe sex than in Armenia. UMCOR started anti-trafficking activities in 2004 with its own funding as well as with the support of UNDP, the MFA of Belgium, US Department of State, and the Dutch MFA. UMCOR currently offers psychological and medical rehabilitation, legal assistance, support in re-integrating in the society, provides a shelter to the victims of trafficking, and has a toll free hot line. Raising awareness on STIs and HIV and VCT as well as providing VCT are integral components of its services. Since the start of the program, the services were provided to around 100 victims of the trafficking, 75% of which were women. None of the trafficking victims were HIV positive.

The projects implemented by UMCOR demonstrated that if proper HIV counseling is provided, and free of charge voluntary and confidential HIV testing is made available and accessible, then approximately 32% of representatives of the general population and 40% of male migrants would voluntarily apply for HIV testing. Given the low HIV testing rate in Armenia, the experience of UMCOR's MMT demonstrates the low effectiveness of the work of Armenian VCT sites. Unfortunately, the project has not been formally evaluated and the project staff provided all the information here. These experiences may serve as a basis for developing an effective package of interventions.

Another organization that has been working with migrants and their family members is the World Vision – Armenia. The first project targeted at migrants was carried out between 2007 and 2010 within the framework of “Mobility Exacerbated HIV Prevention and Impact mitigation in the Southern Caucasus” Program, which was supported by WV Australia and the Middle East/East Europe Region. In Armenia, the project activities were implemented in five communities located in Stepanavan region of Lori marz. The communities were selected from the ones involved in the WV area development program (ADP) because they had a high seasonal migration rate. The project activities included:

- Training of peer educators among male temporary labor migrants; the peer educators were supposed to raise awareness on STIs and HIV, the ways of their transmission, and the methods of protection among their migrant peers inside and outside Armenia (since it was discovered that migrants from one community tend to migrate as a single group).
- Community meetings with women and schoolchildren (separately). All schoolchildren are supposed to have HIV lessons in school within the curriculum of life skills classes. However, the majority of the project participants stated that their teachers (usually, the teacher of physical education class) do not have skills to talk about such sensitive issues with kids. Meanwhile, the demand for these lessons was very high among the children. The meetings were intended to raise awareness on STIs and HIV and change the participants' attitude toward the perceived risk of HIV infection as well as towards stigma and discrimination. The meetings utilized interactive methods.
- Channel of hope – a priest was involved in the project and he put forward moral and Christian values aimed to change unfavorable attitudes toward people living with HIV/AIDS.
- Distribution of printed materials.

Overall, 50 trainings and meetings were conducted and around 2,000 persons participated in the events between 2007 and 2010. In December 2011, with the support of mini-grants provided by the project, an attempt was made to encourage beneficiaries of the project seek out HIV

counseling and testing; 20 beneficiaries were chosen from the aforementioned communities and were offered transportation to the nearest HTC sites for counseling and testing. However, 5 people refused to participate even though initially they provided their consent. In the end, only 14 people participated in the voluntary counseling and testing (Mikaelyan, 2012).

The second project started in April 2011 and will run until September 2013. The project is supported by WV Australia and is a part of the “Cross-border Joint Advocacy for HIV prevention in Southern Caucasus Countries” Program. The project is being implemented in 10 communities of Stepanavan ADP, which are different from the ones involved in the first project. The target population includes labor migrants, their sexual partners and family members, as well as community leaders. The project beneficiaries include 5,602 adult men, 5,343 adult women, and 2,686 young people of both genders. The package of services includes the same activities implemented during the first project with the following new elements:

- Awareness raising for school students includes more interactive elements like a theater and a computer game developed by kids themselves.
- VCT capacity building
- Advertisement on local TV

The third phase of WV’s migrant-related HIV prevention activities started in April 2012 within the framework of the “Cross-border cooperation for HIV/AIDS prevention and impact mitigation in Southern Caucasus and Russian Federation” project. This is a two year sub-regional project funded by the European Union and WV-Germany. The project is implemented in the countries of Southern Caucasus, Armenia, Georgia, and Azerbaijan, and in the Russian Federation. In Armenia, the project is implemented in cooperation with the Real World Real People NGO. The project associates include NCAP and the UMCOR - Armenia. The project's main objective is to mobilize and strengthen national government organizations (GOs) and non-state actors (NSAs) in Southern Caucasus and the Russian Federation with the aim to unite them for joined actions to mitigate HIV/AIDS risks among migrant workers and mobile populations. The goals of this project are to ensure improved access to HIV prevention, treatment, support, and care services for migrants in both source and destination countries.

In Armenia the project is being implemented in 14 communities of Gavar and Stepanavan regions. Main activities at community level include: identification and mobilization of point persons (among target populations) in target communities for sensitization and advocacy on HIV/AIDS and mobility issues; facilitation of joint planning with targeted communities for community and country level advocacy activities; as well as conducting and facilitating awareness raising and mobilization of target mobile population from Armenia and target groups in the destination country for advocacy of migrant rights and needs. At the national level, an in-country network mechanism to create a multi-stakeholder joint group for planning detailed activities for country and community advocacy interventions will be established and supported; advocacy events and workshops will be organized; training for media representatives to better understand HIV and mobility issues will be organized; advocacy and awareness raising media campaigns will be organized; existing materials and training tools will be modified, printed and distributed to identified target audiences; and trainings targeted at NSAs/IOs/GOs in HIV prevention, advocacy, and other topics identified through needs assessment exercise will be delivered. At the regional level, a Regional Core Group to share project experiences and identify good practices as well as a regional network to facilitate discussion and identification of joint advocacy actions will be set up and implemented; a joint regional advocacy action plan will be developed; a regional referral mechanism, allowing countries to share information on services available in the source and destination countries and to provide specific follow up where required will be established.

The project will conclude in March 2014. Around 15,000 of representatives of the target population (including migrants/mobile population/migrants family members, MARPs, PLWHA) will be reached through information and media campaigns in Armenia. These groups will be engaged via printed materials, training sessions, awareness raising and advocacy events, and through media campaigns.

One of the major achievements of the project is that the National and Regional Advocacy Action Plans have been developed. Selected project's activities performed from April 2012 through March 2013 include:

1) Capacity building

- workshops for NGOs and GOs (53 participants);
- training for media representatives on the role of mass media in HIV prevention (23 participants);
- HIV counseling and testing workshop for 27 health care providers in Gegharkunik.

2) Awareness raising and community mobilization;

- seminars on HIV prevention attended by 500 migrants and their family members in 14 project communities in the regions of Stepanavan and Gavar;
- focus group discussions among migrants, PLWHA, and MSM to reveal factors hindering access to HIV related services in Armenia and destination countries;
- working meeting with HIV stakeholders in Vanadzor on HIV testing access (28 participants);

3) Preparation of printed materials (2 brochures, 2 booklets, and a poster).

4) Various media campaign activities.

The only national-level intervention targeted at migrants was implemented by the consortium of AYP and SAMSA between May 2012 and February 2013. The project was supported by the Global Fund RCC grant, Phase 1. The main purpose of the project was to raise awareness on HIV/AIDS. The primary method of delivery of services was community meetings, which were organized in the following locations: the local offices of Youth Foundation, village administration (*gjughapetaran*) buildings, health facilities, schools, and kindergartens. The Youth Foundation has representatives of the Foundation in many locations in Armenia who are local authorities and coordinated the project. Because the representatives are local authorities, they are able to organize the events very effectively and can call the migrants and ask them to come to the given location for meeting.

In the preparation phase of the project, 33 project staff members (three from each marz) were trained by experienced instructors in delivering the project activities. The project activities included: lectures, screening of films (provided by NCAP), distribution of posters, distribution of educational materials (developed by Armenian National AIDS Foundation and provided by Mission East), and distribution of condoms. Condoms were not a part of service package, but were made available in the meeting rooms and the participants were welcomed to pick them up. Besides the community meetings, the implementers also provided individual HIV counseling to those participants who expressed interest. The individual counseling was provided in separate rooms at Youth Foundation offices or other convenient locations. One of the key messages delivered during the awareness-raising events was the importance of getting tested for HIV. At every location where the community meetings were held, a list of locations that provided testing was displayed on the wall, with nearest locations highlighted. Also, outreach workers distributed education materials in the airport.

The project was monitored internally and externally by a monitoring and evaluation officer of the Government Principal Recipient of the GFATM grant. The external monitor had the

schedule of events and could randomly visit any location where an event was scheduled. The monitoring was also done in weeks after an event by randomly selecting and calling a participant to ask if they had participated in an event.

All of the projects described above have a common weakness: they depended on external funding and therefore could not be sustainable. Another common weakness of the implemented projects was that all of them were designed and implemented almost blindly, without a preliminary needs assessment and without having sufficient information on the risk profiles of migrants and their family members. However, such information is not available and it could not be reasonably expected that the implementers could do this research themselves. To understand the impact of migrants to HIV epidemic in Armenia and to develop effective prevention interventions for them, sufficient financial resources should be allocated to research and monitoring studies. It is necessary to regularly carry out full-size BBS among migrants, so that their risk profile can be defined as the one of MARPs. Furthermore, only one of the pilot projects was evaluated, while the others were not and it is not known whether the utilized approaches, strategies, and provided services were effective and whether the objectives of the projects to mitigate the HIV risk of migrants were achieved. Meanwhile, evaluation of those few projects that were implemented is an absolute necessity, because only based on evaluation data it is possible to develop a package of effective services. To understand the influence that migrants have on the HIV epidemic in Armenia and thereby to adopt and improve the relevance and comprehensiveness of the HIV treatment and prevention interventions targeted at migrants, a sufficient amount of funds needs to be allocated to research and monitoring studies among migrants and their family members.

Despite the mentioned weaknesses, all projects are very important since they provide insights into the STI and HIV risks of the understudied population of migrants and their family members, as well as into the issues surrounding HIV counseling and testing. The projects tested different services and educational materials and to some extent showed (at least qualitatively) which of them work best. For the development of effective packages of services for migrants and their family members it would be important to carry out more pilot projects and rigorously evaluate them.

3.2 Findings from the survey of migrant and non-migrant households

3.2.1 *The demographic profile of the survey sample*

The survey sample was designed so as to include married men who had migrated for work at some point during the five years preceding the survey; married men who had no labor migration experience during that period; married women whose husbands were migrants for at least a fraction of the three-year period before the survey (or since marriage if marriage occurred less than three years before the survey); and married women whose husbands never migrated for work in the three years preceding the survey (or since marriage). The sample also included a few women with their own labor migration experience, but the size of that group is too small for sound comparisons and migrant women were therefore excluded from the analyses presented in this report.

Because the migrant subsample included men who were migrants at different time during the three years preceding the survey and recency of migration experience may be an important factor in HIV and STI risks, we distinguish between current/recent migrants and earlier migrants by subdividing the migrant men's subsample into two respective categories: 1. those who migrated during 2012 or 2013; and 2. those who had returned from their last migration

episode before January 2012. Based on this classification, the sample consisted of 444 recent migrants (38.3% of the male subsample), 303 earlier migrants (26.2%), and 411 non-migrants (35.5%). The distribution of the three groups across the three sampling domains and their selected socio-demographic characteristics are presented in Table 1. Table 1 also presents the two groups of female respondents: women married to migrants (66.1% of all surveyed non-migrant women); and women married to non-migrants (33.9%).

As can be seen in Table 1, there was little difference in mean age between migrant and non-migrant men (38.5 and 40.2 years, respectively) and between current/recent and earlier migrants (38.9 and 37.8 years); the mean age of migrants' wives and non-migrants' wives was almost identical (around 35 years). Likewise, the average number of children ever born (live births) did not vary significantly across the sample, although recent migrants appeared to have slightly more children, on average, than earlier migrants. In contrast, Table 1 reveals considerable educational differences. Migrants are negatively selected on education: the share of men with complete university education or a post-graduate degree was 27.0% among non-migrants compared to 17.2% among migrants. Within the migrant subsample, recent migrants are noticeably disadvantaged compared to earlier migrants: only 14.2% among the former had completed higher education compared to 21.5% among the latter. These educational differentials are noteworthy as education may be an important protective factor against STI/HIV.¹ Compared to substantial and statistically significant differences in educational attainment between migrant and non-migrant men, the corresponding differences between migrants' wives and non-migrants' wives were small and statistically non-significant.

Table 3.2.1. The socio-demographic profile of the male and female samples

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
Area of residence (%)						
Yerevan	29.6	20.5*	42.9*	32.8	32	32.5
Other urban	28.1	27.9*	28.4*	27.7	27.3	28
Rural	42.3	51.6*	28.7*	39.4	40.7	39.5
Age (mean)	38.5	38.9	37.8	40.2	35.1	35
Live Births (mean)	2.06	2.11	1.89	2.09	2.19	2.17
Education (%)						
Incomplete secondary	8.0*	10.4*	4.6*	5.1*	2.8	2.2
Complete secondary	53.9*	56.1*	50.5*	43.1*	43.5	40.4
Vocational	17.0*	16.4*	17.8*	18.7*	30.5	31.1
Incomplete higher	3.9*	2.9*	5.3*	6.1*	2.8	2.9
Complete higher	17.2*	14.2*	21.5*	27.0*	20.3	23.4
Car ownership (%)	39.4	37.4	42.2	41	34.9*	44.8*

Note: * significant at $p < .05$ (within each category).

