Brief on HIV Epidemic Situation among MSM and Trans people in Armenia

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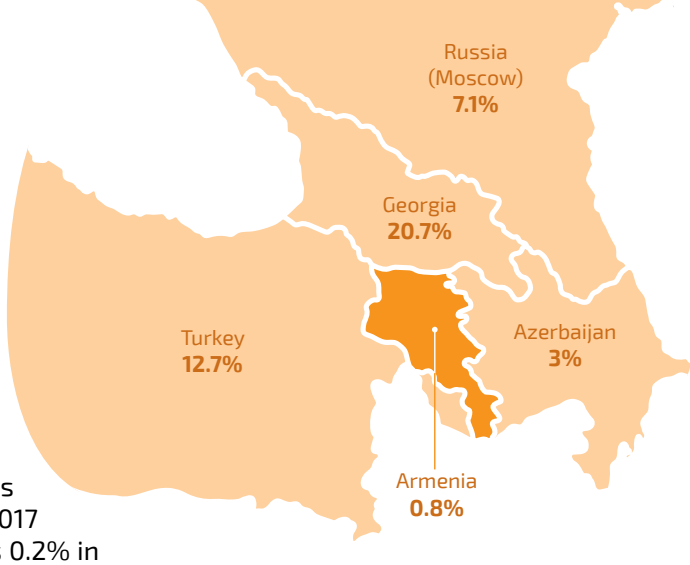

The first HIV case was registered in Armenia in 1988. Overall, as of 31 March 2018, 3,003 HIV cases had been registered in the country with 95 new cases of HIV infection registered during the first quarter of 2018. Males constitute a major part in the total number of HIV cases with 2,083 cases (69%). Of all the people living with HIV, 51% was in the age group of 25–39 at the time when their HIV diagnosis was made.

The HIV/AIDS situation assessment shows that the estimated number of people living with HIV in the country is 3,400 (UNAIDS spectrum estimate), of which by the end of 2017 only 69% were aware of their HIV status. HIV prevalence is 0.2% in the general population, making Armenia a low HIV prevalence country with an epidemic concentrated among key populations (KPs) at higher risk for HIV. The main modes of HIV transmission are through heterosexual contacts (68%) and injecting drug use (22.5%), followed by male-to-male sex, accounting for 3.4% of all registered cases (fig. 1)[1].

Globally, gay men and other men who have sex with men (MSM) accounted for 12% of new infections in 2015 (fig. 2)[2].

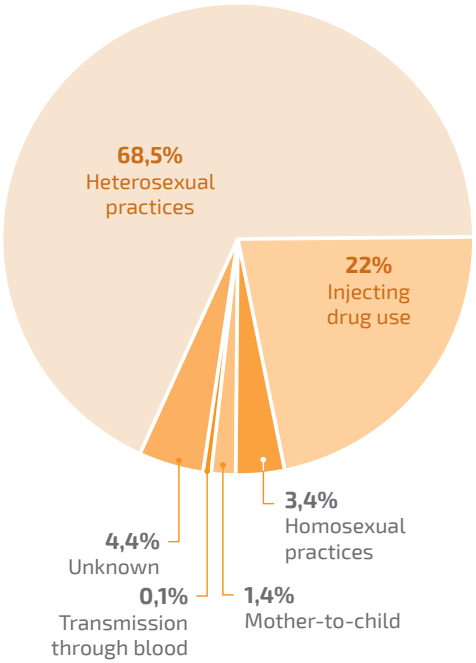

Figure 1. Distribution of HIV cases in Armenia by modes of transmission

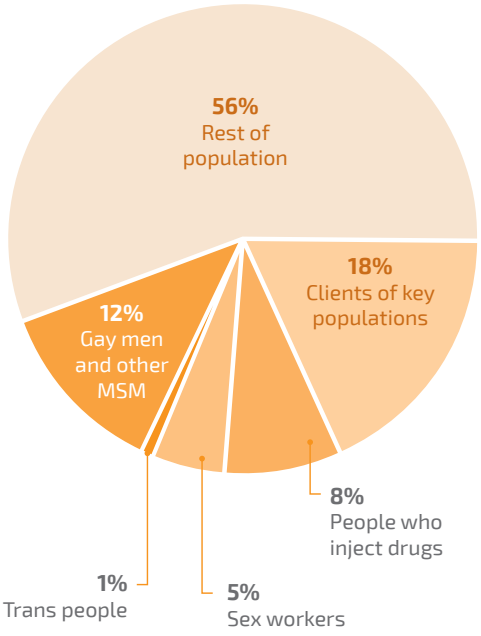

Figure 2 New cases of HIV infection (global), 2015 (UNAIDS, 2017)

