

**RAPID ASSESSMENT AND
RESPONSE OF HIV/AIDS AMONG ESPECIALLY
VULNERABLE YOUNG PEOPLE
IN THE REPUBLIC OF ARMENIA**

**NATIONAL STRATEGIC
PLANNING PROCESS**



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Rapid Assessment and Response Analysis

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List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANAF	Armenian National AIDS Foundation
ARV	Antiretroviral
APEC	“AIDS Prevention, Education, Care” NGO
CCM	Country Coordination Commission on HIV/AIDS, TB and Malaria issues in the Republic of Armenia
CIS	Commonwealth of Independent States
CSWs	Commercial Sex Workers
DHS	Demographic Health Survey
DU	Drug User
EVYP	Especially Vulnerable Young People 10 - 24
IDU	Injecting Drug User
IEM	Information – Educational Materials
HIV	Human Immunodeficiency Virus
KAP	Knowledge, Attitude, Practice
MARA	Most at-Risk Adolescents
LFT	Local Field Team
LSBE	Life Skills Based Education
MoH	Ministry of Health of the Republic of Armenia
MSM	Men who have sex with men
NCAP	National Centre for AIDS Prevention
NGO	Non-Governmental Organization
NST	National Support Team
PAFHA	For Family and Health Pan Armenian Association
PLHIV	People living with HIV
RA	Republic of Armenia
VCT	Voluntary counselling and testing
TOT	Training of trainers
STIs	Sexually Transmitted Infections
SAMSA	Scientific Association of Medical Students of Armenia
UNICEF	United Nations International Children’s Emergency Fund
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Populations Fund
WHO	World Health Organization
WV	World Vision International Armenian Branch
MARA	Most at Risk Adolescents aged 15 - 24
LARA	Low at Risk Adolescents aged 15 - 24
IEC	Information Education Communication
BCC	Behaviour Change Communication

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Executive Summary

The analysis of findings of the Rapid Assessment and Response (RAR) carried out among the Especially Vulnerable Young People (EVYP) and Most at Risk Adolescents (MARA) in Armenia provides a picture of the current HIV/AIDS situation within these populations. This rapid assessment evaluated the level of knowledge on HIV prevention, risk behaviour, vulnerability and accessibility to services among EVYP and MARA. The RAR findings present an opportunity to identify and respond to the needs of EVYP and MARA, and to plan targeted interventions to reduce their risk and vulnerability to HIV infection.

The RAR findings demonstrate low levels of awareness on HIV/AIDS among EVYP and MARA. In particular, 30% of young commercial sex workers (CSWs), 40% of young injecting drug users (IDUs), 38% of young non-injecting drug users (DUs), and 48.5% of young men who have sex with men (MSM) had a clear understanding of the relationship between their own risky behaviour and their vulnerability to HIV. HIV/AIDS awareness is particularly low among Children in Conflict with the Law (ChCL) (16%) and Children Deprived of Parental Care (ChDPC) (12%), including 'street children,' young people attending community centres and those living in state care institutions, orphanages and boarding schools. These findings highlight the need to increase awareness on HIV/AIDS, and to support activities to form safer behaviour.

To address these issues and to increase HIV/AIDS awareness it will be necessary to conduct a combination of targeted Information/Education Campaigns (IEC) and Behaviour Change Communication campaigns (BCC) to reach these particularly hard-to-reach populations.

Only 40% of DUs, 67.3% of ChCL, 43.8% of ChDPC, 68% of young CSWs, 51.4% of young MSM and 8% of IDUs mentioned their friends and peers as the source of information on HIV/AIDS prevention. The fact that very few IDUs mentioned friends and peers as the source of information may mean that current peer education programmes have overlooked or do not involve this high-risk group of young people and requires further investigation.

To raise HIV/AIDS awareness among vulnerable groups, current barriers should be identified, and peer education and other appropriate measures should be provided to help IDUs, DUs, ChCL, ChDPC, young CSWs, young MSM learn how to protect themselves. Interventions should involve children attending special educational institutions and 'street children,' as well as those in mainstream schools and those not attending school.

Very few surveyed young people from any group mentioned school as the source of information. In particular, 10% of DUs, 12.2% of ChCL, 22.9% of ChDPC, 8.6% of young MSM and none of the surveyed CSWs or IDUs reported school as a reliable source of prevention information. The role of schools in promoting healthy lifestyles should therefore be strengthened. To achieve this, it is recommended that HIV/AIDS-themed courses, such as *Life Skills and Healthy Lifestyles* should be incorporated into the curriculum of special educational institutions.

Interviews show that 72% of IDUs, 64% of DUs, 53.1 % of ChCL, 45.8 % of ChDPC, 37.1 % of young MSM and 34% of young CSWs sited mass media as their source of HIV/AIDS prevention information. Based on the outcome of these interviews, it is recommended that mass media is to be involved in future prevention activities.

None of the surveyed IDUs and nearly none of the DUs would seek support from health care institutions or youth-friendly services. This is interpreted to mean that young people do not have confidence in these institutions, and may not understand what types of relevant services they can provide. The survey also revealed that a relatively small number of surveyed MSM ChCL and ChDPC would access health care institutions or youth-friendly services. None of the surveyed young CSWs would go to youth-friendly health services, 40% would go to a health care institution in case of need.

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The low level of involvement of adolescents into youth-friendly health services makes monitoring the trends of STI prevalence among the young people difficult. Based on survey results, it is recommended that:

- Accessibility to Voluntary Counselling and Testing (VCT) and health care institutions services be increased and that services are adapted to the needs of adolescents, making them more youth-friendly;
- Psychological services and support are provided to IDUs and DUs; and,
- Access to early testing and treatment of STIs for young CSWs is improved.

The surveys revealed that EVYP and MARA continue to engage in high-risk behaviours. Among those surveyed ChCL (40%) had experience of drug use, which appears to be starting at increasingly younger ages (10-14) across all of the young populations surveyed. Additionally, more than half (58%) of the young people involved in the RAR were sexually active, and nearly half of them had their first sexual experiences when they were under the age of 14. Less than a quarter (24.1%) of all of the surveyed sexually active youth used condoms consistently.

Risk behaviour increased when sex and drugs were combined. More than one third (32%) of the RAR participants who inject drugs reported sharing syringes in the month prior to the interview and more than half (56%) had injected drugs prepared by someone else.

In terms of condom use, roughly one third (34.2%) of surveyed young MSM used condoms consistently during the year prior to the survey. Less than two thirds of young CSWs reported practicing consistent condom use, although almost all of them successfully identified condoms as a way to reduce risk of HIV transmission.

The analysis of the survey on risk behaviours indicated that the mean age of first experience in drug use among ChCL and ChDPC (13.1 and 13.2 respectively) is lower than that of young IDUs, DUs, young CSWs and young MSM (17.6, 15.6, 18.2 and 18.7 respectively). The mean age at first sexual intercourse, is also lower in ChCL, ChDPC and young MSM (14.4, 13.1 and 14) than that in IDUs, DUs, young CSWs (17.7, 17.9 and 16.6 respectively). There is an urgent need to strengthen STI and primary drug abuse prevention. It is recommended that this be achieved through the strengthening of the prevention component within the primary health care system, engaging relevant specialists and expanding and/or establishing outreach services.,

The surveys show that ChCL, ChDPC and young MSM still place importance on the support of their parents and relatives (56%, 36% and 20.6% respectively). Amongst IDUs, DUs, and young CSWs, an insignificant number indicated that they would turn to their parents and relatives for support (4%, 12% and 2 %). Overall, very small numbers of ChCL, ChDPC, CSWs and MSM, and no IDUs or DUs at all mentioned their families as sources of information. Consequently, it is recommended that family members of EVYP and MARA are involved in prevention activities, to provide them with the opportunity to participate in the prevention and treatment processes.

The interviews demonstrated a low level of community involvement in HIV/AIDS prevention activities. It is important to carry out activities aimed at reducing indifference amongst community leaders and members towards ChCL and ChDPC. At the same time, it is necessary to implement interventions at the community level, aimed at eliminating stigma and discrimination against IDUs, DUs, young CSWs and MSM. To achieve this task, it is proposed that the level of involvement and role of communities in implementing prevention activities is increased.

The survey shows that most young CSWs (70%), some young MSM (26.5%) and very few young IDUs (12%) would seek support and assistance from NGOs in case of need. Almost no ChCL and DUs surveyed would look to NGOs, and none of the surveyed ChDPC mentioned would go to NGOs for care. The capacity and efficacy of NGOs should be increased by involving EVYP and MARA in their activities. An integrated focus on MARA within harm reduction projects aimed at IDUs will allow increased accessibility of syringes and other means of prevention, which will ensure that NGOs reach out to target populations effectively, and are able to appropriately meet their needs.

To increase the efficiency of treatment provided to IDUs it is necessary to:

- Combine existing treatment with rehabilitation.
- Amend existing laws prohibiting drugs and psychotropic substances in drug addiction treatment.
- Study potential obstacles, which can arise when representatives of the surveyed groups attempt to access services at institutions and monitor confidentiality maintenance.

The National Programme on HIV/AIDS Prevention envisages a variety of prevention activities targeted at risk groups (IDUs, MSM and CSWs), and general prevention of HIV/AIDS, sexually transmitted infections and drug abuse to reduce overall prevalence among adolescents and youth.

The results of the survey indicate that the various prevention projects targeting high-risk groups (IDUs, MSM and CSWs) are not reaching EVYP and do not employ specific strategies to reach them. It is therefore necessary to develop new approaches and strategies to implement more effective activities on HIV/AIDS prevention among EVYP. Though the National Programme on HIV/AIDS Prevention plans to involve youth outside of the formal education system and those who do not work in preventive activities, such activities are usually implemented in educational institutions and do not involve children in conflict with the law, children deprived of parental care or those outside the formal education system.

