

**NATIONAL PROGRAMME ON THE
RESPONSE TO THE HIV EPIDEMIC
2013-2016**

TABLE OF CONTENTS

	Abbreviations	3
I	Terms and definitions	4
II	Introduction	6
III	Goal of the National Programme on the Response to the HIV Epidemic, 2013-2016	11
IV	Objectives of the National Programme on the Response to the HIV Epidemic, 2013-2016	11
V	Key Sections of the National Programme on the Response to the HIV Epidemic, 2013-2016	11
VI	An Enabling Environment for an Effective Multi-sector Response to HIV	11
VII	HIV Prevention	12
VIII	Treatment, Care and Support	15
IX	Monitoring and Evaluation	16
X	Management, Coordination and Partnership	17
XI	Financing and Financial Resource Mobilization	18

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV drugs	Antiretroviral Drugs
CCM	Country Coordination Mechanism for HIV/AIDS, TB and Malaria Programs in the Republic of Armenia
CRS	Corporate Social Responsibility
CT	HIV/AIDS Counselling and Testing
DHS	Demographic and Health Survey
EPP	Estimation and projection package
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
MERG	Reference Group for Monitoring and Evaluation
MoH	Ministry of Health
MoT	Modes of Transmission
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NCAP	National Center for AIDS Prevention
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child HIV Transmission
PR	Principal Recipient
PWID	People who Inject Drugs
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
UBRAF	United Budget, Results and Accountability Framework
UNAIDS	The Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

I. TERMS AND DEFINITIONS

1. The following terms and definitions are used in this report:
 - 1) **Advocacy** is a method of influencing decision-makers to introduce relevant strategies addressing the needs of people affected by the HIV epidemic, based on human rights in the context of HIV.
 - 2) **Impact** - expected long-term effects of the programme (e.g. reducing HIV transmission, etc.).
 - 3) **Outputs** - are the immediate results of the activities conducted. They are usually expressed in quantities, either in absolute numbers or as a proportion of a population, e.g. (number of trained individuals, number of conducted seminars, etc.).
 - 4) **Population-based surveys** - the surveys, which are statistically representative of their target populations (e.g. Demographic and Health Surveys).
 - 5) **Evaluation** the rigorous, scientifically-based collection of information about program/intervention activities, characteristics, and outcomes that determine the merit or worth of the program/intervention. Evaluation studies provide credible information for use in improving programs/interventions, identifying lessons learned, and informing decisions about future resource allocation.
 - 6) **Operational research** - assessment of availability, accessibility and quality and/or sustainability of delivered services aimed at their improvement.
 - 7) **Discordant couple** - a pair of long-term sexual partners in which one person is HIV positive and the other is HIV negative.
 - 8) **Outcome** - mid-term results from one or several activities (e.g. reduced risk behaviours, etc.).
 - 9) **Baseline** - the status of services and outcome-related measures such as knowledge, attitudes, norms, behaviours, and conditions before an intervention, against which progress can be assessed or comparisons made.
 - 10) **Target** - the objective a program/intervention is working towards, expressed as a measurable value; the desired value for an indicator at a particular point in time.
 - 11) **Benchmark** - a reference point or standard against which performance or achievements can be assessed.
 - 12) **Relevance** - the extent to which the objectives, outputs, or outcomes of an intervention are consistent with beneficiaries' requirements, organizations' policies, country needs, and/or global priorities.
 - 13) **Report** - an account regularly presented by the Monitoring and Evaluation Unit upon data sources receiving and analyzing.
 - 14) **Facility survey** - a survey of a representative sample of facilities that generally aims to assess the readiness of all elements required to provide services and other aspects of quality of care (e.g., basic infrastructure, drugs, equipment, test kits, client registers, trained staff). The units of observation are facilities of various types and levels in the same health system. The content of the survey may vary but typically includes a facility inventory and, sometimes, health worker interviews, client exit interviews, and client-provider observations.
 - 15) **Peer support group** - is a group of people who share similarities related to social status and have similar interests. Peer support help with solving similar problems.