MSM are considered one of the KP groups most at risk for HIV in East Europe and Central Asia (EECA) region, where HIV prevalence among MSM is also high (Ukraine — 8.5%, Georgia — 20.7%, Moldova — 9%, Russian Federation — 7.1% for Moscow and 22.8% for Saint Petersburg)[3].

Generally, many Armenians have history of working abroad due to difficult economic situation in the country. It is estimated that at any one time there are approximately 80,000–100,000 returning labor migrants in Armenia[4] with travel mostly to Russia (90%)[5] and Ukraine where HIV prevalence is at least 1% in the general population (ages 15–49 years)[6]. Such levels of migration may, in turn, result in increased numbers of HIV cases in Armenia.

1 http://www.armaids.am/en/statistics/stat_2018/april_stat_2018.html
2 http://www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf
3 http://ecom.ngo/en/hiv-msm-eeca/
4 http://publications.iom.int/books/report-household-survey-migration-armenia
5 http://www.smsmta.am/upload/Migration%20and%20Development_Study_in_English.pdf
6 http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/data-and-statistics

HIV Prevention among MSM in Armenia

The most recent MSM population size estimate (PSE) for the country states that there are 12,461 MSM in Armenia[7]. According to the national HIV surveillance data (IBBS), MSM contributed to 3% of registered HIV cases in the period of 1988-2015; an increasing trend of new HIV diagnosis attributed to MSM is being observed. Five or less cases were reported yearly before 2013. This number has increased since 2013 to 10 or more cases diagnosed among MSM each year[8].

The latest IBBS came up with HIV prevalence among MSM of 0.76%, which is lower than HIV prevalence among MSM in other countries of the region. Moreover, while HIV prevalence among MSM has steadily increased in all countries of EECA, it has been decreasing among MSM in Armenia from 2.5% in 2012 to 0.8% in 2016[9].

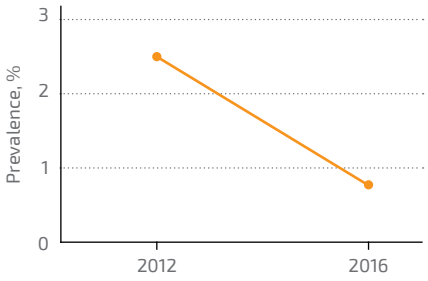

Figure 3. Trends of HIV prevalence among MSM in Armenia, %

Risky sexual behaviors and inconsistent condom use are frequent among MSM in Armenia. According to the IBBS 2016 condom use was inconsistent, ranging from 20% (Yerevan, capital city) to 74% (Gyumri, 2nd largest city in Armenia), reporting not using a condom during their last anal penetrative sex with a male partner. The majority of surveyed MSM knew where to get an HIV test, with most having ever been tested for HIV. Yet, less than 30% of MSM in all cities reported having an HIV test within the last 12 months and having received the result. High stigma and discrimination among general population and health care workers may prevent MSM from accessing testing services[7]. The current legislation permits HIV blood testing only within licensed laboratories, which limits testing coverage particularly among hard-to-reach KPs. To mitigate this challenge community testing with saliva tests for KPs was introduced with the support of Global Fund (GFATM) in August, 2017. The pilot project pointed that community-based saliva testing by NGOs attracts new hard-to-reach beneficiaries into prevention projects. Scale-up of community-based testing with saliva tests was considered by country stakeholders as a measure to alleviate low case detection among KPs in the GFATM proposal development process.

HIV prevention work has been carried out in Armenia since 2003 with the support of the GFATM. In the frames of the current grant (2016–2018) HIV prevention interventions are conducted in the three biggest cities of Armenia: Yerevan, Gyumri and Vanadzor. The minimum package of provided preventive services includes peer education, condom distribution, HCT. Additionally, lubricants are being distributed and STI testing and treatment offered to project beneficiaries. The coverage of MSM with HIV prevention services is low in Armenia. Only 39.7% of MSM are regularly covered by prevention services. The majority of MSM reported that they had not received condoms in the past 12 months from an NGO or from outreach workers. This finding highlights the need to prioritize the development and implementation of effective interventions tailored to meet the needs of MSM[7].