The Response Analysis shows that the effective implementation of interventions among the EVYP and MARA requires the following:

- Increase the level of knowledge of EVYP and MARA by introducing prevention programmes in special educational institutions, providing peer education and conducting Information and Education Communications and Behaviour Change Communications.
- Improve accessibility for adolescents to VCT and health services by creating more youth-friendly services.
- Involve parents of EVYP and MARA in community- and school-based prevention activities to promote greater responsibility.
- Enhance the role of parents and the community in rearing EVYP and forming safer behaviour through community-based events.
- Improve social mobilisation to eliminate stigma and discrimination against EVYP, MARA and PLHIV.
- Increase the accessibility of MARA to needle exchange and other preventive equipment and commodities through incorporating MARA-specific components into harm reduction projects.
- Promote safer sexual behaviour through providing education on abstinence, fidelity and condom use.
- Reduce gender inequality through ensuring equal access to information, promoting girls rights and forming responsible attitudes in young boys.
- Prevent drug abuse and STIs through enhancing the role of primary health care institutions and wider involvement of relevant reproductive health specialists.

The RAR carried out among EVYP and MARA in Armenia proves again the need for a special strategy for this unique group. The strategy must aim to reduce risk behaviours, raise awareness, and improve affordability and accessibility of services, by tailoring existing services to the specific needs of these youth, as well as implementing activities at the community level aimed to overcome public indifference and prejudice.

Introduction

The RAR on HIV/AIDS among EVYP and MARA was conducted in Yerevan and the country regions (Marzes). The RAR was implemented from May through November 2005.

Because there was a general lack of information on EVYP and MARA, the RAR aimed to capture the risk factors and external influences that make these groups especially vulnerable to HIV infection. The Response Analysis shows that HIV/AIDS prevention activities conducted among young people do not specifically target or reach EVYP and MARA, and efforts are not systemized. Thus, these activities cannot efficiently reduce the risk, vulnerability and impact of HIV/AIDS in this highly vulnerable population. Communities are not engaged in the effort to prevent HIV/AIDS and there is no sense of community responsibility in caring for young people. Parents and families are not sufficiently involved in HIV/AIDS prevention activities.

Since 1998, UNICEF and the Ministry of Education and Science launched a systemized *Life Skills-based Education* (LSBE) project in secondary schools. UNICEF has supported the implementation of *Life Skills* in 384 secondary schools throughout the RA. More than 600 teachers have been trained and retrained in *Life Skills*, which targets students in grades one through seven. *Healthy Lifestyles* has been introduced in 30 schools for grades 8 and 9, providing teachers with skills to address smoking, alcohol, drug abuse, risk reduction, health promotion and other HIV/AIDS-related issues. It is additionally envisaged to introduce classes on HIV/AIDS prevention and forming safer behaviour during the first phase of implementation of the National Programme on HIV/AIDS Prevention supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). This effort is supported by the National Programme on HIV/AIDS Prevention and recommended by the RA Ministry of Education and Science to be implemented in 400 secondary schools country-wide. The classes are to be given within lessons of form masters.

The National Centre for AIDS Prevention (NCAP) and the NGOs (*Scientific Association of Medical Students of Armenia (SAMSA)* and *For Family and Health Pan-Armenian Association (PAFHA)*) have implemented preventive activities in secondary schools to raise awareness of the young people with the support of international donors.

In 1999-2000, PAFHA, with support from UNICEF, established a Youth-friendly Health Service Centre at 'Arabkir' Medical Centre, and published the books 'The ABCs of Sexual Health' and 'Children of Armenia Speak about AIDS.'

In 2001, a training of trainers on peer education was provided within the framework of the UNAIDS project, with assistance from UNICEF and an international consultant from UNAIDS.

From December 2001 to January 2002, the NGO *AIDS Prevention, Education and Care (APEC)* implemented a pilot project on 'HIV/AIDS, STDs and Drug Abuse Prevention among Youth' in Syunik Marz, supported by UNICEF. The project aimed to promote the *Healthy Lifestyle* model as a priority among youth through peer education; to reduce the spread of HIV/AIDS and drug abuse; and, to form safer and more responsible behaviours among youth. The project was implemented in the six secondary schools of Kapan and two secondary schools of Qajaran cities.

In addition to this pilot project, APEC supports peer education in secondary schools throughout the RA. To date 2,100 peer educators have been trained in 200 schools within the framework of the prevention project and are providing peer education on HIV/AIDS prevention to fellow schoolchildren. In total, the project will cover 400 schools totalling 30% of all schools in the country. It will be necessary to expand the peer education project to cover more schools, and to introduce the project in special education institutions, with wider involvement of EVYP.

In 2004-2005, three harm reduction projects were implemented among IDUs in Yerevan, Gyumri and Kapan cities by APEC and Kapan State Medical College within the framework of the National Programme on HIV/AIDS Prevention, supported by GFATM. These projects comprise a harm

reduction strategy including needle exchange, VCT provision, outreach work, peer education, condom distribution and information/education materials.

These efforts have been viewed as successful; however they were developed before MARA was identified as a vulnerable group and therefore have no MARA-specific interventions.

Within the framework of the GFATM-supported National Programme, in 2004-2005, six HIV/AIDS prevention projects were implemented among CSWs in the cities of Yerevan, Abovyan, Gyumri, Vanadzor, Kapan, Agarak, Gavar, and Vardenis. The projects were implemented by NGO *AIDS Prevention Union (APU)*, NGO *Family Benefactor*, NGO *Hope and Help*, Kapan State Medical College and the Gavar State Medical College. Activities covered peer education, outreach work, VCT provision, STI treatment, condom distribution and information/education materials. In general, these projects successfully reached their targets. However, the target special needs of MARA are not sufficiently targeted, which may reduce the effectiveness of these preventive activities.

There is one GFATM-supported project that focuses on ensuring access to peer education, VCT services, information/education materials and condoms for MSM in Yerevan. This project focuses on MSM in general, and has no special focus on young MSM leaving them vulnerable and without resources to meet their specific needs.

In conclusion, the Response Analysis shows that HIV/AIDS prevention projects implemented in high-risk populations are highly effective in reducing the spread of HIV among IDUs, CSWs and MSM. However, these interventions often overlook MARA, and fail to address their special needs and a youth-friendly approach. This is especially relevant in regions where MARA/EVYP has no opportunity to access VCT and is not targeted by preventive interventions. To successfully reach MARA and EVYP with prevention efforts, it is necessary to expand current services and develop new, targeted strategies.

The on-going National Programme on HIV/AIDS Prevention and the projects implemented within its framework by NGOs do not target ChDPC and ChCL, which constitute a significant proportion of EVYP and MARA.

The National Programme on HIV/AIDS Prevention implements activities aimed at reducing the rates of HIV/AIDS, STI and drug use prevalence, specifically targeting young people. This is addressed primarily through awareness-raising among minors and youth. The implementation of the National Programme on HIV/AIDS Prevention showed that young people aged 10-24, especially those outside the formal educational system and those who do not work, including DUs, ChCL and ChDPC, are not covered by these prevention activities. The RAR was implemented to support the National Programme on HIV/AIDS Prevention for 2007 - 2011 by identifying gaps in current prevention efforts and developing specific strategies to reach EVYP and MARA.

- To effectively undertake this analysis, the RAR was implemented among the following target groups aged 10-24:
- Young Drug Users (in Yerevan);
- Young Injecting Drug Users (in Yerevan);
- Young Commercial Sex Workers (in Yerevan);
- Young Men who have Sex with Men (in Yerevan);
- Children in Conflict with the Law (in Yerevan and in the six Marzes of Syunik, Kotayk, Lori, Gegharkunik, Tavush and Shirak); and,
- Children Deprived of Parental Care [children living or working on the streets; children attending community centres, young people living in State care institutions including orphanages and boarding schools] (in Yerevan and in the six Marzes of Syunik, Kotayk, Lori, Gegharkunik, Tavush and Shirak).

Obstacles

It was necessary to obtain approval from various authorities in order to implement the RAR among ChCL and ChDPC, which caused some delays.

Low literacy levels in target groups also impacted timely implementation. This issue should be taken into account in further strategy planning and implementation.

All groups surveyed expressed that they did not hold their health as a strong value, and were reluctant to discuss their health in general. Therefore, gaining a clear and firm understanding of health issues pertaining to EVYP and MARA is challenging and not properly capturing these issues risks the development and implementation of misguided interventions.

Goals and objectives

RAR overall goal

The overall goal of the RAR was to collect and analyse data on risk behaviours of EVYP and MARA, and to provide recommendations for interventions that will improve the health of young people in general, by minimizing their risk of HIV infection.

RAR Objectives

- Describe the dimensions and nature of HIV risk behaviours and associated health and social consequences among EVYP and MARA;
- Assess the context in which risk behaviours of EVYP and MARA take place;
- Examine the extent and effectiveness of existing interventions targeting EVYP and MARA;
- Increase awareness and support of local communities towards EVYP and MARA; and,
- Develop activities that improve the health of young people, reduce vulnerability and strengthen prevention by refining existing and implementing the new interventions.

The ultimate aim of the RAR was to identify sufficient information on the target populations to develop effective strategies for HIV/AIDS prevention among EVYP and MARA.

In 2000, UNDP and UNAIDS supported HIV/AIDS situation and response analyses, a rapid assessment on the increase in injecting drug use and HIV infection, and as well as sentinel epidemiological surveillance among vulnerable populations. These assessments targeted IDUs, CSWs, groups at high risk of HIV infection such as MSM, former IDUs, individuals with STIs and individuals demonstrating clinical symptoms, and looked at specific sub-populations, including prisoners and others in the penitentiary system.

Based on the situation and response analyses, the National Strategic Plan on HIV/AIDS Prevention was developed and approved by the college of the Ministry of Health (MoH) of the RA on 6 December 2000 and by the Order No. 14 of 12 January 2001 by the Minister of Health of the RA.