- 16) **Incidence/morbidity** - the number of new cases of a disease that occur in a specified population during a specified time period.
- 17) **Second-generation surveillance** - HIV biological and behavioural surveillance.
- 18) **Routine sentinel surveillance** - ongoing, systematic collection and analysis of HIV-related data from certain sites (e.g. hospitals, health centers, antenatal clinics), its interpretation and dissemination aimed at reducing morbidity and mortality and improving health.
- 19) **Monitoring** - routine tracking and reporting of priority information about a programme/project, its inputs and intended outputs, outcomes and impacts. Monitoring is the continuous, routine, daily, and regular assessment of ongoing activities and/or processes. It aims to provide the management and main stakeholders of an ongoing intervention with early indications of progress (or lack thereof) towards the achievement of outputs.
- 20) **Monitoring and evaluation results chain** - there are four levels of indicators: inputs, outputs, outcomes and impacts.
- 21) **Inputs** - are the resources that are needed to implement the project and its activities. Inputs can be expressed in terms of the infrastructure, human and financial resources, equipment, supplies, means of transport, and other resources needed.
- 22) **Quality assurance** - planned and systematic processes concerned with assessing and improving the merit or worth of an intervention or its compliance with given standards.
- 23) **Qualitative data** - data collected using qualitative methods, such as interviews, focus groups, observation, and key informant interviews.
- 24) **Prevalence** - the total number of persons living with a specific disease or condition at a given time.
- 25) **Data sources** - data sources are tangible sets of information, usually in the form of reports, survey results, monitoring forms from the field, or official government data sets. Data sources provide the values of the indicators at a specific point in time
- 26) **Reliability** - consistency or dependability of data collected through the repeated use of a scientific instrument or a data collection procedure used under the same conditions.
- 27) **Triangulation** - the analysis of data from three or more sources obtained by different methods.
- 28) **Indicator** - a quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention.
- 29) **Research** - a study which intends to generate or contribute to generalizable knowledge to improve public health practice, i.e., the study intends to generate new information that has relevance beyond the population or program from which data are collected. Research typically attempts to make statements about how the different variables under study, in controlled circumstances, affect one another at a given point in time.
- 30) **Quantitative data** - data collected using quantitative methods, such as surveys. Quantitative data are measured on a numerical scale, can be analysed using statistical methods, and can be displayed using tables, charts, histograms and graphs.

II. INTRODUCTION

2. Registration of cases of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) started in the Republic of Armenia in 1988. The HIV/AIDS statistics in the country are as follows - from 1988 to 31 December 2011 1,226 HIV cases had been registered in the country among the citizens of the Republic of Armenia.
3. More than half the all registered HIV and AIDS cases have been diagnosed within the last 4 years. An increase in the number of registered HIV cases is associated with scaling up laboratory diagnostics capacities, increasing accessibility to HIV testing and establishing HIV/AIDS counselling and testing (CT) system. As a result, the number of HIV tests performed has increased and HIV detectability has been improved. Also, the efficiency of the HIV surveillance system has been raised. An increase in the number of registered AIDS cases is associated with scaling up laboratory capacities for diagnostics of AIDS and AIDS-indicator diseases. Improvement of AIDS diagnostics is also associated with a rise in the level of HIV/AIDS-related knowledge among health care workers through relevant training provided by the National Center for AIDS Prevention (NCAP). The number of new HIV and AIDS cases has increased also due to the fact that in recent years, more Armenian citizens with HIV diagnoses and clinical symptoms have been returning to Armenia from CIS countries.
4. In recent years, number of HIV tests performed among pregnant women has been considerably increased, which is also associated with enhancing access to HIV testing. Thus, if only 3,219 pregnant women were tested for HIV in 2004, in 2011 43,330 pregnant women were tested. Along with increasing the number of HIV tested pregnant women, HIV detection was improved among them, which allowed providing mother-to-child HIV transmission prevention and considerably reducing possibility of HIV transmission to a newborn child.
5. More than 57.2% of the HIV-infected individuals belong to the age group of 25-39, i.e. they are in their childbearing years.
6. Males constitute a major part in the total number of HIV cases - 813 cases (70.5%), females make up 340 cases (29.5%).
7. In the Republic of Armenia, the main modes of HIV transmission are through heterosexual contacts (54.3%) and injecting drug use (37%). In addition, there are also registered cases of HIV transmission through homosexual contacts (1.7%), mother-to-child HIV transmission (1.7%) and transmission through blood (0.3%). The mode of HIV transmission for 5% of the registered cases is unclear.
8. Over the past five years the country has experienced a shift in the main mode of HIV transmission from injecting drug use to heterosexual transmission. Transmission through injecting drug use reached a peak of almost 67.0% of registered cases in 2007 and decreased to 32.4% in 2010.
9. The proportion of HIV cases attributed to heterosexual transmission has increased two-fold over the past 10 years, from 27.6% in 2000 to 58.1% in 2010.
10. Analysis of trends of the HIV epidemic by gender shows that over half (53.1%) of the reported cases among males were attributed to injecting drug use, female, on the other hand were predominantly (98.5%) infected through sexual contacts. Of 22 HIV-infected children 20 acquired HIV from their mothers, two - through blood.