¹ It should be noted that the relationship between education and HIV risks is complex and varies across socioeconomic settings and types of the epidemic (e.g., Fortson 2008; Wojcicki 2005).

The household material status is approximated here by automobile ownership. In the male subsample, migration does not seem to produce any material advantage: the share of households owning a car was similar among migrants' and non-migrants' households. Households of earlier migrants were somewhat more likely to own an automobile than those of current/recent migrants, but the difference between the two types of households is not statistically significant. Surprisingly, the female subsample displayed a much more pronounced difference in car ownership, with households of non-migrants' wives having a significantly higher likelihood of possessing an automobile.

3.2.2 Perceptions of STI/HIV risks

Table 2 compares perception of HIV and STI risks across genders and migration status categories. Overall, concern about the risk of HIV infection is low—only 17.3% of migrant men and 15.3% of non-migrant men expressed this concern—and this difference between migrants and non-migrants is not statistically significant. Concern about contracting another STI was only slightly higher, and the difference between migrants and non-migrants, 20.9% and 16.1%, is, again, not significant at the conventional level ($p < .05$). Likewise, the differences between current/recent migrants and earlier migrants on these two measures are not statistically significant. The level of concern about the possibility of contracting HIV or another STI among women was comparable to that among men, and no differences across the husband's migration status can be observed.

Table 3.2.2. Perceptions of HIV and STIs risks

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
Not at all concerned with becoming infected with HIV (%)	82.7	81.1	85.1	84.7	84.4	89.0
Not at all concerned with becoming infected with an STI (%)	79.1*	77.9	80.9	83.9*	85.0	86.0

Note: * significant at $p < .05$ (within each category).

3.2.3 Strategies to avoid STI/HIV infections

The survey respondents were asked about what they had done to avoid HIV or an STI in the 12 months preceding the survey. Just over one-half of both migrant and non-migrant men said they had done nothing to prevent HIV or STIs (52.1% vs. 51.0%), with the two groups being statistically indistinguishable.

However, migrant men were significantly less likely to name having only one partner as their strategy to prevent STI/HIVs, compared to non-migrant men (37.5% vs. 43.6%). At the same time, migrant men were more likely to name consistent condom use as their way to avoid STI/HIVs than their non-migrant counterparts—12.9% vs. 8.0%. The differences between current/recent migrants and earlier migrants with respect to prevention strategies are not significant. No statistically significant differences between female respondents married to

migrants and those married to non-migrants in the choice of strategies to avoid HIV or STIs can be observed either.

Table 3.2.3. Strategies used to avoid STI/HIV in past 12 months

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
In order to avoid STI/HIV infection during the last 12 months I have: (%)						
Had only one sex partner	37.5*	38.3	36.3	43.6*	41.8	42.1
Consistently used condoms	12.9*	14.9*	9.9*	8.0*	4.0	4.0
Done nothing	52.1	50.0	55.1	51.0	56.4	56.0

Note: * significant at $p < .05$ (within each category).

3.2.4 HIV risk factors

Drug use

Use of illicit drugs, especially injection drug use, is widely known to be associated with risky behavior. The survey respondents were asked about their use of illicit drugs. In all, only 4.0% of migrants (3.8% among recent migrants and 4.3% among earlier migrants) and 5.6% of non-migrants reported having tried drugs. This difference is not statistically significant. None of the female respondents reported having ever used an illicit drug. It should be noted that drug use is likely to have been underreported: thus according to the 2010 Biological and Behavioral Surveillance, 18.2% of the surveyed migrants reported having used drugs in their lifetime, including 11.2% who indicated experience with injected drugs (BBS 2010). Possible overall underreporting notwithstanding, our survey data provide no indication that migrants and their wives are more likely to use drugs than their non-migrating counterparts.

Table 3.2.4.1. Reported lifetime illicit drug use (%)

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
Have you ever tried narcotics?	4.0	3.8	4.3	5.6	0	0
If so, have you ever tried injection drugs?	(n=53) 3.3	(n=33) 0	(n=33) 6.6	(n=55) 8.7	N/A	N/A

Note: * significant at $p < .05$ (within each category).

Extramarital sex

The survey respondents were asked if they had had sex with someone other than their marital partners in the past twelve months. Because almost no women in the sample admitted to having had extramarital sex, we discuss only the results for men. These results are presented in Table 3.2.4.2. The share of respondents who reported having had at least one extramarital partner was

significantly higher among migrants, 11.5%, compared to 7.1% among non-migrants. Yet the migrant vs. non-migrant gap was due entirely to the relatively high share of current/recent migrants, 14.6%, reporting at least one instance of extramarital intercourse. The fraction of earlier migrants reporting extramarital sex was almost identical to that among non-migrants. These results illustrate that migrants' disproportionate exposure to extramarital sex does not continue after migration ends: it is due to the opportunity afforded to migrants by their separation from their regular partners and from the social control of their communities and it does not linger after this opportunity ends.

Table 3.2.4.2. Extramarital sex reported by male respondents

Characteristic	Men			
	Migrants			Non-migrants (n=411)
	All (n=747)	Recent (n=444)	Earlier (n=303)	
During the last year, have you had a sex partner other than your spouse?	11.5*	14.6*	6.9*	7.1*
How often do/did you (or your sex partner other than your wife) drink alcohol before or during sexual intercourse?				
Always or almost always	20.9*	20.0*	24.0*	9.1*
Rarely	46.4*	50.6*	32.0*	39.4*
Never	27.3*	22.4*	44.0*	33.3*
Refuse to answer	5.5*	7.1*	0.0*	18.2*
How often do/did you use condoms during the sexual intercourse with your sex partner other than your wife?				
Always	55.5*	56.5	52.0	39.4*
Sometimes	20.0*	20.0	20.0	15.2*
Never	20.0*	17.7	28.0	24.2*
Refuse to answer	4.5*	5.9	0.0	21.2*
In the last year, how often did you refuse to have sex without a condom with a partner other than your wife in order to protect yourself from an STI?				
Every time when I had such an offer	37.3	42.4*	20.0*	18.2
Not always	22.7	24.7*	16.0*	27.3
Never	24.5	18.8*	44.0*	39.4
Refuse to answer	15.5	14.1*	20.0*	15.2

Note: * significant at $p < .05$ (within each category).

The respondents who admitted to having extramarital sex in the twelve months before the survey were asked how often they had consumed alcohol before or during extramarital sex. The results are presented in the Table 3.2.4.2. Migrants were considerably more likely than non-migrants to report having always or almost always accompanied extramarital intercourse with consumption of alcoholic beverages. Interestingly, recent and earlier migrants did not differ much in the likelihood of frequent consumption of alcohol before/during extramarital sex. Likewise, earlier migrants appeared only slightly less likely to have used condoms regularly with extramarital partners than did recent migrants. The share of those who never used condoms in extramarital relationships was noticeably higher among earlier migrants than among recent migrants. However, the differences in condom use between the two subgroups of migrants were not statistically significant. In contrast, the corresponding differences between migrants and

non-migrants were statistically significant. Notably, however, the largest gap between the two groups was in the regular condom use, which was much higher among migrants than non-migrants (55.5% vs. 39.4%). We should note, however, that non-migrants had a much larger share of respondents who refused to answer this question, which may have affected the observed pattern of differences. Finally, instructive differences transpired in responses to the question on refusal to have sex without condom out of fear to contract an STI. Migrants were considerably more likely to always refrain from sex when condom use was not possible, and the migrants' advantage in avoidance of risky sex was concentrated entirely among current/recent migrants.

The surveyed women were asked how likely, in their opinion, were their husbands to have had extramarital sex in the past twelve months. The distribution of the answers to this question is presented in Table 3.2.4.3. As can be seen, migrants' wives are significantly more likely to suspect their husbands of marital infidelity. Yet, only 6.1% of them considered extramarital sex by their husband likely or very likely and more than two-thirds of them thought it was impossible.

Table 3.2.4.3. Women's perceptions on husbands' infidelity

Characteristic	Women	
	Migrants' wives (n=816)	Non-migrants' wives (n=418)
In your opinion, how likely it is that your husband has had sexual intercourse with another woman during last 12 months?		
Very likely	1.5*	0.2*
Possible	4.6*	1.0*
Very unlikely	17.2*	9.5*
Impossible	67.9*	83.2*
I don't know	8.7*	6.1*

Note: * significant at p<.05 (within each category).

Commercial sex

Use of commercial sex services could substantially raise the risk of HIV infection. The survey male respondents were asked about their use of commercial sex services in the twelve months preceding the survey. The distribution of responses to this question is presented in 3.2.4.4. Given the sensitive nature of the question, it is not surprising that a sizeable share of respondents refused to answer this question. Notably, this share was considerably higher among non-migrants (57.3%) than among migrants (30.7%). It is also to note that refusal was more common among earlier migrants (39.0%) than among recent migrants (22.5%). Conforming to the cross-national evidence on use of commercial sex by labor migrants, a significantly larger share of migrant respondents had sex with a CSW in the twelve months before the survey compared to non-migrant respondents. Thus only 6.9% of the migrants said that they had not had sex with a CSW, whereas the corresponding share among non-migrants was twice as large. However, when break the migrant subsample on the basis of recency of migration, earlier migrants are very similar to non-migrants in the likelihood of not having resorted to commercial sex services. In contrast, only 2% of current/recent migrants said they had never had sex with a CSW. Almost eight percent of migrants had used commercial sex frequently, compared to only 2.1% of non-migrants. Interestingly, however, the percentage of recent migrants in that category was slightly lower than that of earlier migrants (6.8% vs. 9.0%). At the same time, recent migrants were more likely to engage in commercial sex infrequently.

Table 3.2.4.4. Use of commercial sex in last 12 months by male respondents who have ever used commercial sex services

Characteristic	Men			
	Migrants			Non-migrants (n=96)
	All (n=202)	Recent (n=102)	Earlier (n=100)	
How often have you used the services of sex workers during the last 12 months? (%)				
Often	7.9*	6.8*	9.0*	2.1*
Rarely	32.2*	37.3*	27.0*	15.6*
1-2 times	18.3*	27.5*	9.0*	8.3*
Never	6.9*	2.0*	12.0*	12.5*
Refuse to answer	30.7*	22.5*	39.0*	57.3*

Note: * significant at p<.05 (within each category).

3.2.5 Spousal communication about STI risks and condom use within marriage

The survey respondents were asked whether they had talked about STI risks with their spouses in the twelve months preceding the survey. The distribution of responses to this question is presented in Table 3.2.5.1. Migrant men were significantly less likely to have talked about STI risks with their wives than were non-migrant men, 17.7% vs. 23.8%, which probably reflects the general communication barriers that migration erects in communication between a migrant and his spouse. Not surprisingly, the likelihood of STI-related communication was particularly low among current/recent migrants even though the difference between this subgroup of migrants and earlier migrants is not statistically significant. Among female respondents, the picture is different: migrants' wives appear more willing to bring up STIs in conversations with their husbands than are non-migrants' wives; yet the difference between the two groups of women is not statistically significant.

Table 3.2.5.1. Spousal STI risk-related communication and mitigation

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
During the last 12 months, have you ever talked to your spouse about risks of sexually transmitted diseases, even if it was a very brief conversation? (%)	17.7*	15.5	20.1	23.8*	39.4	34
How often did you use a condom while having sex with your spouse? (%)						
Always or almost answer	7.1	7.1	7.2	7.8	9.3	11.4
Rarely	21.6	21.6	21.5	21.3	16.1	13.9
Never	56.7	59.5	52.6	56.6	63.8	61.3
Refuse to answer	14.6	11.7	18.8		10.8	13.4
If you offered your spouse a condom to use, would they accept your offer? ** (%)	(n=574)	(n=355)	(n=219)	(n=316)	(n=602)	(n=318)
Yes	47.9	45.4	52.1	53.8	37.7	40.6
No	21.3	19.4	24.2	16.5	28.7	26.1
Don't know	30.8	35.2	23.7	29.7	33.6	33.3

Note: * significant at p<.05 (within each category); ** Respondents who said that usually their spouse offers to use a condom.

Table 3.2.5.1 reported slightly higher condom use than male respondents, but no differences across the migration status are statistically significant. Finally, respondents who usually initiated condom use were asked if, in their opinion, their spouses would accept using a condom if they asked them to. In all, around 50% of male respondents and 40% of female respondents answered affirmatively, but again, the differences across the migration status are not statistically significant.

3.2.6 Access to and use of HIV counseling and testing services

The survey respondents were asked questions assessing their knowledge about, access to, and use of HIV counseling and testing. The distribution of responses to two of those questions is displayed in Table 3.2.6.1. Migrant men were significantly more likely to know where one could be tested for HIV than non-migrant men (54.2% vs. 48.7%). Interestingly, recent/current migrants were less likely to know of an HIV testing place than were earlier migrants, but the difference between the two subgroups of migrant men is not statistically significant. Female respondents were somewhat less informed than were male respondents about places where HIV testing was available, but the difference between migrants' wives and non-migrants' wives is not statistically significant. Migrant men held a considerable advantage over non-migrant men in having ever been tested for HIV (30.7% vs. 4.9%), reflecting, to a large extent, the requirement of an HIV test for at least some forms of legal employment in the Russian Federation. The percentage of those who had been tested for HIV at least once was noticeably higher among current/recent migrants than among earlier migrants, and the difference between the two subgroups is statistically significant. Among female respondents, almost no difference between migrants' wives and non-migrants' wives can be observed.