Based on the National Strategic Plan, the MoH and other key ministries developed the National Programme on HIV/AIDS Prevention for 2002-2006, which was approved on 1 April 2002 by the Government Decision No. 316 and ratified by the President of RA.

The main goal of the National Programme on HIV/AIDS Prevention is to reduce the spread of HIV/AIDS in the Republic of Armenia.

The main objectives are to:

1. Develop and implement the national policy on HIV/AIDS prevention and treatment;
2. Prevent HIV/AIDS among injecting drug users;
3. Form safer sexual behaviours;
4. Prevent mother-to-child HIV transmission;
5. Ensure donated blood safety;
6. Prevent HIV/AIDS and STIs among minors and youth; and,
7. Care for people living with HIV/AIDS.

The framework for the RAR aims to address gaps in the National Programme, and to ensure that the needs of vulnerable young people aged 10 – 24 are included and reflected. The National Programme goal is HIV/AIDS and STI prevention among minors and youth. The following activities are designed to reduce the rates of HIV/AIDS, STI and drug use prevalence among young people through raising awareness among minors and youth:

- Design and introduce education programmes on HIV/AIDS, STIs and drug use prevention into educational establishments;

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- Develop and publish relevant methodological and didactic materials for educational establishments;
- Train education specialists in HIV/AIDS preventive teaching methodology;
- Design and implement information/education programmes for the military and individuals in penitentiary institutions;
- Develop and implement programmes to target and address young people outside of the formal education system and those who do not work; and,
- Design mass media information/education programmes focused on youth.

However, the National Programme on HIV/AIDS Prevention does not implement activities to address young people outside the formal education system and those who do not work. The RAR aims to address these gaps.

Rapid Assessment and Response Team

The **Rapid Assessment and Response Team** included representatives of 3 local NGOs: the Armenian National AIDS Foundation, the AIDS Prevention Union and the French-Armenian Development Fund.

The 17-member **RAR Field Team** included one sociologist from *ALM Holding*; one specialist from the Narcological Branch of the Psychiatric Centre of the MoH; two representatives from the NGO *AIDS Prevention, Education and Care*, two representatives from the NGO Education in the Name of Health, two representatives from the AIDS Prevention Union, one STI specialist from the Medical Scientific Centre of Dermatology and STIs, and eight representatives from the French-Armenian Development Fund.

Local Field Teams consisted of 2-8 members who were young people, young physicians, young women, female NGO staff who work with sex workers and in the area of trafficking and gender issues, medical workers, social workers, sex workers and former drug users who work with NGOs to address MSM and drug users.

RAR Field Team members participated in the RAR National Workshop, on 25-27 May 2005, and their activities were supervised by the three Field Coordinators. Team members attended Local Field Team meetings, collected data, recorded and submitted their results to the Field Coordinators, ensured confidentiality of surveyed participants, provided HIV/AIDS-related information materials when appropriate; reported problems or emerging issues, and reported on the strengths and weaknesses of the RAR design to Field Coordinators.

The **RAR Core Team** was comprised of one National Coordinator, three Field Coordinators, one Data Analyst and one National Consultant on Response Analysis.

The **National Coordinator** managed the RAR project and supervised the Field Coordinators. The National Coordinator was responsible for the preparation of the RAR final report and development of the strategy plan.

The **National Consultant on Response Analysis** performed the HIV response analysis and prepared a report.

The **Field Work Coordinators** oversaw the data collection process and submitted reports to the National Coordinator. They coordinated the regular meetings of Local Field Teams, and were responsible for the logistics of each surveyed area. Field Work Coordinators controlled the quality of collected data, provided ongoing support to the field workers and submitted collected data to the National Coordinator. They were also involved in the preparation of the RAR Report. During the RAR implementation, together with the Field Workers the Field Coordinators ensured the confidentiality of study participants. At the same time, they informed the RAR Core Team about the strengths and weaknesses of the RAR, specifying problems in implementation and recommended solutions.

They also participated in the development of the Strategy Plan.

The **Data Analyst** provided support to the Field Workers in proper data collection and analysis, and participated in the preparation of the final report.

To ensure RAR planning, implementation and advocacy, the Country Coordination Commission on HIV/AIDS, Tuberculosis and Malaria issues (CCM) in the Republic of Armenia designated a *National Support Team* involving representatives from various ministries, local NGOs and UNICEF:

UNICEF's Project Coordinator from the RA Ministry of Health	Ara Babloyan , General Director, "Arabkir" Medical Centre, Institute of Child and Adolescent Health
RA Ministry of Territorial Administration and Coordination of Infrastructure Activities	Gagik Aslanyan , Deputy Minister
RA Ministry of Education and Science	Anahit Mouradyan , Chief Specialist, Secondary Education Department
RA Ministry of Justice	Hayk Khemchyan , Head of Criminal Services Reform Department
RA Ministry of Culture and Youth Affairs	Tamara Torosyan , Chief Specialist, Youth Policy Department
RA Police	Davit Avetyan , Senior Officer of the Fourth Department Arthur Vardanyan , Senior Officer of Special Cases of the Seventh Department of Criminal Investigation
UNICEF	Naira Sargsyan , Assistant Project Officer, Young People's Health and Development
NGO representative	Armen Hovhannisyan , Yerevan Marz Armenian Red Cross Society

Training Workshop

The training workshop on Rapid Assessment and Response Analysis on HIV/AIDS among EVYP was held on 25-27 May 2005 in Yerevan and provided the RAR Field Team with the knowledge and skills for RAR implementation and strategy planning. The objectives of the workshop were to:

1. Introduce the principles and practice of Rapid Assessment and Response to the Coordinators and Field Team members.
2. Ensure that Field Team members practice and understand the principles and purpose of undertaking a Rapid Assessment and Response.
3. Build or strengthen the capacity of Field Team members to:
 - Facilitate focus group discussions
 - Conduct in-depth interviews with key informants
 - Conduct surveys
 - Undertake observations and mapping
 - Accurately record and manage data
 - Analyse data using activity grids

At the workshop, active discussions took place and focused working groups were formed. By the end of the

workshop, the working groups finalised the questionnaires that had been developed before the workshop. The questionnaires were used for conducting surveys among vulnerable groups, as well as for focus group discussions among community leaders, decision-makers and service providers. Each workshop participant received a certificate.

Methods

During RAR implementation, data were collected from EVYP, MARA, service providers, policy makers, community leaders, the police representatives and NGOs.

Data was collected to highlight and assess the context, health status and social consequences, health and risk behaviours, and interventions surrounding HIV/AIDS. Data was drawn from existing information, focus groups, interviews, surveys and observations.

A plan to use mapping for data collection was not realised. Through key informant interviews it was discovered that there are no specific geographical locations where risk groups gather, making targeting interventions by geographic locations ineffective. This must be considered during the development and implementation of prevention activities.

1. Existing information was collected from the Statistical Yearbook of the Republic of Armenia (2004), reports from the Ministry of Health, the National Centre for AIDS Prevention, annual reports from UN Agencies and reports from projects implemented within the framework of the National Programme on HIV/AIDS Prevention.

2. Focus group discussions were conducted using questionnaires (See Appendix 1) Focus group discussions were held among vulnerable groups and service providers.

3. Self-administered questionnaires (See Appendix 2) were developed taking into consideration the revised approaches provided in *Behavioural Surveillance Surveys: Guidelines for Repeated Behavioural Surveys in Populations at Risk of HIV*. At the same time, the questionnaires helped to determine the indicators listed in the United Nations General Assembly Special Session on HIV/AIDS Guidelines on Construction of Core Indicators. Monitoring the Declaration of Commitment on HIV/AIDS, and the Joint United Nations Programme on HIV/AIDS, (UNAIDS) 2005.

A Note on self-administered questionnaires: These contained questions on gender, age, marital status, place of residence, modes of HIV/AIDS prevention and risk behaviours (both sexual behaviour and drug use). The content of the questionnaires was agreed upon by the UNAIDS consultant, experts involved in the development of the National Strategy and Policy on HIV/AIDS prevention and RAR workshop participants. The surveys were conducted among the targeted vulnerable groups. Questionnaires were completed by the respondents or by the Field Workers, in cases where respondents were unable to independently complete the questionnaire. Upon completion, it was concluded that the self-administered questionnaires had certain weaknesses, including the absence of a mechanism to ensure completion and a potential for participants biasing each other, when completing questionnaires at the same time.

4. In-depth interviews were conducted among EVYP, service providers, policy makers, community leaders, NGO and police representatives using preliminary designed questionnaires (See Appendix 3).

Before conducting the RAR, the CCM, Ministry of Health and the Ministry of Education and Science were informed about the proposed project. Prior to conducting the surveys, in-depth interview, and focus group discussions were conducted among representatives of vulnerable groups (ChCL and ChDPC), National and/or Field Coordinators informed parents and key administrators of schools and special educational institutions about the RAR project, and obtained verbal consent to conduct the RAR. IDUs, DUs, young CSWs and young MSM made informed decisions to participate in the RAR. The confidentiality of RAR participants was maintained and participants could withdraw from the survey any time.

5. Observations were conducted by the National and the Field Coordinators in Sisian, Kapan and Gyumri cities. Observations were aimed at social marketing of condoms in those cities.

Distribution of activities conducted with various groups is shown in the tables below.