11. AIDS diagnosis has been made to 596 HIV patients, of whom 141 are women and 11 are children. From the beginning of the epidemic 277 death cases have been registered among HIV patients (including 46 women and 5 children).
12. HIV cases were registered at all marzes (the country administrative divisions) including the capital, Yerevan. The maximum number of HIV cases was reported in Yerevan: 492 cases, which make up 40.1% of all the registered cases. Shirak marz follows next - 10.6% of all the registered cases. The estimation of HIV registered cases per 100 000 population shows the highest rate in Shirak marz - 46.2, followed by Yerevan, Lori, Armavir marzes with the rates of 44.1, 40.5 and 35.9 respectively.
13. The HIV/AIDS situation assessment has shown that the estimated number of people living with HIV in the country is about 3,500.
14. Modelled projections showed an increasing trend of HIV prevalence and incidence among key affected populations, except for a projected decline in HIV incidence among people who inject drugs (PWID). The highest estimated incidence rate was among partners of PWID, through heterosexual contact. At the same time, nearly one-fifth of the new HIV cases were estimated to be among the partners of the key affected populations.
15. In 2007-2011, within the framework of the National Programme on the Response to the HIV Epidemic, numerous HIV prevention programmes were carried out among the key affected populations, including prisoners and youth.
16. Various organizations planned and implemented a number of public events and information campaigns in the process of the National AIDS Programme implementation, aimed to raise HIV/AIDS awareness and form safer behaviour among youth and the general population. TV and radio programmes, TV and public service advertisements were prepared and broadcasted, articles on HIV and AIDS-related issues were published in print media.
17. People living with HIV are given treatment, care and support; they are provided with prevention of mother-to-child HIV transmission, HIV testing and counselling. Also, donated blood safety is ensured, laboratory HIV diagnosis is performed, etc.
18. Harm reduction and HIV prevention programmes are implemented among the key affected populations - persons who inject drugs (PWID), sex workers (SWs), men who have sex with men (MSM). Within the framework of those programmes HIV testing and counselling is provided to representatives of those populations, information/education materials and prevention commodities (condoms) are provided, outreach work is performed, peer education is provided, various information/education events and actions are undertaken.
19. Integrated medical services are provided at NCAP to HIV patients: consultations on reproductive system diseases and STIs, if necessary - testing and treatment provision. Also, it is envisaged to perform TB diagnosis at NCAP, which will increase the timely TB diagnosis (both active and latent), improve control of TB/HIV co-infected cases and their management, and increase the treatment effectiveness. Combined actions on TB/HIV co-infected cases are conducted in line with the activities envisaged by the National TB Programme.
20. Integrated services on reproductive health, STIs, TB consultations and treatment are provided to HIV patients at primary health care facilities.
21. Referral of HIV patients for stationary treatment, obstetrician-gynecological, narcological medical care, TB treatment, specialized medical assistance is carried out in accordance with the relevant standards.

22. Medical care and services for pathological conditions and diseases not associated with HIV, as well as for intensive and specialized stationary treatment associated with HIV are provided to HIV patients on common base at relevant departments of diversified hospitals.
23. A robust health information system forms the basis of an effective response to HIV. The National Programme on the Response to the HIV Epidemic in the Republic of Armenia for 2007 - 2011 prioritized the creation of a unified national monitoring and evaluation system. The Republic of Armenia has a well established national coordinating authority (the National Centre for AIDS Prevention of the Ministry of Health) for all HIV and AIDS monitoring and evaluation. The country has a highly developed surveillance system with effective and centralized data collection and reporting. Biological and behavioural HIV surveillance is active in the key affected populations.
24. Certain progress in the response to the HIV epidemic has been made in the country as a result of the implementation of the National Programme on the Response to the HIV Epidemic in the Republic of Armenia, 2007-2011.
25. ART in Armenia was initiated in 2005. Only 20 HIV patients were receiving treatment in 2005, whereas at the end of 2011, 329 patients were on ART. At present ART is accessible for all the patients eligible to it and who gave their consent to receive it.
26. Starting from 2007 up to date no HIV case has been registered among the children born to HIV-infected mothers, when PMTCT prophylaxis was provided.
27. Starting from 2001 up to date no case of HIV transmission through donated blood has been registered.
28. HIV-related legislation has been significantly improved. In 2009 the Law “On Making Amendments and Supplements to the Law of the Republic of Armenia “On Prevention of the Disease Caused by the Human Immunodeficiency Virus” was passed, thereby, bringing it into consistency with the international guidelines on human rights. In particular, the number of groups subject to mandatory HIV testing was reduced to a considerable extent, the Article, defining conditions of entry to Armenia of foreign citizens and stateless persons (foreign citizens and stateless persons applying for Armenian entry visas for a period exceeding three months were obliged to present an HIV testing certificate), was repealed. Also, the provision of the Article defining the implications of detecting HIV in the body of a foreign citizen or a stateless person (if the presence of HIV in the body of a foreign citizen or stateless person who is in the territory of the Republic of Armenia was confirmed, he/she was subject to administrative deportation from the Republic of Armenia) was repealed. The list of diseases that keep people from entering into Armenia has been reviewed in accordance with the provisions of the Law “On Making Amendments and Supplements to the Law of the Republic of Armenia “On Prevention of the Disease Caused by the Human Immunodeficiency Virus”. The legislation of the Republic of Armenia does not provide any restrictions for PLHIV to hold positions in the government service system. HIV positive status in a person is not a barrier for appointing him or her to a position of a judge, prosecutor, civil servant, customs officer, assessor and public servant and for carrying out relevant duties, for carrying out diplomatic functions. The Decision N517-N of 5 May 2005 of the Government of the Republic of Armenia, defining the list of diseases that do not allow a person to adopt children, or accept children into his/her family for bringing them up and assuming

guardianship (trusteeship), has been amended. The HIV disease has been removed from this list.