Table 3.2.6.1. HIV testing

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
Knew a place where HIV testing is provided	54.2	51.6*	58.1*	48.7	41.3	40.2
Have been tested for HIV during their lifetime	30.7*	36.9*	21.8*	4.9*	9.6	9.3

Note: * significant at $p < .05$ (within each category).

Table 3.2.6.2 refers specifically to HIV testing among migrant men. Forty-seven percent of migrant respondents said that they knew where one could get tested for HIV in the destination country, and 42.4% said that HIV testing was accessible and affordable to them there.

More than one-third of migrant respondents, 37.3%, said that had been required to present the results of an HIV test to obtain employment in the destination country. Not surprisingly, almost 90% of migrant respondents who reported having been tested for HIV at least once said that their last tests had been done outside Armenia, and 69.3% of them had those tests done because they were required for employment purposes. No differences between current/recent migrants and earlier migrants are statistically significant.

Table 3.2.6.2. HIV testing knowledge and experience, migrant men

Characteristic	Men		
	Migrants		
	All (n=747)	Recent (n=444)	Earlier (n=303)
Knew a place where HIV testing is provided in destination country.	46.7	52.0*	38.9*
Reported that VCT services are accessible/affordable for them in destination countries.	42.4	44.6*	39.3*
Reported that they are required to present the result of HIV test in destination country.	37.3	40.8*	32.3*
Location of HIV test	(n=234)	(n=167)	(n=67)
Outside Armenia	89.3*	91.6*	83.6*
Reason you were last tested	(n=231)	(n=167)	(n=64)
Pregnancy	0.4	0.6*	0*
Clinical indication	3.5	3.6*	3.1*
For employment purposes	69.3	70.7*	65.6*
For migration purposes	18.2	19.2*	15.6*
To know my HIV status	7.4	4.8*	14.1*
Other	1.3	1.2*	1.6*

Note: * significant at $p < .05$ (within each category).

3.2.7 Exposure to HIV/AIDS information and programs

The survey included a series of questions regarding their exposure to HIV/AIDS-related information. The responses to these questions are summarized in Table 3.2.7.1. Thus, respondents were asked if they knew where to get information about HIV/AIDS and STIs. About one-third of respondents gave a positive answer. Whereas there was no difference between migrant and non-migrant men, recent/current migrants were significantly less likely to have access to STI/HIV information than were earlier migrants (30.1% vs. 40.1%, respectively). Among women, migrants' wives held a negligible advantage over non-migrants' wives in access to STI/HIV information, 32.7% vs. 30.9%. Respondents' reported involvement in HIV/AIDS awareness campaigns was very low, and no appreciable variation across the migration status either among men or among women can be observed.

Only about a quarter of male respondents felt that they would need more information to protect themselves from STI/HIV risks, paralleling the earlier noted low level of worries about the risk of HIV infection. A slightly higher proportion of migrant men than non-migrant men (26.5% vs. 21.4%) demonstrated such a need, but the difference between the two subgroups of male respondents was not statistically significant. Likewise, no differences within the migrant men's subsample could be observed. Female respondents showed a somewhat higher level of need for information on HIV/AIDS protection, compared to their male counterparts, but the difference between migrants' wives and non-migrants' wives was not statistically significant (33.7% vs. 32.3%). Among the respondents who expressed a need for prevention information, television was seen as the best channel for broadcasting information on HIV prevention among all subgroups of respondents, followed by print media. Interestingly, migrant men saw significantly less importance in STI/HIV-focused lectures and other educational events at health/VCT facilities and in the home distribution of printed materials about STI/HIV prevention, compared to non-migrant men (13.1% vs. 27.3% and 11.1% vs. 23.9%, respectively). No comparably significant contrast can be noticed between current/recent and earlier migrants. Women were generally more likely to favor these two channels of distribution of STI/HIV prevention

information than were men, but the differences between migrants' wives and non-migrants' wives were not statistically significant.

Table 3.2.7.1: Exposure to HIV /AIDS information and programs, respondents who answered yes to the following questions (%)

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
Do you know where you can get information about HIV/AIDS and STIs?	33.9	30.1*	40.1*	33.1	32.7*	30.9*
Have you participated in HIV/AIDS awareness raising program or community events in the last 12 months?	1.5	1.6	1.3	2.2	2.9	3.1
Do you perceive that you need more information/skills to protect yourself from STI/HIVs?	26.5	26.1	27.1	21.4	33.7	32.3
What channels would be good to raise your awareness about STI/HIVs? (n=697)	(n=199)	(116)	(83)	(88)	(275)	(135)
TV	64.3	63.8	65.1	68.2	63.3	58.5
Radio	12.1	6*	20.5*	12.5	6.9	4.4
Newspaper or Journal	39.2	37.9	41	34.1	35.3	33.3
Education materials at health facilities/VCTs	12.6	13.8	10.8	18.2	24.7	20.7
Seminars and lectures at health facilities/VCTs	13.1*	14.7	10.8	27.3*	22.2	25.9
Receiving printed education materials at home	11.1*	9.5	13.3	23.9*	16.4	16.3
Receiving printed education materials or counseling at the airport	6.5	6	7.2	5.7	6.9	4.4
Would you like boys to receive information about STI/HIVs and prevention at school?	92.8	91.2*	95.7*	90.5	92	90.9
Would you like girls to receive information about STI/HIVs and prevention at school?	91.4	89.9*	94.4*	88.6	92	90.7

Note: * significant at p<.05 (within each category).

Distributing printed materials about STI/HIV prevention at the airport was chosen by about 6% of the respondents; although this option seems slightly more popular among male migrants and male non-migrants, the corresponding difference is not statistically significant.

Finally, the survey respondents were asked whether educational information on STI/HIVs should be made available to middle school students. The respondents in all subcategories

overwhelmingly support the distribution of such information among both female and male students. Interestingly, the support was somewhat weaker among recent migrants than earlier migrants (89.9% vs. 94.4%).

3.2.8 Understanding of HIV/STI infection risks

The survey instrument included a battery of questions measuring respondents' knowledge about HIV transmission. The percentages of correct responses to these questions are summarized in Table 3.2.8.1.

Table 3.2.8.1. HIV/AIDS-related knowledge, respondents who answered the questions correctly (%)

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
Do you think a healthy-looking person can be infected with HIV?	71.4	68*	76.2*	69.8	66.7	68.4
Can a person get HIV from a mosquito bite?	36.0	34.6*	37.9*	35.3	43.3	45.7
Can a person get HIV by sharing a meal with an HIV infected person?	60.6	55.6*	68*	63.3	64.2	67.7
Can a person get HIV by having sex without condom with an infected person?	95.7	95.3	96.4	93.4	94.1	91.9
Can a person get HIV by kissing an infected person?	45.5	39.7*	54.1*	47.2	53.1	53.6
Can a person get HIV by shaking hands with an infected person?	70.7*	66.9*	76.2*	77.9*	74.3	79.4
Can a person get HIV by using infected syringes, needles, and other cutting items?	96.3	96.2	96.4	95.4	92.6	91.9
Can a woman infected with HIV transmit the virus to her child during the delivery?	80.5	79.5	81.8	81.8	83.2	84.7
Can a woman with HIV/AIDS transmit the virus to her newborn child through breastfeeding?	74.4	74.3	74.6	71.0	72.7	72.7
Can a person lower the probability of getting infected by HIV by having one uninfected faithful sex partner?	86.5	86.9	86.1	86.6	84.4	80.6
Can people decrease their risk of HIV infection by using condom correctly in each sexual contact?	89.3	89.2	89.8	89.5	84.8*	80.1*

Note: * significant at $p < .05$ (within each category).

Overall, the responses illustrate serious gaps in individuals' understanding of HIV. Thus only two-thirds of respondents correctly answered that a healthy looking person could be HIV-positive. Only forty percent correctly thought that one cannot get infected with HIV through a mosquito bite. Less than two-thirds of respondents, 63.5%, knew that HIV infection cannot be transmitted by sharing a meal with an infected person, and only about 40% knew that HIV cannot be passed through kissing and three-fourths of the sample knew that HIV cannot be passed through a handshake. At the same time, respondents overwhelmingly identified infected syringes, needles and other piercing and cutting objects as potential vehicle of HIV transmission. More than four-fifths of respondents thought that HIV could be transmitted from mother to child during delivery and 73% said that HIV transmission is possible during breastfeeding. Both faithfulness in sexual partnership and correct condom use were identified by a vast majority of respondents as ways to reduce the risk of infection.

Little variations across gender and migration status can be observed in the above response patterns. Among men, only the question on the possibility of HIV transmission through handshake produced statistically significant difference between migrant and non-migrants: the former were less likely than the latter to think that such transmission is not possible (70.7% vs. 77.9%). It is noteworthy that the correct answer to this question was least common among current/recent migrants; however, even among this subgroup, two-thirds knew that handshake could not be a channel of HIV transmission. Among women, the only significant difference was with respect to correct use of condom: 84.8% of migrants' wives thought of it an option to reduce the HIV infection risk, compared to 80.1% of non-migrants' wives.

3.2.9 Tolerance toward persons living with HIV/AIDS (PLWHA)

The survey asked a series of standard questions gauging respondents' attitudes toward PLWHA. The responses, presented in Table 3.2.89.1 reveal both a high level of misconceptions about HIV and a rather low level of tolerance toward PLWHA. Thus, less than a quarter of the respondents, 22.5%, said they would be willing to share a meal with an HIV-infected person. The share of migrant men expressing such willingness was somewhat lower than that of non-migrant men (21.3% vs. 25.3%), but the difference is not statistically significant. However, migrant men said that they would be much less willing than non-migrant men to buy food from an HIV-infected person (14.5% vs. 21.2%). Overall, only about one-half of respondents would be willing to keep a PLWHA living in the family, and not appreciable variations across the subgroups of the sample could be observed. Just over two-thirds of respondents, 69.4%, said they would be willing to care for an HIV-infected family member; there was no variation across migration status among men in responses to this question, but women married to migrants were more willing to provide such care than women married to non-migrants (70.1% vs. 67.5%).

It should be noted that overall the survey respondents had very little practical contact with PLWHA. Thus only 55 men and 53 women knew anyone who had HIV/AIDS or had died from AIDS. Notably, this number was larger among migrant men than among non-migrant men (36 vs. 19), and among the former, current/recent migrants predominated (n=25). Likewise, among female respondents, 34 migrants' wives personally knew of an HIV/AIDS case, compared to 19 non-migrants' wives.

Table 3.2.9.1. Attitude towards people with HIV, respondents who answered yes to the following questions (%)

Characteristic	Men				Women	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
Would you be willing to share a meal with a person you knew had HIV?	21.3	20.5	22.4	25.3	20.0*	26.8*
If you knew a food seller had HIV, would you buy food from him?	14.5*	13.1	16.5	21.2*	17.4	21.5
If a relative of yours had HIV, would you be allowing him/her to come to your house?	26.2	24.8*	28.4*	31.6	31.7	36.1
If a member of your family became HIV infected, would you be willing to keep him/her in family?	51.5	49.8	54.1	56.7	51.1	51.4
If a member of your family became HIV infected, would you be willing to care for him/her?	67.9	67.6	68.3	72.5	70.1*	67.5*
If a member of your family became HIV infected, would you be willing to keep his/her status in secret?	62.5	62.8	62	61.8	72.3*	70.6*

Note: * significant at p<.05 (within each category).

3.3 Insights from in-depth interviews

Overall, 20 migrants and their family members participated in semi-structured in-depth interviews (Table 3.3.1). Eight of the respondents were male migrants and 12 were the partners/wives of migrants. Three of the participants were from cities (Yerevan, Vanadzor and Gumri), eight participants were from semi-urban sites (regional and marz centers), and nine participants were from rural sites (villages).

Participants were selected during the survey and agreed to participate in qualitative in-depth interviews. The duration of interviews ranged from 30 to 40 minutes. All interviews were conducted in private rooms to ensure confidentiality and sincere responses. Most of the interviews were digitally-recorded.

The female respondents ranged in age from 25 to 47 years old, whereas the men were 22 to 54 years old. The vast majority of respondents had children (one to three children) and only one man (from Tavush marz) was single and did not have children. The family size varied from three to six people. Most of the respondents lived in extended families, i.e. with in-laws (parents, brothers and/or sisters-in-law). Women in most the families were unemployed, while men were either working in Armenia or were on a seasonal break from their work abroad.

