MEETING THE CHALLENGE OF INJECTION DRUG USE AND HIV IN ARMENIA

Policy Paper

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ABBREVIATIONS

RA – Republic of Armenia
fSU- former Soviet Union
HIV - Human Immunodeficiency Virus
AIDS – Acquired Immunodeficiency Syndrome
IDU – injection drug use/user
WHO- World Health Organization
UN – United Nations
UNAIDS – United Nations Special Programme on HIV/AIDS
UNGASS – United Nations General Assembly Special Session
CND – Commission on Narcotic Drugs (within United Nations)
INCB – the International Narcotics Control Board (within United Nations)
OSI – Open Society Institute
GFATM – Global Fund to fight AIDS, Malaria and Tuberculosis
UDHR – Universal Declaration of Human Rights
ICCPR - International Covenant on Civil and Political Rights
ICESCR - International Covenant on Economic, Social, and Cultural Rights
STI – sexually transmitted infections
VCT – voluntary counseling and testing
NGO – non-governmental organization
PLWHA – people living with HIV/AIDS
CCM – Country (Armenia) Coordination Mechanism on HIV/AIDS Issues
SCAD - Southern Caucasus Anti-Drug Programme

1. INTRODUCTION

The spread of human immunodeficiency virus (HIV) infection through injection drug use (IDU) is an increasingly serious public health problem in some countries of the former Soviet Union (fSU). Decisive policy action at the national level is needed for an effective response to HIV and injecting drug use.

This policy paper is based on the research of the present situation of response to drugs, drug users and HIV in Armenia and its conflicts with the international law. The research is conducted via *de jure* assessment of legal documents, resolutions and position papers on drugs, human rights and HIV and *de facto* estimate analysis of their practical exercise in Armenia. Review of research articles, books and mass media articles was also part of the research. The paper provides an overview of the challenges to effective responses to drug use and HIV in Armenia, outlines the rationale for adopting public health-oriented approaches to the problems of drug use and HIV, provides justification/evidence that the new approaches would be consistent with the international law and proposes a number of policy recommendations for the promotion of health approaches vs. law enforcement.

2. BACKGROUND

Injection drug use and HIV rates in some countries of the former Soviet Union are still skyrocketing (1). The epidemic of injection drug use is an epidemic of the young. These children deserve attention and care, irrespective of how society feels about drug use. Stigmatizing them could mean letting a generation of children die- a generation on which the promise of transition depends. Their drug use, the reasons behind it, and its consequences must be addressed with effective evidence-based methods, even if those methods may make some people uncomfortable.

Compared to other countries in the region such as Russia and the Ukraine, the prevalence of HIV infection in Armenia is not high. From 1988 to March 1, 2005, 317 HIV carriers were registered in the country, 301 of them are citizens of the Republic of Armenia (2). The estimated prevalence rate according to the Sentinel Epidemiological Surveillance in May 2002 was <0.1 % (3). This rate is relatively low and it alone may not be enough to justify an immediate effort for an HIV prevention program in Armenia.

However, the socio-economic crisis, considerable proportion of displaced and refugee populations, poverty, mass unemployment and out migration to countries where the HIV prevalence is high make the HIV/AIDS epidemic a real danger for a small country with a population about three million. As declared at the Caucasus Area Meeting on National Responses to HIV/AIDS, "…the alarming situation and experience of Ukraine, Belarus and Russia demonstrate that the number of HIV cases can increase from hundreds to thousands within a year. Tomorrow can be late. We have to act today…"(4).

The official statistics show that the HIV epidemic in Armenia, as in other countries of fSU, is driven mostly by injecting drug use (53.5% of all registered cases) (2). In recent years, a considerable increase in the number of cases of infection through IDU has been observed. So far, all the individuals infected via IDU have been men. As a matter of fact, the majority of them temporarily inhabited in the Russian Federation (Moscow, St. Petersburg, Irkoutsk and Rostov) and the Ukraine (Odessa, Tiraspol and Kiev) and were probably infected with HIV there (5).

The studies have demonstrated that when HIV epidemic is driven by IDU, early intervention is critical: once HIV has been introduced into a local community of injection drug users (IDUs), there is a possibility of extremely rapid spread (6). Moreover, once prevalence exceeds 5 to 10 percent among IDUs, overall infection rates frequently climb as high as 50 percent in fewer than five years (7). The rapidity of HIV spread among IDUs means that any delay in implementation of HIV prevention interventions carries particularly serious consequences.