*Table 1.
Young DUs*

Groups	Self-administered Questionnaires	Interviews	Focus Groups	Total
Vulnerable young people	50	10	18 (3 groups)	78
Service providers		8	12 (2 groups)	20
Policy makers, community leaders, NGOs and the police		4		4
Total	50	22	30 (5 groups)	102

*Table 2.
Young IDUs*

Groups	Self-administered Questionnaires	Interviews	Focus Groups	Total
Vulnerable young people	25	10	12 (2 groups)	47
Service providers		6	12 (2 groups)	18
Policy makers, community leaders, NGOs and the police		4		4
Total	25	20	24(4 groups)	69

*Table 3.
Young CSWs*

Groups	Self-administered Questionnaires	Interviews	Focus Groups	Total
Vulnerable young people	50	10	12 (2 groups)	72
Service providers		6		6
Policy makers, community leaders, NGOs and the police		4		4
Total	50	20	12 (2 groups)	82

*Table 4.
Young MSM*

Groups	Self-administered Questionnaires	Interviews	Focus Groups	Total
Vulnerable young people	35	5	10 (2 groups)	50
Service providers		2		2
Policy makers, community leaders, NGOs and the police		4		4
Total	35	11	10 (2 groups)	56

*Table 5.
Children in Conflict with the Law*

Groups	Self-administered Questionnaires	Interviews	Focus Groups	Total
Vulnerable young people	50	10	20 (2 groups)	80
Service providers		4	12(2 groups)	16
Policy makers, community leaders, NGOs and the police		4		4
Total	50	18	32 (4 groups)	100

*Table 6.
Children Deprived of Parental Care*

Groups	Self-administered Questionnaires	Interviews	Focus Groups	Total
Vulnerable young people	50	10	20 (2 groups)	80
Service providers		4	12 (2 groups)	16
Policy makers, community leaders, NGOs and the police		4		4
Total	50	18	32 (4 groups)	100

Theoretical, 'snowball' or network sampling, as described in the Rapid Assessment and Response Technical Guide, (WHO/HIV/2002.2,2 June 2003), were used to identify individuals representative of the ensure sub-population. These sampling methods were used due to the absence of accurate official data on target population size and behaviour. Expert estimations on sample sizes as well as international experience were also taken into account. The sample size shows specificities of the whole target group. The selected method allows for obtaining reliable information in an effective and quick manner, regulating the information flow and avoiding duplications. Also, selection through key informants/participants or those conducting the survey allowing for a flexible array of methods.¹

Following data collection, data were processed using quantitative statistical methodology with 95% confidence interval. In order to ensure the accuracy of the data, data entry was carried out by two independent specialists with further data cleaning. EpiInfo 6.0 software was used for data processing and analysis. Qualitative data analysis from interviews and focus group discussions was performed using mega grids. Data were analyzed using triangulation and induction methods.

The Response Analysis was conducted on the basis of existing data from two major sources: information from official sources including reports from the Principle Recipient and sub-recipients of the GFATM-supported National Programme on HIV/AIDS Prevention, documents from the Country Coordination Commission on HIV/AIDS, TB, and Malaria issues (CCM) in the RA, UN bulletins, reports from various RA ministries, including implementation reports from the National Programme on HIV/AIDS Prevention, results of the situational analysis conducted among EVYP and MARA, and from interviews with key informants, representative from UNICEF and NGOs working in the field of HIV prevention.

Country Experience in Strategy Planning

The Republic of Armenia has already undertaken strategic planning in HIV/AIDS prevention. In 2000, UNDP and UNAIDS supported the implementation of an HIV/AIDS situation analysis and rapid assessment of the situation on the spread of injecting drug use and HIV infection. Additionally, sentinel epidemiological surveillance was undertaken among vulnerable populations, including IDUs, CSWs, groups at high risk of HIV infection in penitentiary institutions (MSM, former IDUs, individuals with STIs and individuals having clinical symptoms), as well as HIV/AIDS response analysis.²

Based on the HIV/AIDS situation and response analyses, the National Strategic Plan on HIV/AIDS Prevention was developed and approved by the college of the Ministry of Health of the RA on 6 December 2000 and by the Order No. 14 of 12 January 2001 of the Minister of Health of the RA.

Based on the National Strategic Plan, the MoH jointly with other key ministries developed the National Programme on HIV/AIDS Prevention for 2002-2006, which was approved on 1 April 2002 by the Government Decision No. 316 and ratified by the President of RA.

Data from second generation HIV surveillance conducted in March-April 2002 IDUs, CSWs, MSM, pregnant women, prisoners and youth indicated HIV prevalence at: 15% among IDUs, and in the range 3% among CSWs and 5-6% among prisoners (with a 90% confidence interval). No cases of HIV infection were revealed among the surveyed MSM or pregnant women. Based on these findings, it was concluded that the Republic of Armenia has a concentrated HIV/AIDS epidemic.

Strategic planning was also undertaken in the framework of the 'HIV/AIDS and Uniformed Services' UNDP/UNAIDS-supported project in 2004-2005 to support the implementation of the National Programme on HIV/AIDS Prevention and HIV prevention within the uniformed services.

Description of the RAR Process

UNICEF and the MoH recognised the lack of reliable, consistent data available on MARA and EVYP, and saw the RAR as an opportunity to address these information gaps. The HIV/AIDS situation analysis conducted in 2000 showed that 15.5% of respondents aged 19-29 used drugs.⁵ The results of second generation HIV surveillance in 2002 showed that 81.5% of the surveyed IDUs started using drugs at the age of 15-29; 3.4% of CSWs were engaged in sex work at the age of 14.² According to findings from the American Fund for Armenian Relief (2003), 17.3% of children under 18 living or working on the streets had a history of STIs.³ The findings of second generation HIV surveillance conducted in 2002 showed that 76% of the surveyed MSM had their first homosexual experience at the age of 7-15.

As of 1 May 2005, 328 HIV-infected individuals were registered in the Republic of Armenia of which 312 were Armenian citizens. Of those reported, there are 6 cases of HIV infection among children, though the majority of the HIV-infected individuals (76.3%) are 20-39 years old.⁴ Many believe that poor social protection mechanisms, rejection of traditional values, increased social inequality and high levels of unemployment seem to be impacting young people's health and development. In

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many cases, poor socio-economic conditions push young people to engage in risk behaviours, such as commercial sex work and drug and alcohol use, increasing their vulnerability to HIV/AIDS.

Based on the results of the above-mentioned surveys and lack of precise information regarding the HIV/AIDS situation among EVYP and MARA, UNICEF and the MoH recognised the importance of obtaining reliable data on to enable effective, targeted interventions to reduce the risk of HIV infection in this population.

UNICEF's regional strategy ensures that EVYP and MARA are at the centre of the HIV/AIDS prevention agenda. UNICEF builds the capacity of Government to halt spread of HIV/AIDS among children aged up to 18 years and reduce the risk and vulnerability of adolescents to HIV/AIDS infection through increased access to information and services and building relevant skills. In 2005, UNICEF supported the Ministry of Culture and Youth Affairs in developing the State Youth Policy Strategy for 2005-2007, which includes the issues of HIV/AIDS and YFHS.

In May 2005 the MoH by its Order N458-A included the conducting of a RAR for EVYP and MARA in its 2005 work plan with UNICEF, and in the same month, the RAR project was launched.

The following activities were conducted in May 2005: the RAR Core Team and the National Support Team were created; preliminary consultations with communities were conducted; candidates for the Field Team were selected; the RAR Team was trained; Local Field Teams were formed; Community Support Boards were established. Field Work was scheduled for July-September 2005 with data analysis and reporting to be completed by October 2005. All planned activities were implemented according to the approved schedule, except the establishment of the Community Support Boards, as potential members were on summer holidays. In the interest of time and efficiency, the RAR was carried out without these Boards.

Within the framework of the Project, a training workshop on Rapid Assessment and Response Analysis on HIV/AIDS among EVYP and MARA was held from 25-27 May 2005 with the support of an international consultant from UNAIDS. Thirty-one specialists attended the workshop and 17 were selected as Field Team members. Working groups for RAR implementation were then formed from representatives and national consultants from the *Armenian National AIDS Foundation, AIDS Prevention Union, French-Armenian Development Fund, AIDS Prevention, Education and Care, Education in the Name of Health* and the Medical Scientific Centre of Dermatology and STIs, Narcological Clinic of the Psychiatric Centre of the MoH.

Field Work was carried out from July-October 2005. Three Local Field Teams were formed and were coordinated by three Field Coordinators. One Local Field Team worked with ChCL and ChDPC. The second team worked with young CSWs. One sub-group of the third Field Team worked with DUs and IDUs, and the second sub-group focusing on young MSM. The activities were monitored and evaluated by Field Coordinators and the National Coordinator through daily random visits to project sites where interviews and focus group discussions were held. Monitoring and evaluation were also carried out by UNICEF representatives. During meetings with each target population, field activities were planned with a time frame for analysis and problem-solving was addressed. Administrative issues related to completion of questionnaires, conducting interviews and focus group discussions were addressed. Completed questionnaires and minutes from interviews were submitted and verified by the Field Coordinators.

The RAR Core Team meetings were held on a monthly basis. During these meetings, RAR activities were planned and Field Coordinators presented activities carried out by their Local Field Teams. The conducted activities and visits to Marzes were discussed and evaluated. During the meetings, other challenges were addressed, and strengths and weaknesses were presented as well as problems that had emerged during implementation

The qualitative and quantitative data analyses were performed in the period of July - mid-October 2005.

RAR findings will be disseminated to relevant governmental, non-governmental and international organizations. A Strategic Plan will be developed based on findings and submitted to the UN Theme Group on HIV/AIDS and CCM for comments and recommendations.

Obstacles and Successes

As was previously mentioned, implementation among ChCL and ChDPC was delayed due to the necessity to obtain the consent of various authorities. An additional unforeseen obstacle was the low level of literacy among all involved target groups. There is some concern that low literacy rates resulted in study bias: self-administered questionnaires were not always completed by study participants alone. This issue should be taken into account in future studies, strategy planning and implementation.

Another area of concern was the finding that study participants do not value their good health. There is great concern that, without using good health as a motivating factor to seek information and form healthy habits, these already hard-to-reach groups may be even more difficult to protect.

A positive result of the RAR implementation is that field workers became more experienced in working with vulnerable groups. Trustful relations with target group representatives were established and can be built upon for future studies and interventions. This will be critical in effectively reaching out to vulnerable groups.

Another successful outcome of RAR implementation resulted from the surveys conducted with service providers, community leaders, policy implementers and the police. Although not the purpose in administering the RAR with this group, implementation effectively drew their attention to the issues of the target groups and promoted deeper acknowledgement of the necessity to find solutions to the problems they face.