29. One of the objectives of the National Programme on the Response to the HIV Epidemic in the Republic of Armenia, 2007-2011 was HIV prevention among adolescents and young people aged 15-24. Among the strategies to attain this objective was further integration of HIV-related issues into educational institutions curricula. In this context, introduction, according to the Decision N23 of 17 June 2011 of the Government of the Republic of Armenia, of the “Healthy Life Style” training course in the curricula of secondary and senior schools has been a significant achievement. The course is taught as a separate subject for 8th and 9th grades students and for 10th and 11th grades students. It includes separate lessons related to the issues of HIV/AIDS, puberty and reproductive health, pernicious habits. Teachers have been retrained on the new training course introduction.
30. Following the National Programme on the Response to the HIV Epidemic in the Republic of Armenia, 2007-2011 with the aim to provide health care workers with retraining and advanced studies on HIV/AIDS, HIV training course was developed and, in 2009 - introduced in the National Institute of Health named after S.Avdalbekyan, the Ministry of Health of the Republic of Armenia for health care managers, physicians of various specializations, paramedical workers, clinical residents. Owing to the advanced studies conducted among the health care workers, their HIV/AIDS awareness has been raised, and, as a result, HIV clinical detection has been improved.
31. One of the Programme’s key achievements is also provision of methadone treatment to PWID with HIV which was initiated in December 2009. Among the benefits of methadone treatment are: significantly reduced use of injection drugs, prevention of HIV and other blood-borne infections (viral hepatitis), as well as other diseases associated with injecting drugs, reduced risk of overdose and mortality, improved general health status, creating conditions for PWID’s social adaptation, reduced criminal activity. Substitution treatment also provides opportunity to put lives of addict persons in order and, if necessary, initiate ARV therapy.
32. Relevant capacity building and strengthening guarantee success for any programme. Within the framework of the National Programme on the Response to the HIV Epidemic in the Republic of Armenia training-seminars were organized and conducted for health care workers and for representatives of governmental and non-governmental institutions, implementing HIV prevention programmes among various populations, on the issues of “HIV prevention programmes among key affected populations”, “Provision of HIV testing and counselling”, “Prevention of mother-to-child HIV transmission”, “HIV diagnosis”, “Provision of ARV treatment”, “Care and Support for people living with HIV”.
33. Key affected populations still experience various forms of stigma and discrimination, making it difficult for them to seek health care, access preventive measures, to protect their rights.
34. International evidence for concentrated epidemics (the HIV epidemic in Armenia remains in concentrated state) is conclusive that effective HIV prevention should be focused towards communities and populations most at risk and most affected by HIV. However, taking into account the fact that heterosexual transmission is becoming increasingly important in the profile of Armenia’s HIV epidemic, reduction of heterosexual transmission of HIV is a priority for prevention.