The data on the prevalence of drug use in Armenia is scarce. According to the operative data of the Ministry of Interior, the number of drug users in Armenia in 2000 was about 20,000 (50% residing in the capital city Yerevan) with 2,000 of them using injecting drugs (3). The "Rapid assessment of the spread of HIV infection including intravenous drug users" conducted by the National Center for AIDS Prevention in Yerevan, provided higher rates. It showed that in 2000 only in Yerevan there were from 19,000-20,000 drug users, of whom approximately 10% were using intravenous drugs. The survey of general population conducted within the framework of the same study demonstrated that approximately 14% of respondents had experience of drug use (3). According to WHO EURO databases, the estimated number of IDUs in Armenia is between 7,000 to 11,000 which makes the prevalence rate of IDU among the general population 0.2-0.3% (8)[1].

The Sentinel Epidemiological Surveillance carried out in year 2000 found the rate of HIV prevalence among IDUs to be about 15% (3) demonstrating thus that IDUs are definitely key to the dynamics of the HIV epidemic in Armenia. In order to prevent a generalized epidemic, there is an urgent need to address the linkage between IDU and HIV infection.

3. CURRENT CONTEXT OF THE ISSUE: CHALLENGES TO EFFECTIVE RESPONSES TO DRUG USE AND HIV IN ARMENIA

In any AIDS epidemic where injection drug use is so central in driving the spread of the disease, the drug-, HIV- and human rights- related legislature and its application, as well as commitment to democratization and sustained engagement from NGOs and, more generally civil society, in issues addressing the problems of IDUs and people infected by HIV – all those are important determinants of the capacity of a country to mount an effective response to HIV/AIDS. This chapter will focus on the state of affairs with these determinants in Armenia.

3.1 Zero Tolerance Approaches to Narcotic Regulation in Armenia

In 1993 the Republic of Armenia (RA) assented to the three major UN Drug Control Conventions. Therefore, the Armenian drug-control legislative framework is closely tracking the Conventions. The guiding principle of Armenian drug-related legislation as it is defined in the 2003 Annual Drug Report of the RA is as follows: "The Government of the Republic of Armenia is ever-vigilant in its crusade against illegal drug trafficking and drug addiction, with the aim of protecting the nation from becoming involved in drug trafficking and drug dependency. The Government is guided by the slogan "Armenia Free of Drugs" (5).

[1] Data in the WHO EURO databases are drawn mainly from national sources, and are generated by national surveillance, service providers, and NGOs, or by such international organizations as the UN Reference group on injecting drug users. Where no published or official data are available, preliminary estimates made by national experts during a workshop on estimating and modeling the HIV/AIDS epidemic in Europe are used. The workshop was jointly organized by WHO EURO and UNAIDS in summer 2003

The Law of the RA on "Narcotic Drugs and Psychotropic Substances" is the cornerstone of "drug law"(9). It was adopted by the National Assembly of the RA on December 26, 2002 and ratified by the president on February 10, 2003. The provisions of the Law concerning the sale, possession and consumption of narcotics can be characterized as "zero tolerance", since not only the sell and possession, but even the consumption of narcotic drugs or psychotropic substances is prohibited under Article 37 of the Armenian drug law. Use of narcotic drugs without medical permission, is punished with a fine in the amount of up to 200 minimal salaries, or with arrest for the term of up to 2 months (see Article 271 of the Criminal Code of the RA (10).

It should be emphasized, that there is some disagreement between terminology of the Drug Law and Criminal Code. While the Drug Law mentions "illegal use of narcotic drugs or psychotropic substances", the article 271 of the Criminal Code speaks about narcotics only, not mentioning psychotropic substances. Therefore, it is not clear whether use of the latter is punishable either.

A similar pattern is seen in application of severe penalties to "traffickers." According to the article 266 of the Criminal Code, illegal manufacture, processing, procurement, keeping, trafficking or supplying of narcotic drugs or psychotropic materials with the purpose of sale, is punished with imprisonment for 3 to 15 years with or without property confiscation (10). It is important to mention here that thresholds for trafficking penalties are very low. For example, 0.025 - 1g of heroin is considered a "large" amount and more than 1g is considered a "particularly large" amount. For hashish 'large' and 'extra large' amounts are 5-100g and more than 100g respectively. Thus, the drug law shows little distinction between small-scale dealers/ producers and industry kingpins.

The interviews with officials involved in drug issues in Armenia have demonstrated, that they don't consider the Armenian drug law to be very strict. Some of them welcome the law which requires to lock up drug users in prisons, because, as they say, this measure contributes to the social order. The others think that Armenia should stick to strict provisions of the law, because this is her obligation under the UN drug control treaties. Some Armenian policy makers are against the harm reduction approaches because they associate the latter with "legalizing" the consumption of narcotics which is again insistent with the U.N. drug conventions.

On the other hand, some NGO representatives (e.g. Anti-Drug Civil Union) state that a well-designed and locally tailored restrictive policy with the optimal balance between public health and law enforcement approaches and broad involvement of central and local governments, society and community as a unique coalition is the only way to succeed.