Contextual Evaluation

Geography

The Republic of Armenia is one of the Transcaucasus countries located in the Northeast part of the Armenian plateau. The area of the country is 29,743 square kilometres. Total border is 1,254 kilometres, of which 566 kilometres on the east and 221 kilometres on the north the country is bordered by Azerbaijan, 164 kilometres by Georgia, 35 kilometres by Iran and 268 kilometres by Turkey. Armenia's economy is primarily reliant on agriculture.⁵

The climate in the country is favourable for cultivating narcotic plants such as wild hemp and opium poppy. The Republic of Armenia has well-developed transportation routes and interstate borders with Iran which contributes to the ease of drug trafficking. Iran has more than 2 thousand kilometres of borders with the countries of the 'Golden Crescent' - Pakistan and Afghanistan, from which criminal drug groups transport drugs. An unstable economic situation in the countries of the Southern Caucasus provides the basis for the formation of a 'Golden' passage, which is the main means of producing (making and preparing) and transporting of heroin.²

Demography and Social Specificities

On 21 September 1991, after the collapse of the Soviet Union, Armenia declared independence and became a sovereign republic. Armenia is comprised of 10 administrative territories called Marzes. The capital city, Yerevan, has a population of 1.1 million people. The administrative territories are divided into 931 regions, with 47 towns, 12 urban settlements and 871 rural settlements, plus Yerevan. According to the National Statistical Service for 2005, there are 3.2 million people living in Armenia, of which more than 97% are ethnic Armenians. National minorities, which constitute 3% of the total population, are mainly Yezids, Kurds, Russians and Ukrainians. Urban centres are highly concentrated, with 64.1% of population living in or around cities.⁵

Demographically, there are 615,600 people aged 15-25 years. People aged 20-39 (956,300) are the most vulnerable to HIV. In this age bracket, 51.1% are women and 48.9% are men.⁶

Table 6.
Age groups of 15-24, allocation by gender per 1 000 population
(as of 1 January 2005)⁵

Age groups	Total	Men	Women
15-19	319.0	161.1	157.9
20-24	296.6	148.5	148.1

As in many of the European countries, birth rates are falling in Armenia, especially during the past ten years. However, unlike the other countries of the European part of the former Soviet Union, the natural growth of population in the country remains rather high. Consequently, mortality rate is rather low, and the population is relatively 'young.' The combination of a devastating earthquake in 1988, and the influx of thousands of refugees as a result of the conflict with Azerbaijan have had a direct impact on Armenia's demography.⁵

Health Status and, Disease Prevalence

Although the health is among the national priorities of the Government of Armenia, the lack of financial resources makes it difficult for the MoH to implement effective programmes to provide complete health coverage. However, the MoH sponsors in-patient treatment of tuberculosis, infectious diseases, syphilis and complicated forms of gonorrhoea as well as support to narcological clinics

Table 8.
Main indicators of the population health.⁵

Indicators	Figures
Life expectancy at birth (in years), 2003	
Total population	68.0
Men	65.0
Women	72.0
Child mortality (The probability of mortality of a child under 5) (per 1000), 2003	
Men	35
Women	31
Adult mortality (The probability of mortality of those aged 15-29) (per 1000), 2003	
Men	240
Women	108
Adjusted Life Expectancy at birth (in number of years), 2002	
Total population	61.0
Men	59.4
Women	62.6
Adjusted Life Expectancy at 60 years of age (in number of years), 2002	
Men aged 60	10.9
Women aged 60	13.3
Disability lost life years (years) 2002	
Men	7.6
Women	10.4
Percentage of total life expectancy , lost due to disability (%) 2002	
Men	11.3
Women	14.2

From 1988 to the end of November 2005, 375 HIV-infected individuals were registered in the Republic of Armenia; 356 of them are Armenian citizens. From January-November 2005, 71 new cases of HIV infection were registered, of which 68 were Armenian citizens. Of HIV positive individuals, 279 cases (78.4%) were men, and 77 cases (21.6%) were women. There are 6 cases of HIV infection among children (1.7%). The majority of the HIV carriers (76.1%) belongs to the age group of 20-39.

The main modes of HIV transmission in the RA are through injecting drug use (54.5 %) and heterosexual sex (37.6%). There are also registered cases of mother-to-child HIV transmission as well as through blood transfusions and homosexual practices.

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HIV Transmission Modes:

Transmission through injecting drug usage	54.5%
Transmission through heterosexual practices	37.6%
Mother-to-child transmission	1.4%
Transmission through blood	0.6%
Transmission through homosexual practices	1.1%
Unknown	4.8%

To date, 101 people have been diagnosed with AIDS, of whom 18 are women and four are children. Of those registered AIDS cases, 37 were revealed in January-November 2005. From the beginning of the epidemic, 76 death cases have been registered among HIV/AIDS patients, including 12 women and 2 children.

All the reported individuals infected via injecting drug use were men, and many had lived abroad for periods of time. The majority (70.2 %) of HIV positive individuals are male and contracted HIV through injecting drug use, whereas the majority of women were infected through heterosexual contacts (92.2 %).

The highest concentration of HIV-positive cases is in Yerevan: 177 cases, constituting 49.7% of all registered HIV cases. Shirak Marz has the second highest prevalence rates in Armenia, with 8.4 % of all the registered cases.⁴

Table 9.

STIs morbidity of the population (per 100,000 population by gender)⁷

Registration of new cases of syphilis						
	1999	2000	2001	2002	2003	2004
Men	11.5	6.7	6.5	3.9	4.1	4.3
Women	11.6	7.1	5.2	4.4	4.4	4.3
Registration of new cases of gonorrhoea						
Men	22.1	21.8	35.8	32.9	28.6	24.3
Women	26.2	25.9	16.7	29.1	18.4	7.7

Social Conditions

According to the National Statistical Service of RA, as of 1 January 2005, the population aged 10-24 is 910,600, or 28.3% of the total population.⁵ Economic recession, deepening social inequality and social vulnerability, deterioration of traditional values and high unemployment rates during the initial years of independence have worsened the living condition of all sectors of the population in Armenia, including those of the younger generation, lowering their living standards. Social services categorises people as 'not poor,' 'poor' and 'extremely poor,' based on income and living conditions

A study of key poverty indices shows that the 'not poor' population increased by 11.8% to 35.5% in 2003, compared to 1996, when it was 27%.

Table 10.
Dynamics of key poverty indicators, by %, as of 2003

<i>Age groups</i>	<i>Not poor</i>	<i>Poor</i>	<i>Extremely poor</i>
7-16	52.3	39.0	8.7
17-22	59.7	34.3	6.0
23-29	56.0	37.4	6.6

Economic stress and poverty directly affect education and health sectors, opportunities for employment and provision of housing for youth. These dynamics pose new challenges, such as increased unemployment, migration, trafficking, juvenile crime and the marginalization of certain groups of youth, making them more vulnerable to HIV.⁸

The labour market is unable to accommodate the population of legal working age. According to official data from 2004, 9.6% of the work force in the country was unemployed, as transition to a market economy has created high unemployment among adults and youth. In 2003, youth in Armenia made up 66.7% of the economically active population, and suffered the most from unemployment as an increasing number of unemployed young people are migrating from Armenia, and those who stay are increasingly engaging in risky behaviours.⁸

Due to insufficient knowledge and experience, job opportunities for youth are scarce, and youth do not participate in the formal economy in large numbers. Unemployment makes young people lose confidence in their own abilities and capacities, and gives them the impression that 'the system' can't take care of them. This filters into the general mentality among Armenia's youth, and has a negative impact on the whole society.

The growth in youth unemployment is attributed to:⁸

- Social and economic changes
- Lack of existing mechanisms to promote economic activities for youth
- Limited professional and economic opportunities and insufficient incentives, lack awareness among young people of existing economic opportunities
- Insufficient life skills of young people resulting in marginalization
- The existence of bureaucratic system, protectionism, corruption and bribery and lack of trust in government

Combined, these factors contribute to making young people highly vulnerable to engaging in risk behaviours that may result in HIV infection. This vulnerability underscores the need for targeted interventions designed to meet the specific needs of EVYP and MARA.

Family Structure

Traditionally, the family in Armenia has always played an important role in raising children. This role has weakened during the transition period, and is recognised by Armenians as being of great concern. Today, Armenian families face a changing society which has transformed the traditional rural family with many children into an urban one with fewer children or no children at all.

The average size of studied not poor families was 3.78%, while that of the poor families was 4.69% and the extremely poor were 5.29%. Families with children under five years old or with three or more children (0-14 years old) as well as multi-member families are more vulnerable to poverty. According to the same study, the extremely poor in the number of families with one child under 18 years old accounted for 3.9%, but increased to 7.9% with 2 children, to 11.8%, with three children, to 11.9% with four children, and to 33.3% with five or more children.⁸

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According to the 2001 census, the number of married people aged 15-30 was 242,710; the number of divorced young people was 10,215. Among those married, 82,401 were men, meaning that of all young men aged 20-30 only 33.9 % start a family before the age of 30.⁸

Despite the difficult socio-economic situation, the family continues to play an important role in children's upbringing. Respectfulness to the elderly has remained an Armenian cultural trait; parents still provide moral examples for their children; parents' opinion is still valued a child idealizes his/her parents, and aims to have a similar of his or her own family. Thus, the role of the family should not be underestimated while implementing future activities; it is necessary to broadly involve family members into planned activities.

Migration and Mobility

The last decade of fluid mobility has made Armenia vulnerable. According to the National Statistical Service, nearly 700,000 people migrated from Armenia from 1991-1997 constituting nearly 18% of total population. Of these, 59.5% were men and 40.5% were women.⁵ Estimates show that one out of four households has a family member who is an economic migrant, who is usually a male member of the household. These men usually go abroad for work, returning to Armenia periodically, in between jobs and on leave. Women with husbands and boyfriends working abroad are especially vulnerable to HIV/AIDS as many partners engage in irregular sexual contacts and drug use while abroad, and return to the RA on visits periodically.⁹ This trend of economic migration is motivated by poor socio-economic conditions in Armenia and the hope that other countries can offer greater opportunities for poverty relief.