Table 3.3.1. Characteristics of in-depth interview participants

Gender	
Men	8
Women	12
Area of residence	
City	3
Other urban	8
Rural	9
Total	20

3.3.1 Household health-related decision making

According to the interviewed participants, in families that lived with in-laws either the father- or mother-in-laws were said to be the household head. In families that did not live with relatives the husband was reported as the head of the household. The respondents unanimously stated that their household structure is similar to most families in their communities. In some families, when the father leaves the country they delegate the responsibilities of household head to their sons. In other families, women become heads of the households when their husbands are away for work. Only one of the female respondents reported to be the household head (even though her mother-in-law was living with her). She acknowledged that her situation was unique because her husband had left them, leaving his mother and their child, and does not care for them.

While men generally lead the households, in most cases health related issues are the responsibility of women: either mother-in-laws or wives. Women were identified by most respondents as the key decision makers on most health issues, especially those that require little or no financial expenditure. Respondents again felt that similar situations exist in the other households of their communities: the father-in-laws and/or husbands lead the household, while mother-in-laws and/or wives are responsible for the health related issues in the family. According to some women, when men migrate for work, their wives must take care of the family and make decisions on important issues in their absence.

“My husband is the head of the family as he earns money... I take care of the family and make decisions on health issues ... In our community the majority of families are headed by the husbands. However, husbands often migrate abroad for jobs, and wives must take care of the family and make decisions on important issues.”

Woman from Lori

In only a couple of families were health-related decisions dealt with by both spouses together or by men. In a few of these cases, when men are abroad, women communicate with them to make a collaborative decision or to know the man's opinion on health issues. In urban sites, some adults make individual decisions on questions related to their health without the help of their spouse. Most men reported that they make personal decisions on questions related to their health; however, they consult with their wives and other people to help them decide.

“My husband and I decide together about health-related issues of family members. Even when he is abroad, I always consult with him on family issues.”

Woman from Lori

“Each adult member in our family makes decisions regarding their own health.”

Woman from Lori

“Every member of our family makes decisions about their own health, except for my 12-year-old son. For him, my husband and I decide together.”

Woman from Yerevan

“I am single and live alone. Sometime I ask neighbors for advice and I would not afraid to share my health status, even if I get STI.”

Man from Lori

As a whole, both men and women reported to have very good relationships with their in-laws, neighbors, and other people from the community. The relatives and community members seem to be very supportive and provide assistance in major and minor household related issues. Although it is often requested, helping each other financially is not very common because almost all the families experience financial difficulties and rarely have the means to support someone else. Although most people mentioned having very good relationships with everyone in the community, frequent communication is limited to close relatives, neighbors, and friends. People from rural areas are much more supportive to each other in helping with food and joint work (even major work, such as construction) than those in urban areas.

“I have very good relationships with all of my in-laws despite the fact that he (the husband) left me and his family.”

Woman from Tavush

“We built a new house (part of the house) and my brother-in-law and uncle-in-law helped us in its construction.”

“I would not ask everyone, but potentially could call for anyone’s help in our community.”

Woman from Gegharkunik

“My parents live in the nearest village. They can’t support me financially but they send some fruits and vegetables to me and my family.”

Man from Vayots Dzor

Most women have frequent communication with their neighbors, friends, and relatives and consider this as mutual emotional support. During this communication health issues are also sometimes discussed.

3.3.2 Gender issues and the role of men and women in the family

Almost all men who participated in the interviews thought that pre-marital sexual relations exist and they are much more common among men than among women. They considered it normal if a man has a sexual experience before getting married, but they disapproved of similar behavior for women. Furthermore, the men thought that young women do not have right to have sexual relationships before marriage. Only one of the male respondents (from Gyumri) stated that both men and women have the right to have pre-marital sexual relations. The respondents reported that this pattern (of pre-marital sexual relations for men, but not women) is very much accepted and considered normal by the community as well, though men acknowledge that most women would not to accept this if given the choice.

Women generally reported that they do not welcome pre-marital sex for either men or women, but they acknowledge that the community and public opinion is more tolerant towards men having pre-marital relations than women. A couple of women mentioned that if it is accepted for men then it should also be accepted for women.

“I think pre-marital sex is common among men. Women are aware that their husbands have had sex with different women before marriage and might still after marriage.”

Man from Tavush

*“I think that men have the right to have sexual relations with different women before he chooses his wife.”
Man from Tavush*

The vast majority of women think that spouses should be loyal to each other and neither of them should be engaged in sexual relationships outside of marriage. They all acknowledge, however, that the community is more tolerant to men having extramarital affairs, while for women it is not accepted at all. Two of the women participating in the interviews mentioned that they felt that men can have sex with other women if they are abroad because it is necessary for their health. This also was stated by one of the men who mentioned that his wife is aware of his second family in Russia, but is very much tolerant towards it.

*“I have seasonally worked in the same city (Vladimir) for last 5 year. In Vladimir, I live with a Russian woman. The woman takes care for me and I consider her as my second wife. My Armenian wife is aware about the Russian woman.”
Man from Tavush*

*“I understand that sometimes married men can be engaged in illicit sexual relations. It is common among married men to have extra-family relationships. Due to their nature, men are engaged in such relationships when they work hard away from the family. This is necessary for men’s health.”
Woman from Tavush*

Most older men said that young people still consult and obey their parents on marriage-related issues, while younger men reported that both men and women currently do not ask their parents for advice on marriage. More than half of the women also believed that young people currently do not follow their parents’ advice in their decisions to marry someone and want to be independent. All respondents who noticed this change felt that it is positive development and approved of it. At the same time, all of those interviewed thought that getting a divorce negatively affects a woman’s potential future marriage.

*“My husband listened to his parents and married me, and now we both are unhappy. I think young people should not obey their parents and should make their own choice on marriage.”
Woman from Tavush*

Most of the men stated that due to current socio-cultural norms in the society, the community, which in past was very against divorce, is becoming more tolerant. Given the economic situation, many men migrate and leave the families in Armenia. Many couples’ lives separate and some of them eventually get divorced and the men marry abroad. Two younger men reported being less tolerant regarding divorces. Women indicated that a couple should make every effort to keep the family together, but if there is no chance of keeping it, divorce is the best option.

Respondents generally reported that communities do not support divorce: the rural communities are more conservative, while the urban communities are mostly indifferent. Some respondents also said that although reasons for divorce are personal, the community members try to find out the causes and take sides accordingly (supporting the wife or husband).

“People are leaving the country and they are looking for permanent jobs in Russia. Marriage with Russian women makes the process of getting the job much easier. After some time they become residents of Russia. For this reason, some of the men are coming back to Armenia to divorce their wives so they can marry Russian women.”
Man from Tavush

“Divorced men can easily get remarried, while divorced women rarely remarry.”
Woman from Tavush

“Young men, especially, have bad attitude towards divorced women.”
Woman from Lori

“(Her husband migrated and has not been back for several years) My husband and I did not divorce officially since there is no reason to divorce someone who does not exist. The community does not take me as a divorced woman because I live with my mother-in-law.”
Woman from Tavush

3.3.3. Reproductive health

Women who participated in the interviews seemed to be aware of several modern methods of family planning; however, many of them rely on traditional methods of birth control, such as interrupted sexual intercourse or the fertility awareness method (also known as the calendar method). There was one health worker (a physician) among the women interviewed, who also reported preferring traditional methods of birth control.

“Due to the nature of my work, I know about many methods of contraception. I prefer the calendar method and withdrawal.”
Woman from Tavush

“Among contraceptive methods I prefer withdrawal. I have never used any other method of contraception because I am afraid of them.”
Woman from Lori

Not using any method of birth control was reported by some younger respondents because of a desire to have babies and by relatively older (about 45 years and older) women due to a decreased chance of getting pregnant. Several older women reported having used different modern methods, such as intra-uterine devices and pills, but some of them discontinued their use and currently rely on traditional methods or condoms.

Condoms seem to be the first choice among modern family planning methods mentioned by all respondents. Many preferred condoms because they are a good means to control pregnancy. At the same time, both men and women stated that the use of condoms is not common in their families or in their community. Women conveyed that men do not like using condoms and some of the men mentioned that they do not like to use condoms with their spouses.

The use of family planning methods (other than condoms) is a woman's decision, which they almost never discuss with their spouses. Most women would prefer to have a discussion on family planning with their spouses, but they do not because it is not commonly accepted. Some newly married women reported that they would prefer that their husbands make a decision on the family planning method to be used, since they believe that their husbands are more

experienced. Several men reported that if their wives suggested using condoms they would not be upset. There was also an opinion that the mother-in-law has an important role to play and sometimes is a decision maker on issues related to child birth and family planning.

At the same time, discussions more generally about family size and about having more children are common. Both men and women reported that the issue of having another child versus terminating the pregnancy is generally discussed between both spouses.

“Even if a man initiates a discussion, a woman will never share her opinion on different type of contraceptives and their use.”
Man from Shirak

“I have many friends, women, who are ashamed to discuss family planning with their husbands.”
Woman from Tavush

“Men in our community are indifferent whether their wives use contraception or not. Women are more aware of these methods and take care of their health.”
Woman from Lori

People obtain information on methods of family planning from TV, print materials (booklets and journals), internet, health talks, as well as from health providers and pharmacists. Women feel very comfortable in going to healthcare providers to ask information on family planning. They prefer to communicate with healthcare providers because they offer a chance to ask questions and clarify uncertainties. Two women from rural areas reported that they prefer to discuss methods of family planning with their relatives and/or other more experienced community members.

3.3.4 Sexually transmitted infections

Most of the respondents mentioned that STIs are not something that they or their community members discuss; this is part of the reason why information about STIs is limited. Generally, men seem to be more knowledgeable in responding to questions about STIs. Most respondents reported being aware of STIs while only two of the women felt they had enough information on STIs (one of them had a medical background, the other was from Yerevan). Almost all men were aware of someone who has had an STI and was either treated abroad or brought the infection to the family. However, only three out of 12 women participating in the interviews reported that they knew someone in their community who had/has an STI.

“Some men prefer to get treatment in Russia before coming back to Armenia. They must pay a huge amount of money for treatment abroad as they are not entitled to free services abroad.”
Man from Gegharkunik

“Migrants are coming back to their families after several months of being abroad. First they will infect their wives with STIs. As they just came back, they have some money, which they earned abroad. There are some prostitutes in each community. These prostitutes also can be infected and diseases can be spread among other community members.”

Man from Yeghegnadzor

“I know a person who got an STI by having sexual intercourse with a prostitute.”

Woman from Tavush

“There are women in our village who have STIs and who were infected by their migrant husbands. These women now try to get pregnant, but cannot due to existing STIs and/or their consequences. Now they are receiving treatment.”

Woman from Gegharkunik

Most of the respondents knew that unprotected sexual intercourse transmits STIs, but there were people who thought that STIs could also be transmitted via shared toilet use, sharing kitchenware, clothes, dentist visits, mosquito bites, etc.

People seemed to be aware of at least one symptom of an STI: several women, mostly from urban and semi-urban sites, reported knowing that STIs can cause itching, bad smelling vaginal discharge, and/or high temperature. A majority of men knew that STIs can cause pain in the urinary tract and fever. Both women and men had a lack of information regarding the pre-symptomatic period, mentioning that there is no pre-symptomatic time or acknowledging that they are not aware of this.

Most of the men reported that STIs are common in Russia and Armenian migrants frequently get infected with STIs. They also stated that some of those who are infected get treated, while the others bring the infection to their families. All men had the common opinion that men get STIs due to lack of knowledge about how infection can occur and by not using condoms during sex with high-risk groups (e.g. CSWs). They suggested that increased awareness of migrants on issues related to STIs would be a good way to prevent infections. Some migrants mentioned that they are aware of the problem and that is why they limit their number of sexual partners.

“In order to protect myself from getting an STI I was only having sexual relationship with one woman.”

Man from Tavush

“In general, men are realizing that they can be infected with STI’s by having sex with prostitutes. At the same time, when you are drunk not having a condom doesn’t seem like an obstacle to having sex with prostitutes.”

Man from Shirak

A majority of women seemed to underestimate their personal risk of getting infected with an STI. Most of them reported that they would not become infected because they were sure their husbands were loyal to them and would not have sexual relations with other women. For some of them, the lack of perceived risk was a reason for not seeking out more information about STIs and not being interested in the issue.

“My husband told me that I am the only woman in his life and that is why I am not interested in information on STIs.”

Woman from Lori

3.3.5 HIV/AIDS awareness and sources of information

All respondents obtain information about HIV/AIDS and STIs from mass media, TV in particular. The respondents also stated that had accessed health related information from print

materials, such as booklets, journals, and magazines. Some of the participants, especially women from urban sites, also referred to the Internet.

Several of the men reported that their awareness about HIV comes from Russia, where HIV is a bigger threat and less stigmatized. According to these men, people talk much more about HIV on TV in Russia. Health facilities in Russia also have educational materials widely displayed.

Most of the men reported that they had enough information about the disease and did not need additional information, while women thought that additional information about HIV would be beneficial for them. Some of the male respondents have an impression that HIV is less common and estimate they have a sufficient knowledge of HIV to prevent getting it. They mentioned that if the threat increases, they will need to obtain additional information. Most of the men reported that the relatively low threat in Armenia is why people talk less about HIV.

“I think that this disease is not widely spread in the community that is why everyone thinks that it will not touch them.”