It is worth mentioning here that recently there have been some positive trends in drug-related policy-making process in Armenia. With the initiative of the Southern Caucasus anti-drug (SCAD) Programme, a package of amendments to the drug-law and corresponding articles of the Criminal Code has been developed. (Include here some provisions of amendments). Although the extent to which the amendments will change the strict provisions is rather limited, nevertheless, the trend is promising.

The analysis of the de facto exercise of the strict provisions of the law demonstrated that although in Armenia "depolarization' and "decriminalization" schemes are not introduced officially, nonetheless, in practice, the police recently has been trying to be less strict with non-violent drug users.

Although cause-and-effect relations between policy and health are difficult to pinpoint, the correlations between zero tolerance approaches and the rapid spread of HIV are striking (11). Strict measures for the possession and sell of small amounts of narcotics as well as for consumption of drugs without medical prescription result in incarceration of non-violent drug users. In Armenia in 2003, 82 persons were convicted for the illegal use of drugs (article 271 part 1 of the criminal code) without doctor's prescription (5).

Meanwhile, it has been demonstrated that in countries with injection-driven HIV epidemics, prisons are the most powerful factor in HIV transmission (11,12). Since sexual relations and drug use are widely practiced there, while condoms and sterile injecting equipment are generally unavailable, many injection drug users resort to unsafe injection practices behind bars (12,13).

The information on the state of affairs with HIV and drug use in Armenian prisons is extremely scarce. The sentinel epidemiological surveillance carried out in Armenia in 2002 found the estimated rate of HIV prevalence among individuals in penitentiary institutions to be 5 to 6% (3). In 2004, the Penitentiary Department of the Ministry of Justice received a sub-grant from the Global Fund to Fight AIDS, Malaria and Tuberculosis to implement harm reduction projects in Armenian prisons. However, so far there is no information on whether the project has started and what services are available for IDUs in prisons. According to unofficial announcements by representatives of the Ministry of Justice, drug use is not practiced in Armenian prisons therefore it is needless to implement harm reduction there. In fall 2004 the International Red Cross carried out a study on the spread of HIV, Hepatitis B and Tuberculosis in Armenian prisons. However, the report on the study is not available either.

Although scarce, yet the data provided above, suggest that in Armenia as in other countries of fSU, zero tolerance approaches may contribute to the spread of HIV.

3.2 Lack of human rights-based policies

The evolving HIV/AIDS pandemic lead to increased understanding of the importance of human rights as a factor in determining people's vulnerability to HIV infection. By the end of 1980s, the call for human rights had been explicitly embodied in the first WHO global response to AIDS (14) This approach was motivated by the recognition that protection of human rights was a necessary element of a worldwide public-health response to the emerging epidemic. The implications of this call were far-reaching.

What does rights discourse add to consideration of issues involved in HIV/AIDS? First of all, conceptualizing something as a right emphasizes its exceptional importance as a social or public goal. Second, use of rights language in connection with any issue emphasizes that the dignity of each person must be central in all aspects of that issue. The utilitarian principle is rejected by a rights approach. The greater good of the greater number may not override individual dignity. And finally, by framing HIV strategy in human rights terms, it became anchored in international law, thereby making governments and intergovernmental organizations publicly accountable for their actions toward people living with HIV/AIDS, as well as those vulnerable to HIV/AIDS (15).

The key human rights document and the cornerstone of the modern human rights movement is the Universal Declaration of Human Rights adopted by the U.N. General Assembly in 1948 (16). The International Covenant on Civil and Political Rights(1966) (17), the Covenant on Economic, Social and Cultural Rights (1966) (18) and a number of other human rights treaties further elaborated the rights set out in the UDHR.

None of these treaties expressly identifies HIV/AIDS, but all human rights elaborated in them can promote accountability in HIV/AIDS related issues. Human rights relevant to HIV/AIDS identified in these treaties, and elaborated by other documents include (but are not limited to) the right to non-discrimination and equality, to health, to liberty and security of the person, to privacy, to seek, receive and impart information, for those who are affected, to participate in developing policies and programs that affect them, to marry and found a family, to work, and the right to freedom of movement, association, and expression.

Armenia is a signatory to the aforementioned treaties. This means that Armenia is obliged to respect, protect and promote the rights recognized in these treaties. However, the analysis of Armenian drug- and HIV-related laws, policies and practices demonstrated that some of them are in conflict with the provisions in the human rights treaties.

3.2.1 Violation of human rights of IDUs, their discrimination and marginalization

The Article 11 of the Armenian Law on HIV/AIDS provides for compulsory testing of at-risk groups of population including IDUs (19). Further, legislation in Armenia does not have statutes that specifically ban the release of confidential HIV information. Vise versa, the Armenian Health Law, the Law on Personal Data and the Law on HIV/AIDS permit disclosure of medical information in cases envisioned by law (HIV positive status may be among these cases).