In 2004, the RA experienced a 7.7% migration rate.⁵ HIV/AIDS is more prevalent in many of the destination countries for Armenian migrants. With increasingly fluid mobility for young Armenians, HIV is being contracted abroad and brought into the RA when migrants come home on visits. Perhaps less substantial, but relevant nonetheless is the increasing rural-to-urban migration and the inherent risk that comes with concentrated urban populations.

Surveys indicate that 43% of surveyed drug users began using while living abroad, 64% of which began while residing in the Russian Federation.² Emigrants often engage in behaviour that increases their risk of HIV infection, such as seeking the services of CSWs or using drugs, behaviours they would not necessarily engage in their home communities. Those working and/or travelling without legal documentation are at an additional risk for HIV infection because they can not access local preventive and health services. Even among those who are legally registered, health services are often difficult to access or are too expensive.

According to the results of surveys conducted among mobile populations in the RA in 2000:

- 31% of migrants use condoms consistently
- 38.3% reported having more than one sexual partner in the past year
- 11.5 % had used drugs, 2.6% of which had injected drugs
- 24.7% had a history of STIs²

Religion

Christianity is the main observed religion in Armenia, led by the Armenian Apostolic Church. In 1997, different religious and religious-charitable organisations were legally permitted to form, and more than 50 organisations representing 13 religions, have been registered in Armenia.¹¹

The role of the church in HIV/AIDS prevention is very important, as the church can promote safer behaviour concerning HIV and create a supportive environment for PLHIV. As a respected and increasingly influential social institution, the Armenian Church wields significant power in social and

political spheres. Currently activities are planned to include the church in HIV prevention. Religious leaders are well-positioned to promote abstinence before marriage, family fidelity and monogamy, preach against stigma and discrimination towards those affected by HIV/AIDS and conduct peer education among other church members/priests.⁹ This potential should be closely monitored and further explored.

Communication, Language, Education, Mass Media

The official language of the Republic of Armenia is Armenian, which belongs to the Indo-European family of languages. The literacy rate of adults as of 1997 was 98.8% and 60% of people aged above 16 have completed secondary education.⁵

Mass media is instrumental in forming public opinion and raising levels of awareness in the general population. Mass media can serve as a powerful tool for accurate, comprehensive HIV prevention and behaviour change. According to the Armenian Demographic Health Survey (DHS), conducted in 2000, roughly one in ten (160 of a total of 1,168) young women aged 15 - 19 years old reported that they had not heard of family planning programs in the media, nor had they discussed family planning with peers, medical personnel, or family members. More than 86% of those surveyed reported accessing information on family planning from one or more sources.

According to a 2005 Knowledge, Attitude, Practice (KAP) study conducted among young males in the military within the frames of UNDP/UNAIDS supported "HIV/AIDS and Uniformed Services" project, 62.1% of those surveyed indicated a lack of access to mass media. The specialists conducted the survey are of the opinion that the above-mentioned high rate is a result of receiving information from the mass media before drafting into the army.⁶

The Role of Man and Woman

In Armenian society the influence of women's role and status with regards to HIV/AIDS is broader than the existing health care system accounts for.⁹ This issue is connected to women's rights and benefits, particularly given the existing gender stereotypes. In any society gender relations are displayed in the family and accordingly, in the public sphere. In traditional Armenian society female and male gender roles were conditioned by a family community, in which the role of women was rather limited and unequal. This was especially true of young women, and visible in prohibitions in their behaviour, and overall subordinate position.⁹ In "Domestic Violence in Armenia" the authors argue that in Armenian traditional society, prohibitive attitudes towards and pressures placed on women by the community and elder family members was theoretically constructed as a positive function regarding family that created a double position for a woman¹².

An Armenian woman's health and safety are largely dependent upon her sexual partner's will. The majority of HIV-positive women were infected not through casual sexual intercourse or drug usage, but through sexual relations with their regular sexual partners. Whether or not a woman becomes infected does not just depend on her lifestyle, the number of her sexual partners, or her 'moral principles' — her level of exposure to HIV is largely affected by her limited ability to negotiate for condom use with her sexual partners. Contrary to the belief of many Armenian women, marriage or a long-lasting monogamous relationship do not guarantee protection of women from HIV infection. The results of DHS survey in 2000 show that only 7% of married couples used condoms during their last sexual intercourse, usually to prevent unplanned pregnancy. Low levels of condom use by married couples, combined with high levels of married male migrants, places married women at great risk for HIV infection. According to the same source, if the husband or sexual partner has a sexually transmitted infection — which increases vulnerability to HIV — more than 21% of women and 27% of men do not think that a woman is justified in refusing to have sexual intercourse or insisting on condom use with the man.¹³

These factors must be considered in determining appropriate interventions for young, often unemployed women. In particular, interventions should be aimed at reducing the vulnerability of girls/young women and boys, and promotion of equal gender roles.

Political Structure

The Republic of Armenia is a multi-party, independent democratic state. The State is charged with protecting human rights and independence based on the constitution (adopted in July 1995) and legislation, in accordance with international legal norms and standards. Legislative power rests with the National Assembly, and executive power belongs to the Prime Minister and various ministries. Governmental decrees are adopted by the Prime Minister and ratified by the President. Judicial power is headed by the Constitutional Court.⁶

Health Care Services

The health care system in Armenia has suffered due to lack of State financing. Schools have also been neglected, with some schools posing risks to children's health. Many schools have poor sanitary conditions with broken toilets, no heating, smoking in the classroom and present an unhealthy environment for children.

Over the last ten years, clinic visits and hospital utilization rates have decreased dramatically in Armenia, mainly due to the financial constraints of health care users. In 2003, an average attendance to health facilities, which provide outpatient and dispensary medical aid dropped to 120 clients per shift, per 10,000 population.⁸

There has been no large-scale epidemiological surveillance in recent years in Armenia. There is some data available on non-infectious diseases and conditions, which indicate that 60% of people under the age of 18 suffer from ailments directly traceable to unhealthy lifestyles and poor environment. Bad habits and a bad environment combined with the fact that there is no strategy for addressing the health concerns of young people in Armenia leave them highly vulnerable to health problems.⁸

Together, these factors contribute to a steady rise in morbidity and mortality rates among young people. Of equal concern is the fact that, according to assessments, Armenians do not seek health services until they are already very ill.

Results of a UNFPA-sponsored survey carried out among youth in Yerevan and the region of Ararat in 2001-2002 show that access to sexual and reproductive health services for young people is very limited. The majority (80%) of survey respondents had never sought counselling or health services in their young adult lives. Access is especially hampered for those young people who do not earn their own income, such as students, orphans, teenagers living or working on the streets, unemployed youth and the like.⁸

Maternal and child health and family planning/abortion services are not accessible to young people. Unmarried youth and married adolescents tend not to access health services before they become pregnant for the first time. Moreover, health care providers often lack special training or appropriate experience to properly provide services on sexual and reproductive health for adolescent boys and girls. Training is needed in order to ready health service providers to facilitate access and proactively provide services to this population.⁸

Young people have limited access to facilities providing counselling services on family planning and STIs including HIV/AIDS. Additionally, cultural stigma associated with sexuality and sexual activity among adolescents blocks young people from seeking the services they need.⁸ In part, this is due to the lack of strategy on the part of health service provider to young people.

Contraceptives, including condoms can be purchased in pharmacies, but for many people, and especially for adolescents, they are unaffordable. In this situation, sexually active young people are at a greater risk of unwanted pregnancy, induced abortion, STI/HIV infection, on top of the associated social and health consequences of engaging in unprotected premarital sex. According to reports from the Ministry of Health, the number of unplanned pregnancies and STI cases among adolescents has significantly increased over the recent years.⁸

The government-funded Basic Benefits Package (BBP) is now being reformed and will include adolescent health care services, PMCT, reproductive health services and provision of medical care to women and children.

National Programme on HIV/AIDS Prevention. Strategies and Activities Currently Implemented within the National Programme on HIV/AIDS Prevention

The process of national strategic planning to address and prevent the spread of HIV/AIDS began in the Republic of Armenia in 2000, with the support of UNDP and UNAIDS. In December 2000, a National Strategic Plan for HIV/AIDS prevention was developed and response analyses were approved by the Ministry of Health. Based on the Armenian National Strategic Plan, the National Programme on HIV/AIDS Prevention was developed.

Prior to 2002, HIV/AIDS prevention activities in Armenia mainly targeted awareness-raising in the general population. The response to the HIV/AIDS epidemic was inadequate, and the fight against the epidemic was ineffective. This failure is attributed to the lack of multisectoral response and poor inter-ministerial coordination at the national and Marz levels. Inadequate funding considerably restricts opportunities for effectively responding to the HIV/AIDS epidemic.

In response, a project to support the National Programme on HIV/AIDS Prevention was developed with UNDP, and approved by the GFATM for financial support. The project proposal was approved by the GFATM Secretariat in the amount of US\$7.2 million for a period of five years.

In April 2002, the National Programme on HIV/AIDS Prevention was launched to ensure an effective multisectoral response to HIV/AIDS epidemic and to reduce the spread of HIV/AIDS in Armenia. As part of the National Programme, a National Inter-ministerial Council on HIV/AIDS Prevention was formed. In response to the UNAIDS 'Three Ones' Key Strategies to enhance the coordination and monitoring of established HIV/AIDS prevention activities, on 26 April 2002, the Country Coordination Commission on HIV/AIDS Prevention (CCM) to safeguard a multisectoral response to the HIV/AIDS epidemic. Additionally, the CCM helps to determine the priorities of on-going strategies for the prevention of HIV/AIDS and to distribute and monitor the expenditure of GFATM funds.