35. It is important to ensure that a comprehensive package for HIV prevention is delivered to those most at risk, including provision of information and equipment to support safer sex and safe injecting practices, provision of peer education, ensuring access to health promotion and health services, reduction of HIV-related stigma and discrimination.
36. Further expansion of HIV testing is a key priority. It is important to ensure access of those most at risk to frequent HIV testing, which would allow early diagnosis of HIV, timely initiation of ART, reducing mortality and further transmission of HIV.
37. Ensuring universal access to HIV prevention, treatment and support is one of the key priorities. ART remains the only treatment demonstrated to reduce morbidity and mortality among PLHIV. In Armenia, the reported mortality rate among people on ART is 0.35%, compared to 35% among people not on ART. Substantial efforts should be made to improve the availability, accessibility and affordability of ART.
38. Armenia developed its first National Programme on HIV/AIDS Prevention for 2002 - 2006. It was followed by the National Programme on the Response to the HIV Epidemic in the Republic of Armenia for 2007-2011. This Programme has been developed to enable continuity of the next five-year strategy from the previous strategies. Governmental, non-governmental and international organizations have been involved into the process of the Programme development. The Programme has been developed with UNAIDS support with the involvement of national and international consultants. The data from the following studies have served as a basis for this Programme development: evaluations of the components of the National Programme on the Response to the HIV Epidemic in the Republic of Armenia for 2007-2011 on HIV treatment and care, on provision of prevention services to the key affected populations, on prevention of mother-to-child HIV transmission, study on estimating the size of populations of sex workers, men who have sex with men, and injecting drug users in the Republic of Armenia, HIV Prevention Response and Modes of Transmission Analysis, HIV Data Triangulation for Public Health Actions in the Republic of Armenia, HIV behavioural and biological surveillance, HIV Situation and Response Analyses, performed by the group of the National Consultants, and Situational Analysis on HIV&AIDS, Republic of Armenia 2011, performed by the specialists of the Kirby Institute, University of New South Wales (Australia).
39. The Programme was developed with the consideration of the international best practices, recommendations made by the international organizations working in the field, their strategies, as well as existing international commitments joined by the Republic of Armenia.
40. The guiding principles underlying Armenia's response to HIV are based on the following: existing international guidelines on human rights, principles of "Universal Access" to HIV/AIDS prevention, treatment and care, Laws of the Republic of Armenia on "Prevention of disease caused by Human Immunodeficiency Virus", and "On Medical Care and Services to the Population".
41. The strategies of the Programme are in line with the following national and international documents: National Strategy on Mother and Child Health 2003-2015, National Strategy on Child and Adolescent Health and Development, 2010-2015, National Program on Reproductive Health Promotion 2007-2015, National Strategy on Youth's State Policy, 2008-2012, National Program on prevention of gender violence, 2011-2015, National Tuberculosis Control Program, 2007-2015, WHO Global Health Sector Strategy on HIV/AIDS, 2011-2015,

WHO European Action Plan for HIV/AIDS 2012-2015, UNAIDS 2011-2015 Strategy “Getting to Zero”, 2012-2015 United Budget, Results and Accountability Framework (UBRAF), Political declaration on HIV/AIDS adopted on 10 June 2011 by the UN General Assembly.

III. GOAL OF THE NATIONAL PROGRAMME ON THE RESPONSE TO THE HIV EPIDEMIC, 2013-2016

42. The overall goal of the National Programme on the Response to HIV&AIDS in the Republic of Armenia is to form an effective response to the HIV epidemic for the period of 2013-2016.

IV. OBJECTIVES OF THE NATIONAL PROGRAMME ON THE RESPONSE TO THE EPIDEMIC, 2013-2016

43. The objectives of the National Programme on the Response to HIV&AIDS, 2013-2016 are:

- 1) To reduce the transmission of HIV; and
- 2) To reduce the morbidity and mortality caused by HIV and AIDS.

V. KEY SECTIONS OF THE NATIONAL PROGRAMME ON THE RESPONSE TO THE EPIDEMIC, 2013-2016

44. The key sections of the Programme are:

- 1) An enabling environment for an effective multi-sector response;
- 2) HIV prevention;
- 3) Treatment, care and support;
- 4) Monitoring and evaluation;
- 5) Management, coordination and partnerships;
- 6) Financing and finance resource mobilisation.

VI. AN ENABLING ENVIRONMENT FOR AN EFFECTIVE MULTI-SECTOR RESPONSE TO HIV

45. The primary goal of this section is to put in place an enabling environment that will facilitate the efficiency of the national response.

- 1) Strategy 1. Reduce stigma and discrimination towards key affected populations and people living with HIV.
- 2) Activities:
 - a. To assess and amend, if necessary the existing legislation concerning human rights priorities in areas of particular relevance to the effective response to HIV.
 - b. To organise media campaigns on HIV and AIDS, in coordination with related organisations within and outside the HIV sector.

- c. To produce articles in print and electronic media related to HIV and AIDS.
 - d. To develop and broadcast TV and radio programmes/clips related to HIV and AIDS.
 - e. To organize community-based public events aimed at raising HIV/AIDS awareness.
 - f. To provide training to the mass media representatives on specificity of media coverage associated with HIV and AIDS.
 - g. To provide technical assistance for activities on HIV prevention at workplaces.
 - h. To ensure attendance of representatives from key affected populations at HIV/AIDS meetings held locally, nationally and regionally.
 - i. To complete The WHO People Living with HIV Stigma Index.
- 3) Expected results:
- a. HIV/AIDS-related legislation will be assessed and, if necessary, amended.
 - b. At least 2 media campaigns on HIV and AIDS will be organised each year.
 - c. At least 50 articles related to HIV and AIDS will be produced in print and electronic media each year.
 - d. TV and radio programmes/clips related to HIV and AIDS will be developed and broadcasted at least 100 times.
 - e. Community-based public events aimed at raising HIV/AIDS awareness will be organized.
 - f. Training to the mass media representatives on specificity of media coverage associated with HIV/AIDS will be provided.
 - g. Technical assistance for activities on HIV prevention at workplaces will be provided.
 - h. Attendance of at least one representative from each key affected population at HIV/AIDS meetings held locally, nationally and regionally.
 - i. The WHO People Living with HIV Stigma Index will be completed the beginning and end of the Programme.
- 4) Strategy 2. Promote human rights and gender equity pertaining to risk and social issues related to HIV.
- 5) Activities:
- a. To advocate and address human rights and gender-based violence issues related to HIV.
 - b. To establish peer support groups which help women who encountered violence.
- 6) Expected results:
- a. Advocacy will be conducted to human rights and gender-based violence issues related to HIV.
 - b. Peer support groups which help women who encountered violence will be established.