It should be noted, however, that recently the Law on AIDS has been revised and the corresponding legislative initiative is in the agenda of the National Assembly. The revision includes elimination of mandatory HIV testing for high-risk groups.

Such practices violate an individual's right to autonomy and privacy. International standards and practices recognize that there are very few circumstances (e.g. when blood or tissues are donated) in which testing should be required, or in which unauthorized disclosure of HIV status is permitted (20). Compulsory HIV testing combined with involuntary disclosure of test results increases the chances that the identity of people living with HIV/AIDS will be revealed without their permission, thereby facilitating official or unofficial discrimination.

Further, equality or non-discrimination is a fundamental principle of human rights law, and prohibition of discrimination is a leitmotif running through all of international human rights law. However, in Armenia the guarantees to non-discrimination are mostly illusory, because Armenia has not passed specific laws designed to protect vulnerable groups. Furthermore, although the Constitution of the RA provides for the basic human rights including the right to life, right to non-discrimination and equality in access to health care, legal representation and support, housing and social interactions, freedom from violence and abuse, freedom from arbitrary arrest and detention (21), these guarantees are not enforced when the IDUs are concerned. The reason for this is widespread disinterest, intolerance, and discrimination. Since IDUs in Armenia are extremely marginalized, they have not been able to build effective social networks and advocate for their own

rights. Therefore, there is little political interest in taking official measures to guarantee their legal rights.

As a result of the aforementioned violations of their rights and discrimination, IDUs are reluctant to seek assistance from public health facilities out of fear that they will be turned over to authorities, denied health care, or even forced into repressive, custodial treatment programs against their will. According to the 2003 annual report on drug, over the past few years, demand for drug treatment in Armenia has been low and steadily declining since 2000. The number of persons registered at the Republican Narcological Center in 2003 was 197, and the number of persons treated was only 7 (5). The reason for such a situation may be that the patients do not trust the health care system.

Criminalization of drug use along with violation of human rights and discrimination of IDUs has devastating epidemiological consequences. It results in so-called "spoiled" identity—a stigmatized status that is applied to drug users as a group even in the absence of particular behaviors. Stigma connected with drug use is strong in Armenia, especially since the media strongly disapprove of drug use behavior regardless of the circumstances. They focus on destructive elements—drug-related crime, overdose, disengagement from society at large—and adopt "blame the victim" mentalities that remain punitive.

Stigma pushes injection drug users further into the social margins. Once there they have little incentive to refrain from such risky behaviors as sharing needles or having unprotected sex. And while IDUs are among those most in need of assistance, public health authorities cannot reach them there, which reduces the effectiveness of prevention and treatment policies.

3.2.2 Controversial status of harm reduction projects

Obstacles to the adoption of comprehensive human rights-based approaches to HIV in Armenia are apparent in policies relating to harm reduction initiatives. Experience from other regions shows that harm reduction activities must form a critical part of the response to HIV/AIDS (22-24). Numerous studies have documented the effectiveness of harm reduction programs to decrease the harm caused by injecting drug use (25). The Declaration of the Special Session of the UN General Assembly on HIV/AIDS and the International Guidelines for HIV and human rights, although not having the force of law, encourage the countries to implement harm reduction strategies as the ones, promoting the individuals right to health (26, 27). Yet, in Armenia, wide gap still exists between what has been scientifically proven and what is politically feasible.

Armenia was the last country in the region (Central and Eastern Europe and fSU) to start up the needle exchange. The first harm reduction project including HIV counseling, condom distribution and needle exchange launched in Armenian in August 2003. In late 2003 – early 2004 four other pilot needle exchange projects launched, funded by the Open Society Institute (OSI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Currently, within the framework of GFATM-funded program, three harm reduction projects are running in Yerevan, Gumry and Kapan. They include syringe/needle exchange, dissemination of condoms and educational-informational material, as well as VCT service, voluntary consulting on STI syndromial treatment and legal advising.

The results of monitoring carried out by the expert of the OSI in December 2004, as well as the interviews with the projects' staff demonstrated that the projects had huge problems with reaching out to the target population. The projects' staff does not enjoy the trust of IDUs, therefore IDUs do not routinely visit the projects' offices. In one of the projects' offices in Yerevan the OSI monitor

met with an outreach staff who was an IDU in the past. That single staff was responsible for providing all harm reduction services to IDUs including needle exchange, distribution of educational materials and condoms. The two projects working in Yerevan (OSI- and Global Fund-funded) cover 147 and 250 IDUs respectively. In another large city, Vanadzor, the OSI-funded project covers 35 IDUs. Thus the coverage of IDUs is very law.

The present situation of harm reduction activities in Armenia can be described as being somewhere between what is tolerated and what is supported. We can not say that they are merely tolerated because the harm-reduction component theoretically is included in the National HIV/AIDS Prevention Program. However, the financial support provided for harm reduction projects by the government is extremely limited (in any) to be able to cover the existing needs.