In 2005, the CCM enlarged its scope of activities to encompass issues related to tuberculosis and malaria.

The CCM's main goals are to:

- Coordinate HIV/AIDS, TB and malaria-related activities implemented by governmental, nongovernmental and international organizations, as well as the private sector and civil society;
- Identify priorities for scientific research on HIV/AIDS, TB and malaria;
- Ensure prevention, diagnosis and treatment of HIV/AIDS, TB and malaria;
- Develop multisectoral HIV/AIDS, TB and malaria preventive activities;
- Ensure wider participation in HIV/AIDS, TB and malaria prevention activities of NGOs, people living with HIV/AIDS, TB and malaria and people affected by the epidemic including community representatives, international organizations and private sector;
- Integrate the Ministries, Governmental Departments and Regional Administrations in responding to the HIV/AIDS epidemic; and,
- Carry out monitoring and evaluation of HIV prevention activities.

The GFATM approved the CCM's proposal for *World Vision-Armenia* to be the Principal Recipient for these funds.

The National Programme on HIV/AIDS Prevention aims to:

- Reduce HIV/AIDS prevalence among different populations
- Improve living conditions for PLHIV and integrate them into society
- Improve the quality of public health activities and services
- Ensure the expansion of collaboration between NGOs, the private sector and Government
- Build the capacity of the educational system relating to the introduction of special education programmes
- Ensure sustainability of mother-to-child transmission prevention
- Reduce and mitigate the negative psycho-social impact of the epidemic.

Peer Education Projects among Youth

Since 2004, APEC has implemented peer education programmes for youth. APEC has vast experience working with youth through various preventive programmes with IDUs, as well as implementing activities among the general population and PLHIV.

The peer education programme aims to reduce the prevalence of HIV/AIDS among youth. The programme is aimed at raising awareness on HIV/AIDS and forming responsible behaviour and safer sexual behaviour (fidelity, monogamy, abstinence, delaying first sex), establishing counselling and peer education systems among students of secondary schools and higher educational institutions and young people outside the formal educational system, as well as those who do not work. The project is being implemented in 200 educational institutions in Yerevan and the Marzes. During the two years of programme implementation to date, 2,100 peer educators have been trained and re-trained. Meetings have been organized with schoolteachers, lecturers and peer educators, and information/education materials and condoms have been provided to young people.

In 2005, UNICEF supported APEC, to organize a summer school for peer educators made up of students from schools in different Marzes. Courses focused on issues surrounding HIV/AIDS prevention, stigma, discrimination, care and support to people living with HIV/AIDS and were intended to further improve peer education efforts.

Harm Reduction Projects among IDUs

APEC joined with other organizations to implement two harm reduction projects for injecting drug users in Gyumri (Shirak Marz) and Yerevan cities. An additional project is being implemented by Kapan State Medical College among IDUs in Kapan city, Syunik Marz. These organizations have vast experience working with different groups through various preventive programmes, as well as among IDUs.

These projects aim to reduce HIV/AIDS prevalence among IDUs in Yerevan, as well as in Shirak and Syunik Marzes. The projects aim to form safer behaviour among IDUs by providing accessibility to condoms and clean injecting equipment and VCT services, and establishing a trustworthy and confidential environment among IDUs. During the two years of project implementation, trained outreach workers, peer educators and project staff undertook a full complement of preventive activities among IDUs, and trained VCT specialists provided counselling to IDUs. Among these activities, needle exchange, condom distribution and information/educational materials were carried out. IDUs were also provided with STI treatment through this project. Finally, one self-help group was formed in each Yerevan, Kapan and Gyumri cities.

HIV/AIDS Prevention Projects among CSWs

Since 2004, a highly specialised group of organisations have been implementing harm reduction and HIV/AIDS prevention projects to benefit CSWs. The *AIDS Prevention Union* in Yerevan and Abovyan, *Hope and Help* in Vanadzor city, *Family Benefactor* in Gyumri city, the Gavar State Medical College in Gavar and Vardenis, and the Kapan State Medical College in Kapan and Agarak carried out HIV/AIDS preventive activities in various populations groups, in particular – among CSWs. Projects aim to form safer behaviour among CSWs by providing accessibility to condoms, VCT services and building trust in CSWs towards service providers.

During implementation, outreach workers, peer educators and project staff were trained in preventive activities targeting CSWs. VCT specialists and STI treatment were made available, condoms and information/educational materials were distributed within the framework of the projects. Self-help groups for CSWs were established in Yerevan, Abovyan, Gavar and Vardenis.

HIV/AIDS Prevention Project among MSM

Since 2004, one project has focused on MSM, implemented by *Education in the Name of Health* in Yerevan. This NGO has extensive experience and has successfully established trusting relationships with beneficiaries from this socially ostracised group. Trust is the cornerstone of any effective HIV/AIDS prevention activities among this marginalised population.

By supporting MSM to form safer behaviour and providing accessibility to condoms and VCT services, this project aims to reduce HIV/AIDS prevalence among MSM. Since the start of the project, the project team, outreach workers, peer educators and VCT specialists have been trained to implement preventive activities among MSM, and have distributed condoms and information/educational materials.

Peer Education Projects in the Military

In 2004-2005, a peer education programme was implemented by the Goris Youth Union aimed at reducing HIV/AIDS prevalence within the military in Syunik Marz. This project raised awareness on HIV/AIDS and supported the formation of responsible and safer sexual behaviour (fidelity, monogamy, abstinence, and delaying first sex), by setting up counselling and peer education systems with the military. During the two years of programme implementation in ten military units within Syunik Marz, peer educators and VCT specialists were trained and carried out condom distribution and dissemination of information/education materials to members of the military. To contribute to sustainability, a training of trainers among military doctors was undertaken within the framework of the GFATM-supported National Programme on HIV/AIDS Prevention. The major success of this programme occurred in November 2005, when the RA Ministry of Defence incorporated HIV/AIDS peer education into its official educational programmes for the military educational institutions.

Harm Reduction and Peer Education Projects in Prisons

Since 2004, the Criminal-Executive Department of the Ministry of Justice of the RA has implemented an HIV/AIDS prevention and harm reduction project for prisoners in three penitentiary institutions. Peer education has been introduced in all three penitentiary institutions. The programme aims to reduce HIV/AIDS prevalence by forming and strengthening safer behaviour by providing accessibility to condoms and providing VCT services, as well as establishing a trusting environment between individuals in penitentiary institutions and service providers. Health care providers working in penitentiary institutions were been trained to provide VCT services to convicts and staff in penitentiary institutions. Condoms, disposable syringes and information/education materials were provided to programme beneficiaries.

In the first year of implementation, one harm reduction project was piloted in the Erebuni Criminal-Executive Institution. Two more harm reduction projects were implemented during the second year in the Kosh and Vanadzor Criminal-Executive Institutions. Peer education programs have been conducted among the staff of target Criminal-Executive Institutions and individuals in all penitentiary institutions nationwide. Project staff members have been trained for effective implementation of preventive activities among convicts.

During the second phase of implementation of the GFATM supported National AIDS Programme, activities have been implemented in Criminal-Executive Institutions through these new mechanisms. One of the main successes of this programme is that, in November 2005, the RA Ministry of Justice incorporated peer education and other HIV/AIDS prevention-related issues into its annual education course for staff of Criminal-Executive Institutions.

Integration of HIV/AIDS Preventive Projects in Secondary Schools and Higher Educational Institutions

In 2004, a project to integrate HIV/AIDS prevention programs into the curricula of secondary schools and higher educational institutions to reduce prevalence among youth was implemented by the *Scientific Association of Medical Students of Armenia (SAMSA)*. Since 1996, SAMSA has carried out various programmes and activities to raise awareness in the general population and among youth, in order to further prevent the spread of HIV/AIDS. The project develops and integrates HIV/AIDS prevention programs into the educational programmes of secondary schools and higher educational institutions, undertakes information/education campaigns and provides condoms and information/educational materials.

Mass Media Awareness-Raising Campaigns

In 2004-2005, information campaigns were conducted within the framework of two projects implemented by *SAMSA* and *Health Care, Statistics and Education*. The programme aims to reduce HIV/AIDS prevalence among youth by raising awareness on HIV/AIDS-related issues and building relevant preventive skills. During the two years of project implementation, 7 information campaigns targeted the general population, and 10 information campaigns were aimed directly at raising HIV/AIDS awareness among youth. As a result, a number of articles on HIV/AIDS-related issues have been published in the newspapers issued in Yerevan and Marzes, and awareness-raising website has been created. Condoms and information/education materials have been distributed during the project implementation. Impressively, number of HIV prevention-themed TV and radio programs has been broadcast by one Yerevan-based TV company, and in all of the Marzes.

Care and Support to People Living with HIV/AIDS

Since 2004, *Real World, Real People* has implemented a project to provide care and support to people living with HIV/AIDS (PLHIV) in Armenia. During the two years of project implementation, specialists have been trained for providing care and support to people living with HIV/AIDS. PLHIV have been provided with social supports, psychological and legal counselling. An Information Centre has been established to provide information and counselling support to 129 PLHIV and their family members; the Centre also serves as the premises for two self-help groups for PLHIV.

VCT and Youth-Friendly Health Services

As is the global trend, in Armenia, unmarried young people often do not seek support from health care institutions regarding their sexual and reproductive health. Generally speaking, such services are not considered by young people to be youth-friendly. According to surveys, the main obstacles

for young people to accessing services are: lack of information, embarrassment, fear of pain, complications and side effects, cultural and psychosocial barriers, and lack of availability and statutory protections.¹⁴

Lack of information: Unmarried adolescents often believe that reproductive services are not designed or intended for them, or they are unaware that such services are available. Young people often do not fully understand the changes and needs of their adolescent bodies; many are unaware of how to protect themselves from unwanted pregnancy, STIs and HIV infection, as well as how to detect symptoms if they are exposed, and are therefore unaware that they need help. Very often, adolescents are not informed of the types of services available, and do not know where and how to access information and care.