VII. HIV PREVENTION

46. The primary goal of this section is that all sexual transmission is reduced by half.

1) Strategy 1. Reduction in HIV infection through injecting drug use.

2) Activities:

- a. To expand HIV prevention and harm reduction programmes among PWID.
- b. To implement needle and syringe exchange programmes.
- c. To evaluate pilot project on methadone substitution therapy.
- d. To expand provision of methadone substitution therapy.

- e. To build capacity of organizations implementing preventive activities among PWID.
 - f. To increase the scope of services provided to PWID, including prevention and treatment of viral hepatitis B and C.
- 3) Expected results:
- a. HIV prevention and harm reduction programmes among PWID will be expanded.
 - b. New infections acquired through injecting drugs will be reduced by 25%.
 - c. Pilot project on methadone substitution therapy will be evaluated.
 - d. Provision of methadone substitution therapy will be expanded.
 - e. Training-seminars will be conducted aimed at building capacity of organizations implementing preventive activities among PWID.
 - f. HIV-testing rates among PWID will increase, such that 60% of all PWID will be tested by the end of the Programme.
 - g. Awareness of PWID on HIV prevention issues will increase.
 - h. HIV indicators (sharing injecting equipment in the last month, condom use at a last intercourse) will be improved among PWID.
- 4) Strategy 2. Reduction in HIV infection through sex work.
- 5) Activities:
- a. To expand HIV prevention programmes among SWs.
 - b. To provide commodities for HIV prevention (condoms and lubricants).
 - c. To build capacity of organizations implementing preventive activities among SWs.
- 6) Expected results:
- a. HIV prevention programmes among SWs will be expanded.
 - b. New infections acquired through commercial sex will be reduced by 25%.
 - c. HIV-testing rates among SWs will increase, such that 60% of all SWs will be tested by the end of the Programme.
 - d. Awareness of SWs on HIV prevention issues will increase.
 - e. HIV indicators (condom use with clients and non-clients partners) will be improved among SWs.
 - f. Training-seminars will be conducted aimed at building capacity of organizations implementing preventive activities among SWs.
- 7) Strategy 3. Reduction in HIV infection through MSM contact.
- 8) Activities:
- a. To expand HIV prevention programmes among MSM.
 - b. To provide commodities for HIV prevention (condoms and lubricants).
 - c. To build capacity of organizations implementing preventive activities among MSM.
- 9) Expected results:
- a. HIV prevention programmes among MSM will be expanded.
 - b. The number of new HIV infections acquired through male-to-male sex will not increase.
 - c. HIV-testing rates among MSM will increase, such that 70% of all MSM will be tested by the end of the Programme.
 - d. Knowledge of MSM on HIV prevention will increase.
 - e. Indicator of condom use at last anal intercourse will be improved among MSM.
 - f. Training-seminars will be conducted aimed at building capacity of organizations implementing preventive activities among MSM.

- 10) Strategy 4. Reduction in HIV infection among migrants.
- 11) Activities:
 - a. To conduct research aimed at developing the most effective HIV prevention programmes among migrants.
 - b. To implement HIV prevention programmes among migrants.
 - c. To build capacity of organizations implementing preventive activities among migrants.
 - e. To study the existing laws and regulatory acts related to migration and, if necessary, amend them.
- 12) Expected results:
 - a. Researches will be conducted aimed at developing the most effective HIV prevention programmes among migrants.
 - b. HIV prevention programmes will be implemented among migrants.
 - c. The number of new HIV infections among migrants will not increase.
 - d. The existing laws and regulatory acts related to migration will be studied, and if necessary - amended with the aim to bring them into consistency with international standards; to ensure effective cooperation and coordination with the host countries respective authorities of HIV/AIDS issues.
 - e. HIV-testing rates among migrants will increase, such that 40% of migrants will be tested by the end of the Programme.
 - f. Knowledge of migrants on HIV prevention issues will increase.
 - g. Training-seminars will be conducted aimed at building capacity of organizations implementing preventive activities among migrants.
- 13) Strategy 5. HIV prevention among other vulnerable populations (including prisoners, refugees and especially vulnerable young people).
- 14) Activities:
 - a. To implement HIV prevention programmes among prisoners.
 - b. To provide clean syringes and condoms in prisons.
 - c. To build capacity for implementing HIV preventive activities among prisoners.
 - d. To carry out activities aimed at raising HIV awareness among refugees.
 - e. To expand HIV testing and outreach services for young people.
 - f. To retrain teachers for provision of “Healthy Life Style” training course at schools.
- 15) Expected results:
 - a. HIV prevention programmes will be conducted among prisoners.
 - b. Training-seminars will be conducted aimed at building capacity for implementing HIV preventive activities among prisoners.
 - c. Awareness on HIV prevention among the vulnerable populations will increase.
 - d. The number of new HIV infections among the vulnerable populations will not increase.
 - e. HIV-testing rates among the vulnerable populations will increase.
 - f. Required number of teachers will be retrained for provision of “Healthy Life Style” training course at schools.
- 16) Strategy 6. Reduction of heterosexual transmission of HIV.
- 17) Activities:
 - a. To expand provider-initiated HIV testing and counselling.
 - b. To provide HIV testing and counselling, HIV final diagnosis.