So far, the staff of pilot harm reduction projects has not had any problems with the law enforcement authorities which may be explained by the fact, that the representatives of the Ministry of Internal Affairs are involved in the country coordination mechanism (CCM) on HIV/AIDS issues. However, if the initiative is to be implemented in a broad scale, some legal issues may arise under Armenian law with regard to each component of harm reduction programs. Let us analyze possible legal constraints for each component.

A "needle/syringe exchange center" is a place, usually comprising two or three small rooms, located in an area frequented by persons who consume narcotic means or psychotropic substances where sterile syringes and/or needles, swabs, condoms, and special literature are distributed free of charge to registered persons and used syringes and needles are collected in exchange for proper sterilization and destruction. Seen through the eyes of a jurist, a "needle exchange center" is a place visited by individuals known to acquire and keep narcotics or psychotropic substances who register and by doing so, confirm their past record and their present intention to engage in behavior that did or will constitute an administrative or criminal offence (Article 271 of the Criminal Code of the RA). Although it is crucial to such programs that the clients of the centers are protected by confidentiality, there is doubt as to the extent to which center personnel can properly withhold information should the law enforcement personnel insist upon disclosure.

Thus, this legal perception places needle exchange programs directly at odds with a sophisticated strategy that emphasizes the exclusion of narcotic means and psychotropic substances from society through zero or low levels of tolerance and severe repressive measures.

Further, in addition to needle exchange, the centers may offer counseling on how to clean needles and syringes, eliminate or reduce contaminants, or take other measures to reduce HIV and hepatitis. Counseling and, through the distribution of literature, education are intended to form or alter social norms of behavior and make HIV prevention and reduction of narcotics consumption the norm. Harm reduction programs cannot be truly effective if this aspect of their operation is prohibited or curtailed. Meanwhile, the article 42 of the Armenian drug law prohibits the advertisement and propaganda of narcotic drugs as well as the activities of the natural or legal persons targeted at the dissemination of the information about the forms of the use of narcotic drugs. It also prohibits the propaganda of the advantages of the narcotic drugs over one another. The article defines "propaganda" so broadly that virtually any activity or literature would seem to fall within the propaganda (9).

As a result of the aforementioned factors, neither the concept of needle exchange centers itself nor its implementation may enjoy the full support of authorized agencies in Armenia.

Another harm reduction approach is establishment of safe drug injection rooms, where intravenous (IV) drug abusers may inject themselves. The stated purpose of such a practice would be to provide addicts with a hygienic environment where to inject, reducing their exposure to infectious diseases and making available minimum health services to them. However, through eyes of some jurists, establishment of drug injection rooms can be seen as organization of dens, which is a criminal offence under the law of the RA (9).

The last harm reduction strategy is substitution treatment which can be defined as the prescription of a drug with similar action to the drug of dependence, but with lower degree of risk, with specific treatment aims. Substitution therapies do not in and of themselves treat HIV infection. Their role in the reduction of HIV is indirect. Insofar as they help the consumers of narcotic means and psychotropic substances to reduce or cease injecting, they decrease the incidence of behavior deemed to be primarily responsible for the spread of HIV. Experience in the United States suggests that people who consumed methadone on the basis of individually-tailored prescriptions were half as likely to be infected with HIV when compared with consumers not participating in methadone programs (28).

However, in Armenia substitution therapies remain, insofar as methadone and buprenorphine are concerned, illegal under the 2003 Law on Narcotic Drugs and Psychotropic Substances (9). Methadone, being a List I narcotic drug, is categorically prohibited, and buprenorphine, a List II narcotic drug, is prohibited under Article 28 of the Law (9). The available treatment of drug addiction in Armenia is limited to the first stage (poisoning), second stage (abstinence) and third stage (post-abstinence) treatments. There is no remission put into practice in the country (5).

Thus, unfortunately, harm reduction remains controversial in Armenia. This strategy cannot be implemented optimally on a nationwide scale unless it can be introduced in its entirety without legal risk, challenge or unwarranted intrusion. Without changes in legislature and policy, the promise of harm reduction in reducing HIV risk and improving the lives of drug users cannot be realized.

Some Armenian policy makers are against the harm reduction approaches because they associate the latter with “legalizing” the consumption of narcotics. They claim that Armenian can not legalize harm reduction approaches because the latter are inconsistent with the U.N. drug conventions. However, although UN drug Conventions predated the HIV epidemics driven by injection drug use and therefore they do not address the linkage of IDU and HIV, nevertheless, some three important features of the conventions could justify drug substitution therapy, safer injection rooms, and syringe exchange. First, all of these measures could be seen as medical treatment, and permissible under the conventions. Second, the conventions urged reduction of drug use and its adverse consequences, which clearly include HIV, thus potentially justifying measures to reduce infection. Finally, the conventions prohibited intentional incitement to or encouragement of drug use, and none of the harm reduction measures could be said to be performed with the intent of incitement of greater drug use (29).