Man from Vayots Dzor

In contrast to men, women are more eager to get additional information about the disease. However, three of the women (all from Lori marz) estimated their risk of getting HIV as very low and therefore felt they did not need additional information. Some of them mentioned viewing health programs, talk shows on STIs and HIV/AIDS, and programs on other health related issues. Few of the women (two out of 12) reported having access to the Internet and the ability to search and find health related information there.

Overall, very few of the participants reported having participated in any event related to HIV/AIDS (only two out of 20 respondents mentioned having participated in any HIV-related event, both of whom were women). The female respondents from Tavush region reported about World Vision organizing community events related to STIs and HIV in their communities, while two women from Gegharkunik reported that there were HIV/AIDS-related health programs for youth in schools and in higher educational institutions. All of them appreciate the information provided at events and consider this information very valuable. There were also some women who had not participated in HIV-related health events, but who expressed willingness to participate in such an event in the future.

Almost all of the women (nine out of 12) mentioned that health care providers are the most reliable source of information about STIs and HIV. They reported that they would go to them with questions and concerns related to HIV because the health care provider would be able to explain misunderstandings and provide necessary information. One of the women mentioned that the healthcare providers are not adequately trained and have the same sources of information they do, so there would be no need for her to go to the healthcare provider for additional information.

“Don’t they use the same sources of information – TV, journals, and internet? So why should I ask them? I will find it myself... They don’t have anything extra...”

Woman from Gegarkunik

Another woman mentioned that healthcare providers are a valuable source of information on sexual-health related issues, but said that she would not initiate a discussion with her health provider about HIV if she does not have such a health issue and would opt to find this information online. She reported that the provider might think that if a client is initiating a talk about HIV, there is a chance that the client is infected or is engaged in risky behavior.

“I would not initiate this type of discussion with my doctor because if I do, she may think that I have some concerns about being infected and that is why I initiated this talk with her...”

Woman from Gegarkunik

Most respondents felt that they did not have much information about HIV/AIDS. Most of them said that HIV/AIDS can be transmitted via sexual intercourse and via blood. Some of the respondents also mentioned sharing needles could lead to infection and that mother-to-child HIV transmission is possible. There were a couple of people who thought that HIV/AIDS can be transmitted via sex only. Most respondents were aware that a healthy looking person can be HIV-positive and therefore there is a pre-symptomatic period.

Similar to the risk of getting STIs, women universally were certain that their husbands were not at risk of infection.

In general, both men and women were confident that HIV/AIDS is not a common problem in their communities. At the same time, a couple of men mentioned that they advised their friends to be cautious about STIs. There were a few people, mostly men, who reported knowing someone who was HIV-positive.

“HIV/AIDS is not common in our community....I met one person with HIV/AIDS in Russia.”

Man from Shirak

“Usually men are discussing their health issues with each other, especially if they have been abroad together. The closest big city where they can be diagnosed and receive treatment is Vanadzor. Some of the men from Tumanyan are already familiar with doctor (urologist) from Vanadzor. If they have a problem, they visit him.”

Man from Lori

Neither women nor men were usually able to mention any symptoms that could indicate an HIV/AIDS infection; however, they all knew that the disease has a pre-symptomatic period. Some respondents mentioned that STI symptoms are similar to HIV/AIDS. People generally believed that HIV cannot be cured.

Overall, women did not feel that they were at risk of being infected with HIV/AIDS. Most of them stated that their husbands are loyal to them and they will not get infected.

“I don’t think I need information on HIV/AIDS as I don’t have any sexual contact.”

Woman from Tavush (her husband is away and has not been back for several years)

Many of the respondents mentioned that they have heard about HIV/AIDS from TV and read about it in newspapers and magazines. HIV/AIDS seems to be an even less common topic for discussion between spouses than STIs in general. Women mostly reported being open to discuss HIV with their spouses, but felt that this is unacceptable behavior and that their husbands would not welcome this discussion. According to women, these discussions are not common between other spouses in their communities either. The women mentioned that if they were to initiate a conversation on STIs or HIV/AIDS with their husbands, it may become an issue of conflict since it could create concerns about her behavior (i.e. her husband might think that she has had

sexual intercourse with someone else) or the husband might feel he is being accused of having sex with another woman. For these reasons, women said they prefer not to talk about HIV/AIDS with their partners. Very few women mentioned that they had talked about STIs and HIV/AIDS related issues with their spouses.

“It is not common for couples in Spitak to discuss HIV/AIDS. However, I discuss STIs with my husband a lot, especially before his goes to Russia.”
Woman from Lori

“I regularly talk about STIs, HIV/AIDS with my husband. Last time it happened was after a quantitative survey conducted by your organization.”
Woman from Lori

In contrast to how many women feel, half of men mentioned that they think that HIV/AIDS-related conversations between couples are acceptable. Men from urban sites seemed to be more open to discussing HIV/AIDS with their spouses, while men from rural areas thought that these types of discussions were not acceptable and/or could lead to conflict between the spouses. Those who were open to discussing HIV with their spouses reported that this type of discussion may prevent transmission of diseases and that all migrants and their families should be mindful of STIs and HIV/AIDS. They also think that if men suspect they could be HIV-positive they should suggest using a condom during sex. However, recommendation to use condoms was in conflict with the concern that the use of condoms in the family is not acceptable, because can be a sign of having concerns about STIs and/or HIV/AIDS.

“Discussions about HIV/AIDS between couples will create tension inside the family. If after coming home (from Russia), I start a discussion about HIV/AIDS with my wife she will divorce me. The man will lose the trust of his wife.”
Man from Vayots Dzor

“I do not use condoms during sex with wife. Family planning is mostly the woman’s responsibility.”
Man from Gegharkunik

Some people knew HIV-positive people in their communities. Two women from Gavar area reported that they knew someone who had died that was HIV-positive, but they were not aware of anyone else. Only one of the men reported that he knew someone in his community who was HIV-positive.

“All of Dilijan became aware of this case. This HIV/AIDS patient was a migrant for the last three years. I think some complications accrued (bleeding) and the man was transported by ambulance to Yerevan (one of the specialized hospitals).”
Man from Tavush

Everyone knew that condoms can prevent getting an infection; however, almost all women believed that it would be unacceptable to suggest using a condom to the husband. There were only a few women who said that they would consider suggesting using condoms to their husbands. Furthermore, some women mentioned that if their husbands offered, they would be offended, since it would mean that the husband had sex with another woman. Only one man said that he used condoms with his wife.

“I would be offended if he offered to use a condom. If he does so, that would mean that he had sex with someone else and now thinks he could have an STI.”

Woman from Gegharkunik

“Woman can offer her husband a condom. I did so upon my husband’s return, though I trust him.... There is no shame to suggest using condoms; it is a shame to get a disease.... I also advised him to use condoms if he is abroad and has occasional sexual contacts. It is better to use condoms during sex with other woman than to get a disease and transmit it to me.”

Woman from Lori

“They (discussions on HIV/AIDS and STIs between couples) are common. I personally talk a lot with my husband about it, especially before his departure to Russia and upon his return. Sometimes I suggest him to use a condom to prevent transmission if he has sex abroad, though he denies that such a thing would happen.”

Woman from Tavush

3.3.6 Attitude towards people with HIV

Respondents in general reported that people in their communities would not feel safe communicating with an HIV-positive person. Some said that if people were better informed on HIV transmission they would be less scared of getting the disease in everyday communication. At the same time, most respondents reported that the majority of community members would not treat a person with HIV/AIDS well. Though in general people were aware about means of HIV transmission, most of the respondents answered that they would avoid communication with an HIV-positive person because HIV is not curable, contagious, and a dangerous disease. Some even stated that they would also avoid communication with family members that were HIV positive.

Several women expressed the opinion that someone who did not get the disease from sexual intercourse would be treated better.

“If I knew someone who had HIV, I would not communicate with that person at all. Any contact may be dangerous... Mostly prostitutes are infected with HIV.”

Woman from Tavush

“A woman from our village left for Russia and had multiple sexual contacts with different men. She got HIV and came back. Though she receives treatment now, she has serious health problems. This woman does not communicate with others and rarely goes out of her home. Other community members also avoid communication with her family. I feel sorry for her.”

Woman from Lori

Men seemed to be more tolerant towards people with HIV. They highlighted that although the community would not accept the people with the disease, they personally would be more tolerant, since they know that HIV is not spread by general contact. They think that due to the lack of knowledge of people in the community, an HIV-positive person would be isolated.

Women mentioned that it is not acceptable to leave a spouse if they found out that he is HIV-positive; most reported that they would stay with the family and support the spouse. They did mention that this would negatively influence their sexual life, but they would stay with the family, in some cases even risking their personal health (having sex with their husbands). Some women said that if their husband did not get HIV via sexual intercourse, the women would be completely loyal to their husbands. If their husband did get HIV from sexual relations, they accept leaving him. There were also women who mentioned that it is the husband who should leave the family if he gets HIV.

“It is not accepted that a wife leaves her husband if he is HIV-positive. The wife should always assist her husband. However, if a wife is HIV-positive, the husband should leave her because it is not accepted that the wife had extra-family relations with someone.”

Woman from Lori

“I would never leave my husband if he had HIV... However, in general, the husband should leave his HIV-positive wife because she cheated on him and got the infection. I think such a woman should not be kept in the family.”

Woman from Lori

Most of the men felt that living with an HIV-positive partner would have a negative impact on the family, since a limited sexual relationship hurts family relationships. Some were more straightforward, saying that the woman would be left immediately.

“I think only prostitutes can be infected with HIV. If a woman is HIV-positive, the man should immediately leave this woman.”

Man from Gegharkunik

3.3.7 Migration and HIV

In nearly all communities there are many people who migrate to other countries for work, many of whom leave their families in Armenia. On average, people reported that 40% to 90% of the families in their communities have a migrant family member. About half of the migrants return home once a year, but there are some who do not come back for several years. Migrants generally are gone from spring to fall and return for three months in winter. Construction is the most common work for the migrants and almost all of these migrants get a significant break in the winter.

Some women do join their husbands abroad, but in most cases, the men migrate alone. As a consequence of such long separations from each other, some families get divorced. Women, in general, very rarely migrate alone, however some of the men reported knowing a migrant woman.

Both men and women in general agreed that STIs and HIV/AIDS are threats for migrants. Men commonly stated that the high rate of migration from Armenia increases the risk of HIV/AIDS infection for the population of both communities and the nation. The men mentioned that sexual relationships with other women, including CSWs, are frequent for migrants and that some of these women could be HIV-positive.

In contrast to men, women felt that HIV/AIDS is a risk for the population of Armenia in general, but not for small communities. They also were confident that they were not at risk since their husbands do not have sexual relationships with other women in Armenia or abroad.

Women were sure that the men do not change their behavior abroad and most even said that they actually begin valuing the family relationships more when they return. Some women were confident that when having sex with CSWs men always use condoms. There were also a few women who thought that men generally have another partner in Russia (but their husbands were loyal). Only one of the female respondents mentioned that she has some fears of getting an STI or HIV/AIDS.

“Migrant men are not likely to change their behavior when abroad. They are not very affected by the foreign culture. Upon return, my husband became more caring for the family.”
Woman from Tavush

“Migrants do not change much abroad. Some of them might have girlfriends, but I personally don’t know anyone who has... The chance that I and my husband catch HIV is very low as we are loyal to each other... But, I am scared to catch the disease, that’s why I have had several tests. The results were negative.”
Woman from Lori

“My personal risk of HIV is very low. My husband may catch it and that is why we use condoms, to reduce the risk.”
Woman from Yerevan

3.3.8 Experience of HIV testing

Several women reported that they had been tested for HIV. Four female respondents from Tavush and Lori marzes reported having been tested for HIV after the quantitative interview from this project, which offered free HIV testing. Another woman was tested in different health center (not their local one). There was also a couple that went to be tested together. Some women reported that their husbands had been tested in Russia to get a work permit. One of the respondents mentioned that she was tested during her most recent pregnancy and there was no reason to re-take the test. Another woman reported that though she has never been tested, she asked her husband to get tested and he refused, saying that he does not have a problem. One of the participants mentioned that when she was offered a free test she went to the testing center and stood in front of it, but did not dare to enter.

“I went to the local facility for testing, but I did not dare to enter the testing center. I stood in front of the center for a couple of minutes, but did not enter... Our city is small and the people all know each other. Only the fact that I was tested for HIV could become a topic for discussion. If people know that I went for testing, regardless of the test results, they would think that if I went for HIV testing I have some concerns.”
Woman from Gegharkunik

Other reasons for not being tested for HIV were lack of time, no perceived risk, or fear to get the infection during the test.

Five out of eight men participating in the study reported that they had been tested for HIV; among them, four were tested in Russia to get a work permit and one man, from a rural site, was tested in Yerevan. In general, men would prefer to be tested in Yerevan (for both STIs and HIV/AIDS), since they trusted the Yerevan facilities more, and similar to women, they are more confident that if they are tested in Yerevan, members of their community would not find out.

Men also mentioned that their friends have had exams and treatments for STIs in Yerevan or another larger city to avoid rumors and gossip. Only one of them mentioned that he would potentially get tested in a local facility.