- d. To trace contacts of people diagnosed with HIV, and to test them for HIV.
 - e. To provide counselling on HIV prevention for serodiscordant couples.
 - f. To expand testing services for pregnant women in antenatal clinics and maternity hospitals.
 - g. To provide mother-to-child HIV transmission prevention.
 - h. To provide HIV testing of donated blood.
- 18) Expected results:
- a. New heterosexually-acquired infections will be reduced by 20%.
 - b. At least 90% of pregnant women will have been tested for HIV.
 - c. No new HIV infections will be registered among children born to pregnant women provided with prevention of mother-to-child HIV transmission.
 - d. 75% of partners of people diagnosed with HIV will be tested for HIV.
 - e. No new HIV infections will be registered among recipients of blood products.
 - f. Integration of services on STIs, reproductive health, and HIV prevention will be improved.
 - g. All serodiscordant couples will be provided with counselling on HIV prevention.
 - h. All HIV-infected pregnant women and children born to them will be provided with prevention of mother-to-child HIV transmission.
 - i. 100% of donated blood samples will be tested for HIV.

VIII. TREATMENT, CARE AND SUPPORT

47. The primary goal of this section is that all registered PLHIV in Armenia are treated with ART according to the National HIV/AIDS Treatment and Care Protocols.
- 1) Strategy 1. Ensure access to antiretroviral therapy for people living with HIV.
 - 2) Activities:
 - a. To review regularly the National HIV/AIDS Treatment and Care Protocols to ensure they align with the WHO Treatment Guidelines.
 - b. To provide follow-up of HIV patients.
 - c. To improve system of HIV patients follow-up.
 - d. To provide regular clinical monitoring of HIV patients, including regular CD4 and viral load testing.
 - e. To provide ART for all HIV patients who are eligible for ART.
 - f. To provide second-line of antiretroviral drug regimens for people who have drug resistance to first-line regimens.
 - g. To ensure uninterrupted supply of ARV drugs, test-kits, and other commodities for uninterrupted provision of ART.
 - h. To provide in-patient ARV treatment.
 - i. To provide post-exposure prophylaxis.
 - j. To provide diagnosis, treatment and prevention of opportunistic infections.
 - ja. To provide care and support for HIV patients.
 - jb. To ensure sustainability of ART programmes by developing long-term funding plan.

- jc. Provide further education and training of the health care workforce to prioritise the use of ART for PLHIV.
- 3) Expected results:
- a. The National HIV/AIDS Treatment and Care Protocols will be regularly reviewed in accordance with WHO recommendations.
 - b. Follow-up of HIV patients will be provided.
 - c. Patients follow-up system will be improved through providing follow-up with all registered patients.
 - d. All HIV patients eligible for ART are provided with ART.
 - e. In-patient ARV treatment will be provided.
 - f. Post-exposure prophylaxis will be provided.
 - g. Diagnosis, treatment and prevention of opportunistic infections will be provided.
 - h. HIV patients will be provided with care and support.
 - i. Mortality due to HIV infection will be reduced.
 - j. HIV training course will be provided to continuously train and retrain health care workers on the issues of HIV and AIDS.

IX. MONITORING AND EVALUATION

48. The primary goal of this section is to improve the rigour of the M&E system and produce annual M&E reports.
- 1) Strategy 1. Ensure a robust and comprehensive HIV surveillance system.
- 2) Activities:
- a. To monitor and evaluate the National Programme on the Response to the HIV Epidemic.
 - b. To carry out routine HIV surveillance.
 - c. To carry out HIV biological and behavioural surveillance.
 - d. To produce annual surveillance and monitoring reports.
 - e. To monitor HIV transmission among partners of PWID, MSM, SWs and clients of SWs or conduct other surveys.
 - f. To ensure a functioning long-term patient monitoring system to prevent and assess drug resistance.
- 3) Expecting results:
- a. National HIV&AIDS Monitoring and Evaluation System will be strengthened.
 - b. Monitoring and Evaluation of the National Programme on the Response to the HIV Epidemic will be carried out using standardised data collection and reporting indicators.
 - c. Routine HIV surveillance will be carried out to ensure collecting reliable information on HIV/AIDS.
 - d. HIV biological and behavioural surveillance will be conducted, ensuring that data on HIV prevalence and on risk behaviour are obtained.
 - e. Annual surveillance and monitoring reports will be produced.
 - f. HIV transmission will be monitored among partners of PWID, MSM, SWs and clients of SWs, and other surveys will be conducted.