Basing on those features, legal analysts within and outside the UN system have noted that measures to reduce the spread of drug-related HIV infections, including distribution of clean syringes, can be interpreted as legal under the conventions, which call for alleviation of human suffering, exempt

appropriate medical interventions from criminalization, and specify that demand reduction should aim both at preventing the use of drugs and at reducing adverse consequences of drug use 29-30).

Poor democratization and underdeveloped civil society

As it was stated above, respecting the human rights and responding to the concerns of people infected by HIV as well as those vulnerable to the infection must be vital elements of any effective response to the epidemic. Such concerns can only be articulated, understood, and addressed when the individuals and communities with the most at stake are included in policy making processes, and when supportive environments for dialogue and mutual understanding are established.

Countries that have had success in stemming the spread of HIV/AIDS have done so thanks to sustained engagement from non-governmental organizations (NGOs) and more generally civil society (20). Key cornerstones of effective responses to HIV—confidentiality, counseling, support and community empowerment, efforts to overcome stigma and discrimination, harm reduction practices, patient treatment literacy—have been developed and implemented by community-based organizations.

In Armenia, however, as in other countries of fSU, communism's aftermath has not provided fertile soil for the flowering of civil society. Alienation from the state was a key factor behind the collapse of the old order in the late 1980s and early 1990s. Pervasive social controls and the cynicism and apathy they generated atomized the society and hindered the development of the grass roots organizations needed to articulate individual and community concern.

Of several dozens of Armenian NGOs whose missions among others include HIV/AIDS and injection drug use issues, only few are active. The others from time to time apply for grants, but usually do not succeed in securing them. However, the adjective "non-governmental" is hardly applicable to those organizations which are active, because the majority of them are managed, staffed or supported by people occupying high-level positions in governmental organizations. The latter statement is true for all 8 NGOs, which are represented in the Country Coordination Mechanism (CCM) on HIV/AIDS prevention. The leaders of those NGOs formerly worked (some of them are still working) at the National Center for AIDS Prevention, at the Republican Nacological Center or at the Ministry of Health. At least two of those NGOs were established in 2003, solely with the purpose to apply for sub-grants within the scope of GFATM grant. Since the decision on who receives the sub-grants was also made by CCM, it is not surprising that all 8 NGOs, members of CCM, became the main sub-recipients of the GFATM grant, as well as other funds intended for HIV- and drug-related NGOs.

The number of skilled staff working in those NGOs is limited to their leaders. The rest of the staff which in practice bares the responsibility for implementation of main components of the National Program on HIV Prevention has inadequate skills and knowledge in the area of HIV/AIDS, as well as poor management experience. This may undermine the success of the National Program. Another weakness of NGOs working in the areas of HIV/AIDS and drugs is the lack of strong ties with vulnerable populations. In each NGO there are just a couple of representatives of at-risk groups which is not sufficient to get decision-makers to listen to their opinions.

The reason why the vulnerable populations do not participate in issues affecting them is that some of the high-risk behaviors are criminalized in Armenia (for example, injecting drug use). Given this, it is hard to imagine how people engaged in such behaviors can officially establish an NGO or get involved in an NGO. Many people who are HIV- positive or who engage in high-risk forms of

behavior believe that candid discourse with government or other actors in these matters will result in punishment and social exclusion. Many harbor doubts about whether their government and the society value and want to help them. They do not always believe the official information they receive concerning the choices they can make. They are far from thinking that they are entitled to services that government should provide. Distrust in the state undermines the success of public policies seeking to reverse the spread of HIV.

Thus, while the commitment to democratization and sustained engagement from NGOs and more generally civil society are critical for stemming the spread of HIV/AIDS, Armenia, has not been effective in that. The NGOs working in the area can hardly articulate the concerns of vulnerable groups. The decision making remains vertical and advocacy efforts are poor. This situation is far from what could be called "developed civil society".

At the conclusion of the chapter it can be stated that the punitive drug law, the lack of anti-discrimination provisions in other laws and policies, the controversial status of harm reduction projects, as well as the lack of commitment to democratization and sustained engagement from NGOs and, more generally civil society, in issues addressing the problems of people infected with HIV or those vulnerable to the virus – all those factors are challenging effective responses to drugs, drug users and HIV in Armenia.