“I was tested for HIV/AIDS in Yerevan. I advised some of my friends to go for HIV-testing in Yerevan.... Conditions and specialists are better in Yerevan and another advantage of being examined there is to avoid rumors among neighbors.”
Man from Vayots Dzor

3.3.9 Access to and utilization of VCT centers

Everyone who was interviewed was aware of outpatient health services available in their communities, but very few of them were aware of local VCT services and even fewer had ever used them. Regardless of low awareness, most of the respondents said that they would never go to this center seeking information on HIV/AIDS or to be tested. They all were sure that their visit to the center would not be confidential and everyone in the community would know and discuss it.

While some of the respondents mentioned that the facilities (mostly urban or semi-urban) are well equipped and have all the available tools for HIV testing, most of the respondents perceived that the quality of health services is poor.

Very few of the participants had experience with VCT services. One woman shared her experience in visiting the VCT center and having an HIV test.

“I visited our local health care unit for an HIV test. After blood collection, the health provider at the unit gave me a code and a phone number to call to find out the result of the test.... There was no pre- or post-test counseling. I think that in the case of a positive result the information would be spread in our small community. If I suspected I was HIV positive, I would not have taken this test in our local unit and would have gone to Yerevan.”
Woman from Lori

Most men did know much about their local health facility and only stated that their family uses this facility. Most also reported that their families were satisfied with the services available there. Most of the men were concerned about the confidentiality of information in the local health center.

“I have never used the local HIV testing point because I am afraid there will be a lack of confidentiality.”
Man from Tavush

“For VCT issues, I visit Vanadzor (the neighboring city, instead of the community VCT center) and I satisfied with the service. I think migrants need to use VCT points or be tested in other places in order to avoid the spread of STIs among their families and communities... Thinking about the community, I think men prefer to be examined in Vanadzor or Yerevan in order to keep confidentiality.”
Man from Lori

“I have never used the local VCT point as I am afraid about confidentiality - that information will disseminate among the general population very soon. Of course, this situation would affect my family. It is better to visit a private VCT in Russia rather than a free one in Armenia (again due to confidentiality issue).”
Man from Tavush

People also expressed concern that even if the test is anonymous and taken in a city where the provider does not know the client, if the test comes back positive, the communication will no longer be anonymous. There were also people that thought all health services are fee based, including HIV testing.

3.3.10 Health services and HIV testing in destination countries

The female respondents seemed to have little information about health services, including HIV/AIDS services, in the countries their husbands migrate to. Very few of the women have ever discussed foreign HIV/AIDS services with their husbands. However, the vast majority of them were aware of a requirement to undergo a medical check-up, which includes HIV testing, to get permission to work in the Russian Federation. The women were aware that their partners have to comply with this rule and as part of this medical check-up underwent HIV testing. The information obtained from men was concordant: in order to get a work permit they had to undergo medical check-ups, which include HIV and STI testing, chest x-ray, urine test, and other medical examinations.

Most respondents said that these check-ups needed to be conducted in the Russian Federation. Men described that often the company that employs the migrants organizes these check-ups and tests. According to one of the respondents, the medical check-up in Russia costs 2,000 Russian Rubles (approximately \$65 USD).

Only one of the male respondents reported never using the health services in the host country. According to him, the health services are too expensive and unaffordable for migrants because they are trying to save some money for their families. This man reported preferring to use health services in Armenia, which are free for Armenian citizens.

Overall, the perception of the quality of health services in Armenia versus in foreign countries varied. Men generally said that the quality of the services does not differ much, while only one of the male respondents believed that he could get better health services in Armenia. There was also a respondent who highlighted that, although the services are very similar, the main difference between them is that there is less stigmatization of HIV in Russia. This trust in the confidentiality of the test makes a big difference, and migrants are not scared to undergo the medical exams in Russia.

“You can easily speak about STIs in Russia. There are a lot of health education materials: posters, booklets, and leaflets are all available in polyclinics in Russia. On Russian TV, you can watch a lot of programs about STIs and HIV/AIDS. If someone in Armenia speaks about STIs, people will think that this man has a problem. People will try to avoid having a relationship with such a person.”
Man from Tavush

3.3.11 Summary of in-depth interview findings

- People have very good relationships and communication within their communities, relatives, friends, and neighbors. They also communicate with others on issues related to health.
- While men mostly lead the households, health-related issues are, in most cases, the responsibility of women: either mother-in-laws or wives. Nevertheless, most women would not feel comfortable suggesting their partners take an HIV test or use condoms, since they believe this may create conflict in the family. Men, however, said they would not be against a woman initiating discussions about STIs and/or HIV/AIDS.
- The most popular means of family planning are condoms, the fertility awareness method, and/or withdrawal or interrupted sex. This could be due to fact that migrants are away during most of the year and the couples do not have regular and consistent sexual relations.
- Though not accepting of it in general, some women are tolerant to their husbands having extra-marital sexual relationships abroad.
- Although both migrants and their wives agree that migration increases the risk of HIV/AIDS for the country and the community, they estimate their personal risk as very low.
 - Women underestimate their risk of getting an infection because they are confident that their husbands do not have sexual relationships abroad.
 - Men underestimate their risk of getting HIV because they practice safe sex and seemed to be more concerned about STIs other than HIV/AIDS.
- Even though most respondents know that HIV/AIDS is transmitted via sex and blood, they would avoid communication with people with HIV. Another reason to avoid communication with an HIV-positive person is the perception that mostly people with HIV engage in risky and negative behavior.
- Men seemed to be more tolerant towards people with HIV. They highlighted that though the community would not accept the people with HIV, they personally would be more tolerant since they know that HIV is not spread by general contact. This more positive attitude may be due to the fact that men generally have more interaction with HIV positive people in the Russian Federation, where HIV is less stigmatized.
- Both men and women are not confident that the results of an HIV test would be confidential. Furthermore, they think that only the fact that they have been tested would create some issues for them in their community.
- Health providers are considered reliable source of information, since in addition to just providing the information, they can answer questions and clarify any uncertainties. However, it is unlikely that the client will initiate an HIV-related discussion; therefore, the provider should initiate it.

3.4. HIV testing

One of the objectives of the study was to provide estimates on the prevalence of HIV. Because it was known that the utilization of HIV testing services by migrants in Armenia is very low, an attempt was undertaken to encourage testing by providing a short pre-test counseling combined with free and accessible testing. It was hoped that after the counseling, 30% of respondents would utilize HIV testing.

However, the target was not reached. Out of 2478 respondents included into the study analysis, only 133 (5.4%) went for HIV and STI testing (80 for HIV only and 53 for both HIV and STI).

It should be noted that none of the HIV test results were positive, while 17 persons who passed the STI tests were infected (5 cases of Chlamydia, 2 cases of Gonorrhoea, 3 cases of Trichomoniasis, 10 cases of Bacterial Vaginosis, etc).

The proportions of male and female respondents who were tested were almost equal (5.1% and 5.6% of the respective subsamples, see Table 3.4.1). There was a statistically significant difference between migrant and non-migrant male respondents, with migrant males being more likely to utilize HIV testing (7.0%) than non-migrant males (3.4%). The proportion of tested recent migrants was higher than the corresponding proportion of earlier migrants, but the difference between the two groups was not statistically significant. Also, migrants' wives were more likely to utilize the HIV testing (6.1%) than non-migrant wives (3.6%), and the difference between the groups was approaching the conventional threshold of statistical significance ($p=0.059$).

Table 3.4.1. HIV/STI testing

Characteristic	Men (n=1166)				Women (n=1312)	
	Migrants			Non-migrants (n=411)	Migrants' wives (n=816)	Non-migrants' wives (n=418)
	All (n=747)	Recent (n=444)	Earlier (n=303)			
HIV/STI testing (%)*	7.0**	7.7	5.9	3.4**	6.1	3.6
HIV/STI testing (%)	5.1				5.6	

Notes: *Female migrants (76 in total) and their husbands (8) were not taken into account.

** significant at $p<.05$ (within each category).

Education and age both had statistically insignificant impacts on who received testing. There was essentially no difference between those that completed higher education or postgraduate (4.9%) compared to those with only vocational education (4.8%). Only those with incomplete secondary or less education vary from the mean (9.3%) but not significantly. More 18-35 year olds were tested (6.3%) than 36-55 year olds (4.5%) or 56+ year olds (2.6%), but the result is not statistically significant ($p=.102$).

When looking only at HIV testing, respondents outside of Yerevan were much more interested in testing than respondents in Yerevan. Only 3.5% of respondents in Yerevan received testing compared to 5.7% in urban settlements and 6.7% in rural settlements, a statistically significant difference. Meantime all the Yerevanees who volunteered to take the offer, enjoyed both HIV and STI testing; the share of respondents from the capital city who was tested for HIV+STI comprised 53% of such respondents (vs. 33% in all respondents).

The marzes of Tavush (16.7%) and Vayots Dzor (13.3%) had the highest turnout while Syunik (2.5%) and Shirak (1.0%) had the lowest. This extremely low turnout for Shirak marz is particularly worrisome as it has the highest percentage of registered cases of HIV out of all the marzes. Notably, Shirak marz is one of the marzes selected by the recently launched UNICEF program, "Social Response to Labour Migration in Armenia," that aims to mitigate the negative consequences of labor migration.²

² United Nations in Armenia. (April 5, 2013). *EU, UNICEF launch project on labour migration in Armenia*. Retrieved April 9, 2013, from <http://www.un.am/en/News/1188>.

While looking for the reasons for the low utilization of HIV/STI testing offered within the framework of this study one should recall that the blood samples for HIV testing were taken in both Yerevan and at the local health centers while STI testing required the respondent to go to the STI center in Yerevan. This required travel for people outside of Yerevan perhaps affected the number of people interested in taking an STI test for those from outside of Yerevan. Every respondent that took an STI test also took an HIV test.

The reasons for the low utilization of HIV/STI testing offered might be as follows:

- 1) Insufficient baseline HIV/STI knowledge and low risk perception of respondents. A short counseling session could not change these conditions considerably.
- 2) Stigma might be a significant barrier. The respondents were supposed to go to the local health facility to provide blood samples and the health provider knew what blood was drawn for. As the experience of UMCOR shows (see the section “Mapping of existing projects), the rate of VCT utilization is far greater when it is provided by MMT and the local providers are not involved in the process.
- 3) Inadequate HIV/STI counseling that was possible to provide within a sociological survey even though the supervisors and interviewers were properly trained, and their motivation was increased upon the course of implementation of the fieldwork.

3.5 Findings of expert interviews: Existing problems and their possible solutions

3.5.1 Specific HIV and STI risks of Armenian migrants and their family members and recommendations on how to reduce these risks

All interviewed experts mentioned that the Armenian migrants are exposed to an elevated risk of HIV/AIDS infection. According to the experts, one of the factors that could potentially contribute to the risk of migrants is the lack of knowledge on the ways of HIV transmission and on the methods and means to prevent the transmission of the virus. The migrants also lack knowledge on the HIV situation in destination countries; many of them don't know that in the Russian Federation (the main destination country) the prevalence of HIV is 10 times higher than in Armenia. As a result, even if a migrant knows that having one permanent sex partner is a protective behavior, they will not see having a permanent sex partner in the Russian federation as a larger risk than one in Armenia. In general, the lack of knowledge results in a low risk perception, which in turn leads to risky behaviors in migrants in destination countries. It was also noted that male migrants very often have irregular sexual lives, use services of sex workers and practice other unsafe behaviors.

Further, having such a low risk perception, migrants don't get tested for HIV before or immediately upon returning to Armenia (the barriers to HIV testing and the recommendations of experts on how to overcome these barriers and increase the rate of VCT utilization are detailed in the next section). Upon their return home, migrants, without identifying their HIV status or discussing STI and HIV issues with their wives, engage in sex and exposing them to the risk of STI and HIV infection. The risk of HIV infection for wives increases due to the widely-accepted attitude by men that condom use with marital partners can be seen as an insult. Women in Armenia share the same attitude; therefore the wives of migrants do not attempt to use condoms either. Others reasons why women do not try to use condoms is the traditional Armenian mentality, gender inequality, and lack of empowerment of women. One of the interviewed experts shared the results of the Nation-wide Survey on Domestic Violence against Women in Armenia, conducted in 2008 and 2009 (UNFPA, 2009). According to the study,

violence against women is a common occurrence in Armenia and intimate partner violence accounts for the greatest share of physical and psychological violence, controlling behavior, and sexual violence. The expert noted that given these facts, the HIV prevention programs targeting female partners of migrants should first of all empower them so that they can protect themselves from the risk of HIV infection without becoming victims of violence. Another expression of the gender power imbalance is the perception that men can have sex with casual partners, particularly when they are outside Armenia, while the women have to remain loyal to their husbands in their absence.