- g. Long-term patient monitoring system will be operated to assess possible drug resistance and timely prevent it.
- h. The National Composite Policy Index will be completed.

X. MANAGEMENT, COORDINATION AND PARTNERSHIP

49. The primary goal of this section is to scale up collaboration between CCM, local authorities and the stakeholders for addressing the challenges that directly influence the outcomes of the HIV response.

- 1) Strategy 1. To increase the leadership capacity of CCM and local authorities.
- 2) Activities:
 - a. To conduct a needs assessment survey regarding the technical support required for increasing leadership capacity of CCM and local authorities.
 - b. To conduct technical support workshops for CCM on the issues of financial management, proposals development and review processes, programme management and governance.
- 3) Expected results:
 - a. The needs assessment survey will be conducted regarding the technical support required for increasing leadership capacity of CCM and local authorities.
 - b. Workshops for CCM members will be conducted for CCM members to develop their skills on financial management, proposals development and review, programme management and governance.
- 4) Strategy 2. Leverage partnership between stakeholders and programmes for better performance-based results.
- 5) Activities:
 - a. To establish and strengthen partnerships between HIV/AIDS stakeholders and other allied organizations at national and international levels.
 - b. To establish and strengthen partnerships between community-based organizations and programmes in marzes.
 - c. To organise workshops to build the capacity of community-based organizations in order for them to be able to take up HIV intervention programme.
 - d. To build a database of national consultants amongst public authorities, service providers, community-based, faith-based and other allied civil society and community organisations for providing technical support.
 - e. To ensure participation of representatives of governmental organizations in international AIDS symposiums, conferences, workshops.
 - f. To keep the interested organizations and programmes informed of the most up-to-date information and best practice regarding HIV and AIDS.
- 6) Expected results:
 - a. Partnerships between HIV/AIDS stakeholders and other allied organizations will be established and strengthened at national and international levels.
 - b. Partnerships between interested community-based organizations and programmes in marzes will be established and strengthened.
 - c. Workshops will be conducted to build the capacity of community-based organizations.

- d. Database of national consultants will be built for providing technical support.
- e. Participation of representatives of governmental organizations in international AIDS symposiums, conferences, workshops will be ensured.
- f. The interested organizations and programmes will be kept informed of the most up-to-date information and best practice regarding HIV and AIDS through workshops, CCM website, e-Groups, etc.

XI. FINANCING AND FINANCIAL RESOURCE MOBILISATION

50. The primary goal of this section is to ensure sustainability of the budget to maintain the continuity of the activities implemented under the Programme on the Response to the HIV Epidemic.
- 1) Strategy 1. Increase efficiency and effectiveness of funding.
 - 2) Activities:
 - a. To conduct one normative costing of HIV/AIDS, TB/HIV, HBV/HIV, and HCV/HIV management protocols.
 - b. To conduct a National AIDS spending assessment.
 - c. To develop TB/HIV/AIDS subaccounts within the National Health Accounts framework.
 - d. To strengthen the capacity of procurement specialists.
 - e. To conduct a review of M&E data with financial allocations.
 - 3) Expected results:
 - a. Efficiency and effectiveness of funding of the Programme on the Response to the HIV Epidemic will be increased.
 - b. Allocation of resources will be identified based on the Programme results and cost-effectiveness.
 - c. Funding will be directed to those most in need and will be aligned for prevention to the estimated modes of current transmission.
 - 4) Strategy 2. Increase new funding resources and sustain the existing funding.
 - 5) Activities:
 - a. To increase private sector funding of the total HIV/AIDS spending.
 - b. To enhance efforts in innovative financing to the HIV/AIDS response through encouraging private sector contributions, encouraging Corporate Social Responsibility (CRS), developing PLHIV entrepreneurship scheme to sustain the HIV programme.
 - c. To increase the share of the State Budget in the total HIV/AIDS spending.
 - d. To develop and submit proposals for GFATM and international organisations for funding.
 - 6) Expected results:
 - a. Private sector funding of the total HIV/AIDS spending will be increased.
 - b. Mechanisms on innovative financing to the HIV/AIDS response will be integrated.
 - c. Share of the State Budget in the spendings on HIV prevention and treatment.
 - d. Proposals for GFATM and International organisations for funding will be developed and submitted.
 - e. Needed resources will be mobilized to meet the forecasted demands.