4. POLICY OPTIONS

Two competitive frameworks have defined national and international responses to injecting drug use, drug users, and HIV infection. The first of these, which has a longer history, is the law enforcement framework. It views illicit drug use as "abnormal" and seeks to track, restrict, or eliminate illicit drugs, and those who sell or buy them, from social circulation. In this framework, primary emphasis rests on supply of and demand for drugs—drug users are understood and responded to as participants in illegal patterns of exchange. Emphasizing criminalization and containment, this framework identifies police action, interruption of trafficking, and penal institutions such as prisons as pivotal to effective response. Even those measures offered as an alternative to incarceration in many countries—forced drug treatment, for example—rely upon a punitive, law enforcement approach. Health care workers, nongovernmental organizations, and treatment programs are supposed to offer services to drug users without suspicion of undermining public order, violating moral norms, or contributing to unhealthy behavior (20, 31, 32).

This traditional approach to drugs and drug users reflects the position of drug control entities of the United Nations (e.g., CND- Commission on Narcotic Drugs and INCB – International Narcotics Control Board). It is based on three protocols known collectively as the UN Drug Conventions—the 1961 Single Convention on Narcotic Drugs as amended in 1972, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

The influence of conventions cannot be overstated: Countries (including Armenia) that have ratified and signed the conventions have been obliged to incorporate their provisions into domestic law. It was surely never the intention of UN policymakers and national government officials that these treaties would hinder efforts to adequately confront epidemics. Yet, since the first two drug conventions predate the HIV epidemic entirely, and the third one was approved before widespread awareness of the role injection drug use would play in driving the epidemics of the former Soviet Union and Asia, they turned out inadequate to address drug-related HIV infection. Moreover, while

compliance with conventions proved unable to stem the tide of drug use or the associated social and health risks, it appears to be accelerating, rather than containing, the spread of HIV (11,12, 33,34).

The second approach to drug and drug users emerged as a response to a global crisis of HIV infection among people who inject. It is a public health approach and is widely known as harm reduction. The advocates of harm reduction are reasoning that dangerous drugs will always be with us and that we had better learn how to live with them in a way that minimizes their adverse health and social consequences. Harm reduction approach focuses on risks rather than on the drugs themselves, considering both adverse health effects and the range of people affected. These include drug users, who are recognized as part of the deserving public, as well as their sexual partners, their children, and their extended families or communities. Similarly, this approach recognizes that all illegal drug use does not carry equal risk, identifies mediating factors that increase drug risk and related disease, and seeks to identify the tools and interventions that might best contain adverse health effects among the largest number of people. These include interventions for those drug users who are outside correctional or drug treatment systems, or those who have returned to drug use after a period of abstinence. According to this approach, the majority of drug users remain outside treatment or penal systems (6, 20, 22-26, 31-35).

Interventions to stem HIV and other harms among injecting drug users have proven both easy to implement and highly effective. Almost no drug user chooses to share needles if offered another option. Ongoing treatment with methadone, widely tested in developing and industrialized countries alike, has been shown to reduce both injection and social costs associated with drug use. More broadly, researchers evaluating the full spectrum of efforts to reduce drug-related harm—which include peer education, syringe exchange and safer injection rooms, methadone maintenance, overdose prevention—have demonstrated positive outcomes in countries from Australia, the United States, Belarus, and Thailand. Representatives of the Joint United Nations Programme on HIV/AIDS (UNAIDS) phrase it simply in their speeches and publications: “harm reduction works” (6, 20, 22-26, 31-35).

However, years after gold-standard research has shown how swiftly injecting drug use can spread HIV—and how evidence-based approaches can effectively contain that explosive growth— Armenia continues to emphasize criminal enforcement over the best practices of public health. The U.N. drug conventions are used by policy makers either as a cause or as a convenient excuse for their unwillingness to adopt public-health-oriented approaches. Besides, Armenia is not stricken by HIV/AIDS as severely as some other countries of fSU, therefore it is easy for policy makers to deny the existence of the epidemic and necessity to take measures to control it. Moreover, some policy makers claim, that behaviors leading to HIV/AIDS are inconsistent with Armenian traditional morale and thus they justify their unwillingness to “legalize” those behaviors.

The epidemic is nonetheless real and growing. And fortunately, there are some policy-makers in Armenia, who understand that. Besides being concerned with the growing twin epidemics, they come to understand that those very provisions in Armenian laws and policies that are unfavorable for the reduction of harm caused by injection drug use, are at the same time in conflict/inconsistent with the obligations of the country under international treaties. If Armenia is willing to ascent to the European Union, she has to revise her legislation to bring it into compliance with her international obligations.

5. CONCLUSION AND RECOMMENDATIONS

Responding to the epidemic means acknowledging its existence and finding the commitment to confront it. Because in Armenia HIV epidemic is not widely spread yet, it is therefore more easily denied.

The analysis of policy issues associated with injecting drug use and HIV in Armenia suggests that, it is overcriminalization of drug use and the inability of the government to reach out to IDUs that threaten the effective response to drugs, drug users and HIV.