Because the main factors perceived to fuel the HIV risk behaviors were low HIV awareness and low HIV risk perception, most experts said focusing on raising the HIV awareness is the best way to reduce the risky behaviors of migrants. Specifically, experts mentioned that awareness raising campaigns aimed to increase the risk perception, change unfavorable attitudes and behaviors, and to promote the need for HIV service utilization should be expanded. They recommended scaling up information and educational activities within the framework of the National Behavior Change Communication (BCC) strategy to broadly involve the mass media into their implementation. A wide range of approaches was recommended including:

- Develop information and educational programs as well as public service advertisements (PSAs) and broadcasting them regularly (several times per day) on TV, as this is the most widely used communication method in Armenia. To further increase their reach, implementers should consider focusing their broadcasting during popular serials. The experts added that only the state TV channels (national H1 and h2) and local channels should be considered, because private TV channels charge a lot (80,000 dram per minute) and the donor funds can not cover regular advertisement on them. Further, the experts added that the government should pass a law on advertisement which would require state TV channels to broadcast free regular social advertisement in prime times. In other countries (e.g., the Russian Federation) this practice already exists.
- Radio can be utilized for information and educational programs and PSAs; however, the limited use of radio should be taken into account.
- Publish articles on HIV/AIDS-related issues in national and local newspapers. However, the limited utilization of newspapers by the Armenian population should be considered.
- Develop, print, and disseminate special information and educational materials related to the issue of migration and HIV/AIDS prevention; consider making the printed materials available at health facilities, as well as other locations frequented by migrants and their family members (marzpetarans, supermarkets, cafeteria, barber's/hairdressing salons, etc.); also consider disseminating the printed materials at migrants' homes by outreach workers.
- Provide HIV-related information in various forms (videos, printed materials) at the airports, inside the airplanes (a small brochure can be placed into the back seat on the board of airplane), at the air tickets booking offices, as well as at the land borders posts.
- Consider disseminating HIV- and migrant-related information through Internet and SMS.
- Design and implement special awareness-raising events (e.g., community meetings, lectures, etc.).

Further, the interviewed experts noted that the HIV risk of migrants and their family members is exacerbated by the fact that they do not have access to HIV/AIDS prevention programs in Armenia, nor in the destination countries. HIV prevention activities targeting migrants and their family members in Armenia are neither sustainable nor comprehensive, which reduces their effectiveness. Interviewed experts identified only several short-term HIV prevention pilot projects implemented by UMCOR and World Vision - Armenia offices and one nation-wide

project implemented by the consortium of AYF and SAMSA. The scope and geographical coverage of the projects have not been sufficient to meet the today's existing needs. The experts noted that in order to develop successful HIV prevention programs for migrants and their family members, it is necessary to study those needs more comprehensively.

Furthermore, the experts mentioned that there are few organizations in Armenia that have experience in conducting HIV prevention among migrants and even less have capacity to implement country wide programs. Most of the well-established NGOs are located in Yerevan and have no infrastructure for interventions in rural communities, where level of migration is the highest.

Given the lack of experience in implementing HIV prevention projects, the capacity of those NGOs that were recently involved in the implementation of such activities has to be strengthened and fully utilized for implementing future interventions.

The interviewed experts also recommended building HIV-prevention capacity in other NGOs conducting non-HIV-related activities among the migrants (e.g., counseling on legal issues, support in job placement, etc.) or in the NGOs implementing non-HIV related health projects and use the capacity of those NGOs for implementing HIV-preventive activities among migrants. Also, given that the social services regularly conduct registration of families in marzes, it was recommended to use this capacity for providing HIV-related information to migrants and their family members by providing relevant training to the representatives of social services. Furthermore, it was mentioned that in order to increase the effectiveness of future prevention programs, it is necessary to involve the migrants themselves and the broader communities into the HIV-prevention projects by using the capacity of village administrations, rural ambulatories, and other active community members. Finally, the experts noted that in order to make a real difference, it is necessary to switch from irregularly implemented activities to those implemented on programmatic and continuous basis as well as scale up collaboration between governmental and non-governmental organizations.

Faith-based organizations and particularly of the Armenian Apostolic Church also have an important role in shaping social values, promoting responsible behavior, increasing public awareness, and influencing the public opinion. The interviewed experts noted that the church leaders can be especially helpful in eradicating the stigma and discrimination against people living with HIV/AIDS and in creating a supportive environment for them. The experts pointed out several projects implemented in Armenia showed effectiveness of church involvement in promoting healthy lifestyle, creating appropriate skills, and mobilizing the community. The experts recommended to train church leaders on HIV prevention and migration issues and to involve them in future prevention programs targeted at migrants and their family members.

Experts also mentioned that worldwide, peer education is one of the most widely used strategies to address the HIV/AIDS epidemic among various vulnerable groups. Some projects implemented in Armenia for migrants used the peer-education approach to deliver HIV prevention messages. It was recommended to develop models for creating and maintaining a network of experienced migrant peer educators; to continue and expand per educators/peer-counselors trainings; to use this resource to raise awareness among younger and inexperienced migrants; and to integrate and scale-up HIV/AIDS peer-education with other HIV prevention interventions among migrants and their family members as well as within community development initiatives.

Finally, many experts stated that the education is playing increasingly important role in the multi-sectoral response to HIV/AIDS. According to them, it is very important to provide sufficient HIV prevention knowledge and skills to the students in order to reduce their HIV risk

during their adult life. The experts mentioned that integration of the “Healthy Life Style” program into the curricula of the secondary and senior schools has been a significant achievement. The course is taught as a separate subject for 8-9 and 10-11 grades. It includes separate chapters related to the issues of HIV/AIDS, puberty and reproductive health, and bad habits. Teachers have been trained to deliver the course and use more interactive teaching methods. However, for the majority of teachers dealing with sensitive issues (e.g. sex) and using participatory approaches to teaching remains a challenge. Another challenge is the lack of capacity for assessing the quality and impact of these courses. Some of the experts mentioned that while the demand for this course is very high, the majority of students and their parents are not satisfied with the quality of its delivery. They recommended:

- Conduct expert assessment of the “Healthy Life Style” curriculum content, approach, and implementation by applying UNESCO standards for curriculum based reproductive health and HIV education programs.
- Ensure that the “Healthy Life Style” education curricula address the harmful gender norms.
- Expand the “Healthy Life Style” education to cover specialized secondary and high institutions as well as evening, special, and boarding schools.
- Develop relevant capacities for delivering “Healthy Life Style” in all mentioned educational institutions.
- Ensure the sufficient quality and quantity of education materials.
- Strengthen the role of school directors and parents by involving them into implementation of HIV prevention interventions in schools, especially in rural communities.
- Conduct quality and impact assessment.
- Develop monitoring and evaluation system, including a set of M&E indicators at the Ministry of Education and Science as well as implementing organizations that will measure the effectiveness and efficiency of HIV prevention education interventions in educational facilities.

3.5.2. Limitations to the principle of universal access to HIV counseling and testing:

Recommendations on how to increase the access and utilization of VCT

The interviewed experts mentioned that even though the Law of the RA on “Prevention of disease caused by Human Immunodeficiency Virus” and the Standard of “Provision of HIV/AIDS services within the state basic benefit package” (hereafter “the Standard”) are guided by the principle of universal access to HIV/AIDS testing, treatment and care”, in practice free, anonymous, confidential, and informed voluntary HIV counseling and testing (HCT) is only available at the NCAP and Medical Scientific Center of Dermatology and STIs in Yerevan, which are not easily accessible for people from remote regions. For this population segment, as well as for everyone who does not want to go to the NCAP for HIV testing, it can be organized through the primary health care point where the person is registered.

However, at the primary health care level proof of residency is required for service, so anonymous health service (including HIV testing) is impossible. Confidentiality is also a concern at the primary health care points because even though health personnel are required to keep the medical information confidential, some of them do not comply with this requirement. Furthermore, a provider of VCT does not have a separate room; the rooms are usually occupied by several providers, which makes confidential counseling impossible. The issue becomes even more problematic because a number of providers (e.g., a family physician, a specialist, a lab technician in the local facility drawing the blood, and a provider of HIV testing in the regional specialized HIV testing laboratory) are involved in the process due to a long chain on referrals.

Some interviewed experts said that the test result go back through the same chain so that several providers know the results, further increasing the chance that confidentiality could be breached. However, according to some interviewed experts, steps have been taken to guarantee at least partial confidentiality; when the test result is positive, the lab directly reports it to the NCAP. The NCAP and the health staff involved in the actual treatment then contacts the patient about their status. Some providers are unhappy with this situation because they want to know the status of their patient in order to protect themselves from HIV infection. But the NCAP response is that the providers have to be careful with all patients, irrespective of their status.

Other concerns with the primary health care points are that informed consent or the voluntary nature of HCT are not always ensured. For example, pregnant women are one of the groups for which, according to the Standard, providers are required to initiate HIV counseling and testing. Many providers understood this requirement to mean that testing is mandatory. Furthermore, because many providers do not want to spend their time on counseling, or are not motivated to provide, they often simply inform their pregnant patients that the blood drawn will be used for HIV testing among other analyses. As a result, some pregnant women refused to have the test. According to some experts, the providers that had low testing rates in their areas were warned by monitoring officials that this can be considered as an indication of insufficient counseling. After that warning, the majority of those providers decided that in order to keep testing rates high, it is better not to inform pregnant women about HIV test at all.

All interviewed experts stated that providers lack motivation to initiate HIV counseling with groups of population that are eligible for provider-initiated testing under the Standard. As a result, the rate of PITC with groups of population other than pregnant women has been very low. Another reason for low rate of PITC may be because there is nothing in the job description of VCT providers that indicates that they are required to initiate counseling with the categories of people mentioned in the Standard. They are only required to fill in a registry form and submit it to the marz health authority. However, since their compensation does not depend on the number of persons which they provided counseling for, this measure can hardly motivate them to do a good job.

The low rate of patient-initiated HIV testing may be associated with the need to pay for testing. However, as noted by a number of interviewed VCT providers and some policy-level providers, even though they are technically free of charge, HIV testing is only available to pregnant women and persons with clinical symptoms, providers often offer free of charge testing to all people who apply because health facilities have supplies of HIV test kits provided by GFATM that are not used.

Besides, as noted by a policy-level expert:

“The main problem here is not that the migrants cannot afford to apply for paid HIV testing. After all, migrants and their family members aren’t the poorest groups of population. The problem is that in Armenia there is a mentality to not value one’s own health and attend a health facility only when the health problem becomes very serious. I think that if we are able to make people value their health, if we are able to form a demand for HIV testing by raising the migrants’ awareness on the HIV risks associated with their status, and by increasing their perception of HIV risks, then they will find resources to get tested”.

All interviewed experts were concerned with the low rate of HIV testing utilization by migrants. They gave some ideas on how the situation could be improved. The opinions expressed included:

- Revise the HIV-related regulations and policies to ensure real universal access to and high utilization of HIV counseling and testing services by migrants and their family members.

- In collaboration with the SHA, solve the problem of full coverage from the state budget of all costs connected with the provision of HIV counseling and testing, particularly when the services are provided to migrants and their spouses
- Consider including in the job description of PHC physicians trained in providing VCT / VCT providers the provision of mandatory comprehensive HIV counseling to all migrants and their family members who apply to health facility for any reason and encouraging them to get tested.
- Include in the job description of family physicians having a list of all migrants residing in their catchment area and providing home visits and comprehensive HIV counseling to family members as well as to the migrants as soon as they return home from migration.
- Design special HIV prevention programs which would focus on changing the Armenian mentality so that people start to value their own health.
- Create demand for HIV testing by raising migrants' awareness of HIV risks associated with migration and by increasing their perception of HIV risks.
- Raise the awareness of migrants on the availability of HIV counseling and testing services locally, elsewhere in Armenia, and in destination places.
- Build new / improve the existing capacity for the provision of quality HIV pre- and post-test counseling at the primary health care level and at all women's consultations (important for migrants' wives).
- Ensure uninterrupted procurement and supply of HIV test kits.
- Supply rapid HIV tests to all primary health care units and women consultations as an auxiliary means in case of interrupted supply of regular test kits.
- Establish a health unit at the customs station, providing VCT, syndromic management of STIs, and other non-sexual health-related services.
- Establish a VCT point at the airport and find a way to identify migrants among the passengers and initiate with them a comprehensive HIV counseling; think of incentives that can motivate the majority of migrants to apply for HIV testing at the VCT in the airport.
- Consider utilizing MMT for providing HIV counseling and testing services. This approach was especially stressed by interviewed experts because it has a number of advantages compared to providing VCT through regular health care services. First, MMTs ensure access to VCT for people residing in marzes (especially in remote ones). Second, because an MMT is comprised of health care providers who usually do not know local residents and because an MMT can ensure anonymity and confidentiality of HIV testing, HIV-related stigma, a major barrier to VCT utilization, becomes much less important. Finally, the vast majority of the Armenian population outside Yerevan and particularly in rural areas trusts the professionalism of Yerevan-based health care providers much more than that of local providers. Although the lack of trust in the local staff was mentioned as a reason for not applying for HIV testing by a very small proportion of survey respondents, this attitude seems widespread in Armenia. One of interviewed experts brought up such an example demonstrating this attitude: while usually health services are poorly utilized in rural areas, this rate greatly increases when a health campaign utilizing an MMT is organized within the framework of election campaigns.