Strategic Information

Solid evidence and reliable data are of key importance for strategic planning and budgeting of national response to HIV among MSM in the country. IBBS is conducted in Armenia on biannual basis. The most recent IBBS among KPs in Yerevan, Gyumri and Vanadzor, Armenia was conducted in 2016. Trans people are not involved in BBS as a separate group. PSE of MSM population has also been carried out in 2016. However, there are a number of limitations and issues with regards to PSE, such as issues with sampling (e. g. difficulties reaching hidden MSM groups), inadequate involvement of LGBT community in the process of survey planning and implementation. Some NGOs question the validity of the results of PSE exercise and a consensus between state institutions and CSOs with regards to accepting and approving the survey results was not reached[10]. PSE of trans population group has not been carried out.

[7] http://www.armaids.am/images/pdf/BBS_PWID_FSW_MSM_ARM_REPORT_FINAL_2016_eng.pdf
[8] http://www.euro.who.int/__data/assets/pdf_file/0007/355570/20171127-Annual_HIV_Report.pdf
[9] http://www.armaids.am/images/pdf/Report_Annual_HIV_Surveillance_2016_Armenia_arm_eng.pdf
[10] "Assessment of existing Strategic Information on HIV among MSM and Trans People in Armenia, Belarus, Georgia, Kyrgyzstan, and Macedonia". S. Chikhladze, M. Kasianczuk. 2017

In addition, information on a number of studies conducted and some national documents and reports are available only in Armenian. The annual bilingual report on HIV epidemiological surveillance in the Republic of Armenia for 2016 was published in 2017.

Role of Communities in HIV response

Throughout the world, grassroots community-based and community-led organizations have worked on the frontlines of the global AIDS response, putting efforts on provision of much needed HIV and AIDS services to MSM and trans people. They have led development of innovative and effective programs for MSM and trans populations[11]. Mostly, the efforts in implementing a Fast-Track approach, such as scale-up of service coverage, improving retention in care, quality monitoring, human rights advocacy, and addressing stigma and discrimination issues, requires strong and united community voice and presence[12].

One MSM-led NGO providing HIV prevention services to MSM in Armenia in the frames of the GFATM grant (peer education, provision of condoms and lubricants, HCT, psychological and social support). A number of MSM-led organizations are involved in advocacy and human rights protection issues. Advocacy activities are implemented within the framework of different projects funded by international donors. Community members recognize the need of strengthening their advocacy skills for better advocacy for the needs of MSM in the country. LGBT communities in Armenia are not actively involved in the process of survey planning, implementation, analysis and interpretation, though there are no legal barriers for that. Rather, poor communication with state institutions and lack of analytical and research capacity prevents community representatives from participation at all stages of HIV strategic research[10].

Recommendations / Areas of improvement

- State and society organizations should reach a consensus on the results of studies and surveys. It is recommended to conduct PSE of MSM population based on best practices in the region and with wider involvement of international experts, Armenian public health specialists, Ministry of Health, the NGO sector and MSM as a whole. The results of such participatory exercises should be widely distributed and promoted among country stakeholders and international organizations.
- The analytical and survey skills, capacity and potential of community organizations, and NGOs as a whole, should be assessed and further developed to enable their proper involvement at all stages of surveys planning (design, implementation, analysis and interpretation of findings, distribution of data).
- Collaboration and communication between the state actors and the community-based organizations should be strengthened to improve informed data availability and to strengthen the capacity of communities.
- The advocacy skills of community organizations should be developed for stronger united advocacy campaigns to secure state funding of HIV prevention work among MSM.
- The national and other research reports should be available in international languages so they are accessible for the stakeholders in the region.

[11] http://www.amfar.org/uploadedFiles/_amfarorg/Around_the_World/Lessons-Front-Lines.pdf
[12] http://www.unaids.org/sites/default/files/media_asset/UNAIDS_JC2725_CommunitiesDeliver_en.pdf