- The punitive drug law results in incarceration of non-violent drug users, increasing thus their vulnerability to HIV.
- Exclusionary policies effectively deny the human rights of IDUs and exacerbate the public health threat posed by the HIV epidemic.
- The controversial status of harm reduction initiatives limits their promise to guarantee the right to health for IDUs and reduce their HIV risk.
- Due to obstacles for IDUs to get engaged in programming directed at the twin epidemics, their human rights guarantees remain abstractions and their needs - unarticulated and unmet.

Many provisions of Armenian laws and policies which are not favorable for the reduction of harm caused by injecting drug use, are in conflict with the International Law. The Declaration of the Commonwealth of Independent States for Expanded Regional Response to the HIV/AIDS Epidemic calls for revisions of national legislation to bring it into full compliance with international obligations (36). The International Conventions on human rights, as well as the UNGASS Declaration of Commitment, the United Nations guidelines on HIV and Human Rights and evidence-based best practices can guide legislators in improving the legal framework so that it would be favorable for reducing the harm caused by injecting drug use. Besides, while some provisions of outdated UN Drug Conventions were used by national decision-makers as an excuse for implementing zero tolerance approaches to drug users, the updated commentaries to them can be used for re-orienting the laws and policies towards harm reduction.

These conclusions suggest a number of policy recommendations:

RECOMMENDATIONS

1. Social priorities should be rebalanced, away from claims of morality, intolerance and law enforcement approaches that exclude injecting drug users from the social mainstream.

2. Mandatory imprisonment/institutionalization for possession of small amounts of illicit drugs which serve to accelerate HIV infection must be repealed.

3. Overall, the legal framework has to be brought into full compliance with international obligations. In particular,
    - policies that violate the right to non-mandatory HIV testing must be eliminated;
    - a policy or official edict should be issued to specifically ban the release of confidential HIV information;
    - another policy or official edict should be issued to interpret the article of the Armenian Constitution on non-discrimination to ensure that no person can be discriminated against based on HIV status or injecting drug use.

4. The legislation should be changed in order to enable harm reduction programs to operate in their entirety on a nationwide scale without legal risk, challenge, or unwarranted intrusion. In particular,
    - the legal definitions and interpretations of "inclining", "propaganda" and "den" should be changed so as to exclude actions which are an integral part of a harm reduction strategy or program;
    - since methadone is expressly prohibited under Armenian law and the use of other narcotics for substitution therapy is problematic, it is recommended that the medical use of methadone and other narcotic substitutes, such as buprenorphine, be authorized for experimental use under appropriate control of relevant governmental agencies.

5. The governments should play an active role in establishing and supporting a large, strategically located network of harm reduction programs, and in providing adequate training to program personnel.

6. Obstacles to greater engagement in HIV/AIDS programming by civil society groups must be identified and removed.

7. The representatives of IDUs and persons infected by HIV should be included in policy making and other initiatives directed at the epidemic. Otherwise many human rights guarantees will remain abstractions for these groups.

6. IMPLEMENTATION ISSUES

As it has been mentioned, harm reduction approaches are understood by many people as "legalization" of narcotics. Due to the strong stigma connected with drug use in Armenia, the implementation of aforementioned recommendations may encounter strong opposition from both the political leaders and the society. Therefore, organizations and individuals concerned with the spread of HIV through injection drug use should unite their efforts and launch an advocacy campaign for dealing with that. The advocacy coalition may include NGOs and civil society groups as well as mass media groups. Taking into consideration the lack of resources in the country, the international donor organizations should also be involved in the campaign. The members of the coalition should use public events as well as policy discussions to condemn persecution and harassment of IDUs and to reiterate the crucial importance of HIV/AIDS prevention services for them. They should organize information campaigns that explain the basic facts of HIV/AIDS to the general population, including to young people in schools and young men doing their obligatory military service, as well as to the decision-makers. Such campaigns should stress the importance of not criminalizing or stigmatizing either IDUs or PLWHA. Regular monitoring and follow-up of human rights abuses against IDUs should also be included in the work plan of the coalition.

Since law enforcement personnel plays a crucial role in issues relating to drug use and HIV, the work plan of the coalition may include organizing a program of training for police at all levels on HIV/AIDS, the importance of harm reduction services, and related human rights issues. Police and legal and judicial officers should also be trained on recent international agreements on the right to nondiscrimination.

7. COMMUNICATIONS ANALYSIS

Communication analysis demonstrate that the most widely used communication channel in Armenia is TV. Therefore, TV programs should be used to influence the public perceptions and attitudes towards IDUs and PWLHA and respectively impacting the receptivity of educational and awareness campaigns. This can be supplemented by coverage of harm reduction issue in printed mass media the utilization of which is rather limited in Armenia. And finally, harm reduction issues have to be integrated into national forums, conferences, summits, seminars, etc. which is a way to influence public health professionals, law enforcement personnel and finally, the decision-makers.

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