Additional ideas on how to increase the rate of utilization of HIV/STI services were connected with utilization of the NGO capacity:

- Encourage NGOs working with migrants to apply for and obtain a medical license to conduct HIV rapid tests in local communities;
- Build capacity for quality HIV pre and post-test counseling as well as for conducting HIV rapid tests in NGOs working with migrants;
- Ensure an uninterrupted supply of rapid HIV tests to NGOs working with migrants;

- Consider modifications in Law on Licensing for provision of simplified licensing procedure for NGOs offering HIV testing using rapid HIV tests.

Finally, the experts suggested reviving the user-friendly clinic (UFC) which was operating in Yerevan and neighboring areas until the end of September, 2011; they believe that provision of VCT services by UFC to groups that were particularly vulnerable to HIV infection and stigmatized, which limited their access to regular health services was a significant contribution to a multi-sectoral approach to the HIV and AIDS response in Armenia. Meantime, as the public opinion survey results showed, strengthening capacities of PHC facilities and bringing services close to target population to increase utilization of VCT services at PHC, thus improving geographic/physical access to VCT services are much more desirable, though perhaps more expensive due to absence of the scale effect.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 Strengthening research on HIV risks and prevention among migrants

To understand the impact of migration on the HIV epidemic in Armenia, sufficient funds need to be allocated to research and monitoring studies among migrants and their family members. It is necessary to regularly carry out full-sized BBS (including assessment of HIV prevalence) among migrants and their partners so that their risk profile can be defined as the one of MARPs. Special studies with a representative sample of Armenian migrants, utilizing internationally acceptable methodologies, to investigate the STI/HIV risk profile of Armenian migrants and their partners are also needed.

The few HIV prevention interventions that have already been implemented among migrants and their family members should be evaluated. It is also necessary to carry out more intervention research with rigorous evaluation plans. Cost-effectiveness studies should be conducted to provide insights into what HIV investments have accomplished, whether interventions averted new infections and AIDS deaths, and if they did, at what cost. Only based on high quality research data, it is possible to improve the relevance and comprehensiveness of HIV prevention interventions and to develop a package of effective services for migrants and their partners.

4.2 Awareness raising

Because the findings of both qualitative and quantitative components of the study show that low HIV awareness and low HIV risk perception fuel the HIV risk behaviors, the recommendations on how to reduce the risky behaviors of migrants mostly focusing on raising the HIV awareness. Awareness raising campaigns aimed to increase the risk perception, change unfavorable attitudes and behaviors, and increase the demand for HIV testing should be expanded. It is necessary to scale up information and educational activities within the framework of the National BCC strategy and broadly involve the mass media in their implementation.

To reach the majority of the population, including migrants, a strong media campaign on television, the most widely accessible communication channel, is needed. However, because TV advertisement is very expensive and given the limited resources of the NAP, it is necessary that the Government along with passing laws that enable social advertisement (see article 13 of RA Law “On Advertisements” accepted in 1996) or prohibit commercial advertisements of blood related medical testing and treatment (see article 9 of RA Law on Human Blood and its components...” accepted on 15th of November 2011), but also implement mechanisms that

oblige state TV channels to broadcast regularly social advertisements during the prime time for free³.

The following specific approaches are recommended:

- Design information and educational programs and public service advertisements (PSAs) and broadcast them regularly (several times per day) on TV, as this most widely used communication method in Armenia. To further increase their reach, implementers should consider focusing their broadcasting during popular serials.
- Radio can be utilized for information and educational programs and PSAs; however, the limited use of radio should be taken into account.
- Publish articles on HIV/AIDS-related issues in national and local newspapers. However, the limited utilization of newspapers by the Armenian population should be considered.
- Develop, print, and disseminate special information and educational materials related to the issue of migration and HIV/AIDS prevention; consider making the printed materials available at health facilities, as well as other locations frequented by migrants and their family members (marzpetarans, supermarkets, cafeteria, barber's/hairdressing salons, etc.); also consider disseminating the printed materials at migrants' homes by outreach workers.
- Provide HIV-related information in various forms (videos, printed materials) at the airports, inside the airplanes (a small brochure can be placed into the back seat on the board of airplane), at the air tickets booking offices, as well as at the land borders posts.
- Consider disseminating HIV- and migrant-related information through Internet and SMS.
- Design and implement special awareness-raising events (e.g., community meetings, lectures, etc.).

4.3 Increasing migrants' access to and utilization of VCT services

Given the low rate of HIV testing utilization by migrants, several measures are recommended improve the situation:

- Design special HIV prevention programs, which would focus on changing the Armenian mentality so that people start to value their own health.
- Form a demand for HIV testing by raising the migrants' awareness on the HIV risks associated with migration, and their own personal HIV infection risks.
- Raise the awareness of migrants on the availability of HIV counseling and testing services locally, throughout Armenia, and in destination countries and cities.
- Build new and improve the existing capacity for quality HIV pre and post-test counseling at primary health care facilities and in all women consultations (important for migrants' wives).
- Ensure uninterrupted procurement and supply of HIV test kits.
- Supply rapid HIV tests to all primary health care units and women consultations as an auxiliary means in case of interrupted supply of regular test kits.
- Ensure, with the help of the SHA, that the state budget covers all costs connected with HIV counseling and testing, particularly when the services are provided to migrants and their spouses.

³ A thorough Concept on Social Advertisement that was discussed and approved by the Government of Armenia on December 30th, 2010 was somehow suspended..

- Consider including mandatory comprehensive HIV counseling to all migrants and their family members who apply to health facility for any reason and encouraging testing into the job description of PHC physicians trained in providing VCT.
- Include holding a list of all migrants residing in their catchment area and providing home visits and comprehensive HIV counseling to family members as well as to the migrants as soon as they return home after migrant work into the job description of family physicians.
- Ensure access for the migrants and their family members residing in marzes (especially in remote marzes) to HIV/AIDS healthcare services through MMTs.
- Establish a health unit at customs stations, providing VCT, syndromic management of STIs, and other non-sexual health-related services.
- Establish a VCT point at the airport, find ways to identify migrants among the passengers, and initiate with them comprehensive HIV counseling. Think of incentives that will motivate the majority of migrants to seek HIV testing at the VCT in the airport.

Additional ideas on how to increase the rate of utilization of HIV/STI services were connected with utilization of NGO capacity.

- Encourage healthcare oriented NGOs working with migrants to apply for and obtain a permit or license to conduct HIV rapid tests in local communities.
- Build capacity for quality HIV pre and post-test counseling as well as for conducting HIV rapid tests in NGOs working with migrants.
- Ensure an uninterrupted supply of rapid HIV tests to NGOs working with migrants.
- Consider modifications in Law on Licensing for provision of simplified licensing procedure for NGOs offering HIV testing using rapid HIV tests.

4.4 Improving HIV prevention interventions targeting migrants

The organizations implementing HIV prevention projects in Armenia should coordinate their activities and more effectively share their experience and best practices with each other so that every project can benefit from the experience of others.

To make the impact of HIV prevention programs more sustainable, it is necessary to switch from irregularly implemented activities to those implemented on programmatic and continuous basis and scale up collaboration between governmental and non-governmental organizations.

The capacity of NGOs that were recently involved in the implementation of HIV prevention projects for migrants has to be strengthened and fully utilized for implementing future interventions.

It is necessary to build HIV-prevention capacity in other NGOs conducting non-HIV-related activities among the migrants (e.g., counseling on legal issues, support in job placement, etc.) and in the NGOs implementing non-HIV related health projects and use this new capacity to implement HIV preventive activities among migrants.

Given that the social services regularly conduct registration of families in marzes, this capacity should be used for providing HIV-related information to migrants and their family members by providing relevant training to the representatives of social services.

Community leaders and active members should be engaged in HIV/STI prevention activities.

Given the evidence demonstrating the important role of faith-based organizations and particularly of the Armenian Apostolic Church in shaping social values, promoting responsible

behavior, increasing public awareness, and influencing the public opinion, it is recommended to train church leaders on HIV/STI prevention and migration issues and involve them into the future prevention programs to be targeted at migrants and their family members throughout Armenia. Could be worth if church leaders in destination countries are also trained so that their role in social protection (including health services) of incoming migrants becomes more sound.

Given that worldwide, peer education is one of the most widely used strategies to address the HIV/AIDS epidemic among various vulnerable groups, it is recommended to develop models for creating and maintaining a network of experienced migrant peer educators; to continue and expand peer educators and peer-counselors trainings; to use this resource to raise awareness among younger and inexperienced migrants; and to integrate and scale-up HIV/AIDS peer-education with other HIV prevention interventions among migrants and their family members as well as within community development initiatives.

Education is playing increasingly important role in the multi-sectoral response to HIV/AIDS. Given that the respondents of our survey overwhelmingly supported the idea of making educational information on STI/HIVs available to school students (7-11 grades), it is recommended to improve the “Healthy Life Style” program, which is already included into the curricula of the secondary and senior schools and that has separate chapters related to the issues of HIV/AIDS, puberty and reproductive health. In order to improve the program, it is recommended to conduct expert assessment of the curriculum content, approach, and implementation by applying UNESCO standards for curriculum based reproductive health and HIV education programs. It is also recommended to expand the “Healthy Life Style” education to cover specialized secondary and high institutions as well as evening, special, and boarding schools and to develop relevant capacities for delivering the course in all mentioned educational institutions.

More needs to be done to improve the regulation and management of migration. The Armenian government should take more active steps to regulate and manage the migration and to protect the legal interests and rights of its migrant citizens within official intergovernmental agreements, which would stipulate legislative responsibilities of both sending and receiving countries. Public health authorities and experts should actively participate in the development of intergovernmental agreements or any other documents aimed at coordinating the migration issues between Armenia and destination countries so that these documents adequately address the rights of migrants to health and access to health services in destination countries.

All stakeholders involved in HIV and migrant issues in Armenia should actively support and contribute their input to the “Cross-border Cooperation for HIV/AIDS Prevention and Impact Mitigation in Southern Caucasus and the Russian Federation Project” so that Armenian migrants benefit from the project and get access to the HIV/AIDS prevention, testing, and treatment services in the Russian Federation.

Because the findings of both the qualitative and quantitative components of the study show that the main factors that increase risky behaviors among migrants are low HIV awareness and low HIV risk perception, the recommendations on how to reduce the risky behaviors of migrants mostly focus on raising awareness about HIV.

4.5 Optimizing migration policies and cross border cooperation for HIV/AIDS prevention

More needs to be done to improve the regulation and management of migration. Armenian government should take more active steps to regulate and manage the migration and to protect the legal interests and rights of its migrant citizens within official intergovernmental agreements

which would stipulate legislative responsibilities of both sending and receiving countries. Public health authorities/experts should actively participate in the development of intergovernmental agreements or any other documents aimed at coordinating the migration issues between Armenia and destination countries so that these documents adequately address the rights of migrants to health and access to health services in destination countries.

All stakeholders involved in HIV/STI and migrant issues in Armenia should actively support and contribute their input to the “Cross-border cooperation for HIV/AIDS Prevention and Impact Mitigation in Southern Caucasus and the Russian Federation Project” so that Armenian migrants could maximally benefit from the project and get access to the HIV/AIDS prevention, testing and treatment services in the Russian Federation.

4.6 Optimal package of services for migrants and their spouses

The findings of our study do not provide sufficient evidence to recommend any of the services or strategies for nationwide implementation. Therefore, for the current program (2013-2015) we recommend choosing one or two of the most popular or effective interventions and pilot testing them in a limited number of communities to compare their efficiency and cost effectiveness based on indicators selected in advance (e.g., the rate of VCT utilization).

Based on the results of mapping of projects and expert interviews, the services and strategies that show some evidence of effectiveness are those utilized by UMCOR. We recommend including in a potential package of services for migrants and their spouses the following:

- 1) awareness-raising sessions provided by experienced professionals utilizing appropriate demonstration materials (like video films) and interactive methods of delivery, and
- 2) availability of MMT at intervention sites on a regular basis to provide HIV counseling and testing services.

To make the MMT more attractive to the target population and to overcome the barriers to VCT utilization, including stigmatization and fear of HIV/AIDS, other popular health services should be included to the MMT package. Besides HIV counseling, other services could be:

- counseling on all health problems or concerns that an applicant may have and referring him or her to a relevant, accessible specialist;
- testing for common STIs, hepatitis B and C, and referring for follow up treatment; and
- providing diagnostic sonographs (ultrasounds), which are very popular in Armenia.

We recommend comparing the aforementioned package of services with another intervention, which could be as follows:

- 1) strengthen the capacity of local primary health providers in HIV counseling and testing, and
- 2) motivate and oblige them to provide mandatory HIV counseling to all migrants and their family members in their community.

Once both pilot interventions are implemented, it is recommended to assess their efficiency and cost-effectiveness using a rigorous evaluation design and valid indicators of success (e.g., VCT utilization).

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ANNEXES: LABOR MIGRATION AND STI/HIV RISKS IN ARMENIA SURVEY INSTRUMENTS

A1. Title page of the Survey Questionnaire (for female and male)



Title Page

A2. Survey Questionnaire for Female



Questionnaire for
Female

A3. Survey Questionnaire for Male



Questionnaire for
Male

A4. Expert interview Guide



Expert Interview
Guide

A5. In-depth interview guide



In-Depth Interview
Guide