Fear of pain, embarrassment: Health care facilities can be very intimidating to adolescents, who may associate medical care with pain, fear and suffering. Moreover, they are convinced that health care providers may embarrass them for not having protected themselves or for having engaged in risk behaviours.

Cultural and psychological obstacles: Confidentiality and privacy issues are of key concern to adolescents when it comes to their sexual and reproductive health. Girls are often embarrassed to discuss issues of reproductive and sexual health, since they are afraid of being judged, and as a result of cultural taboos towards pre-marital sex. Young males usually do not speak about sexuality for fear of sounding naive and inexperienced.

Limitation due to state policies: Very often, the legislative and regulatory acts dealing with young people's sexual and reproductive health are not clearly stated. Despite statutory provisions that should provide access to health services for young people, in practise, great barriers remain in place.

Operational obstacles: As a rule, adolescents in Armenia do not work or have independent access to funds. Therefore, the cost of health care can be prohibitive for a young person, especially if they are seeking care for a sexually transmitted infection and their parents do not know that they are sexually active.

The frequency with which young people access sexual and reproductive health service range, and differ significantly, based on location. Societal and cultural norms are also determinants of accessibility and availability.¹⁴

In 2005, PAFHA was assisted by UNICEF to organise and provide a training of trainers on peer education for Youth-Friendly Health Services in Yerevan and in Aragatsothn, Gegharkunik, Lori, Shirak and Syunik Marzes. These trainings were based on a Youth-Friendly Health Services (YFHS) concept paper, developed by public health specialists, and approved by the MoH. The VCT system was established in Yerevan and the country regions in 2004 – 2005, with 135 VCT sites providing services within health care institutions and in international NGOs. These sites provide voluntary HIV counselling and testing services to the general population as well as to those most vulnerable to HIV infection. It is recommended that integration of VCT sites and Youth Friendly Health Services be included in the Strategic Plan on HIV/AIDS Prevention among EVYP and MARA.

Educational System

In Armenia, general education is designed to provide a comprehensive and harmonious development of the mental, moral, physical and social capabilities of students and the formation of appropriate attitudes and behaviours. Currently, secondary general education is provided through 1,323 state schools, 36 colleges and 26 vocational schools throughout the RA, educating 501,886 pupils in schools, 49.3% of which are girls. However, the number of students has decreased by 14% since 1991 and continues to decline as a result of low birth rates and migration.¹⁵ This decrease in school

attendance is an emerging area of concern, which can be traced to declining social conditions. The result of challenging socio-economic conditions is that the majority of older students are girls, partly due to the migration of young men, and partly due to boys leaving school, usually to help their families. In addition to state schools, 33 private schools serve 3,436 students, and some 50,000 young people graduate from Armenian secondary schools every year.

Children with special educational needs, including children deprived of parental care and gifted children, are catered to by special educational institutions (boarding or extended-day) that implement general and special education programmes. Presently, of the 54 public boarding schools, 41 are for children with physical and mental disabilities, 5 are for children deprived of parental care or for children from socially vulnerable families, and 8 are for gifted children. A total of 10,585, or 52 % of all children, are enrolled in residential boarding schools where they receive special education services. Enrolment in these institutions increases steadily, mainly as a result of an increase in number of children from socially vulnerable families.¹⁵

Education is part of Armenian national pride and priority, and there is a long history of Armenians valuing literacy. School has always been at the heart of the nation's political and cultural identity, and serves as an incentive for national progress. According to the Constitution of the Republic of Armenia (1995), every citizen is entitled to state-sponsored education. Secondary education in public schools is free, and every citizen has the right to higher and professional education. One of government's top priorities is developing and reforming the educational system and ensuring its compatibility with international standards. In June 2001, the National Assembly approved the State Programme for Educational Sector Development for 2001-2005, the main goal of which is to ensure the progressive development of education, and to support socio-economic development of the society as a whole.

According to the Poverty, Education and Economic Activities survey (PEEA, 2002) 6% of children aged 7-16 and 7% of extremely poor children do not attend school. The survey has also revealed that 43-48% of young people do not continue their education after completing high school, due to the lack of financial means. It is anticipated that those who do not continue with their education will be unable to find employment, and will constitute the growing population of unemployed poor.⁸

The Armenian *Law on Medical Aid and Services*, states that everyone, including adolescents, has the right to receive information on issues of sexual health protection, including risks associated with HIV and other STIs. According to the *Law on Education*, secondary school education includes a focus on healthy lifestyles, natural and global sciences, and preparation for carrying out independent activities.¹⁵

Health education is an integral part of the secondary education curriculum. To graduate secondary school, a student must be able to:

- understand and practice healthy lifestyles and safer behaviour;
- be aware of his/her rights and obligations
- have his/her thinking, to be able to act in different situations
- express mutual understanding and be able to cooperate
- realize the necessity of starting family, be prepared for domestic life
- be able to adequately evaluate his/her capacities and be self-confident

In 1999, a *Life Skills* course was introduced in grades one through seven for pupils aged 6-13, in 384 secondary schools in Armenia. The course promotes the concept of individual awareness and social responsibilities. This is the first programme in the State curriculum that takes culture into consideration in addition to academic knowledge, and which tries to establish a shared system of values. The *Life Skills* curriculum addresses sex education by covering sexual hygiene, HIV prevention, delaying sexual activity and preventing unwanted pregnancy.¹⁵

Within the framework of the National Programme, a *Life Skills* course on HIV/AIDS prevention and the formation of safer behaviour targets secondary school pupils in grades eight and nine, aged 14-15 years. The course covers sex education, HIV/AIDS prevention and drug abuse prevention, delivered through 24 lessons.

Through *Life Skills* courses, youth are educated on the consequences of alcohol use, smoking, drug use, violence, HIV infection and STIs. The course also covers the impact of unplanned pregnancy which often leads to the pursuit of unsafe and illegal abortions, presenting huge health risks for women. By providing young generations with the knowledge to protect themselves and pursue healthy lifestyles, and the skills to withstand peer pressure and make informed decisions, such health risks can be confronted.⁹ Through these interventions, teenagers are trained on negotiation skills, and are better able to navigate social norms and behave in ways which both protect them and allow them to flourish.

Prior to the introduction of *Life Skills* and other safer behaviour interventions, discussing sex with teenagers was taboo. Now, the traditional belief that sex education promotes sexual activity has been proven false, as teenagers exposed to these courses enter into sexual relations later, and practice safer sexual behaviours. More and more, young people are able to withstand peer pressure, and negotiate their own terms of sexual activity. The positive outcomes clearly demonstrate the need for frank and open discussion and educational interventions with adolescents and young people.

Drug Use and Injecting Drug Use

Conceptual evaluation

The Republic of Armenia is not considered a major drug producing country and the local consumption of drugs is lower than those in the neighbouring countries. Currently, the limited transport flow between Armenia and its neighbours makes Armenia a secondary drug route for illegal trafficking. The borders with Turkey and Azerbaijan remain closed, but there are reports that heroin and opium are smuggled to Armenia from Turkey through Georgia. It is possible that once the borders are opened, drug trafficking will significantly increase, however, the situation remains stable and there are no known organized drug groups or active criminal gangs.¹⁶ However, the surveys conducted within the framework of the Rapid Assessment and Response on HIV/AIDS among EVYP and MARA revealed an increase in drug use in Armenia, and suggests that this is due to available, inexpensive drugs, combined with social problems such as unemployment and high rates of migration.

1. Availability and Accessibility of drugs

"The geographical location of our country is of importance: our borders are transparent, demand is great, and the amount of smuggled in drugs is increasing day after day"(from an interview with service providers)

According to official data, the amount of drugs seized by law enforcement is also increasing: in 2003 7,932.1 grams of marijuana was seized, 58,415.93 grams in 2003; 310.108 grams of heroin was seized, in 2003; 1,010.666 grams in 2004; 106.57 grams of hashish was seized; in 2003, 1,171.42 grams in 2004; no cocaine was seized, whereas in 2004, 943.8 grams of cocaine was seized.¹⁶

Table 11.
Types of drugs seized in the Republic of Armenia in 2002-2004

Type of drug	2002 (in grams)	2003 (in grams)	2004 (in grams)
Marijuana	76,083.695	7,932.1	58,415.93
Hashish	84.75	106.57	1,171.42
Cocaine	0	0	943,8
Heroin	175.293	310.108	1,010.666

2. There is insufficient media coverage on drug use to make an impact on prevention.

3. Social problems

4. Unemployment

Based on official data from 2003, the overall unemployment rate in the country was 10.1, with a rate of 2.8 among young people aged 16-30. Compared to the number of drug users and persons committing and convicted of drug-related crimes, it can be concluded that 80% drug users are unemployed and belong to the 25-50 age group, and drug-related crimes are committed by unemployed men.

5. High rates of migration

'The high rates of migration fuel the spread of drug use and HIV infection among youth: on the one hand, injecting drugs (especially heroin) are cheaper in Armenia, on the other hand they are afford-

able abroad, since the earnings there are also higher than in Armenia. That is why the majority of HIV-infected drug users and injecting drug users are those who lived outside Armenia permanently or temporarily.' (from an interview with service providers).

6. Age characteristics of adolescents

'Adolescents face the problem of self-confidence, and that is why they use drugs.' (from an interview with service providers)

7. Accessibility of new kinds of drugs

'Drug use is increasing, previously-used drugs of choice, such as opium and cannabis continue to be used, and at the same time new synthetic drugs such as LSD, ecstasy, Subutex have appeared.' (from an interview with service providers)

Drug use is mainly concentrated in major cities, particularly in the capital. The population in the Marzes in most cases consume locally-produced drugs based on hemp, cannabis, marijuana or hashish. Inhabitants of big cities often consume opium-based drugs, which have not been widely spread throughout Armenia, although recent trends indicate that this may be changing. Heroin and opium are smuggled into the country mainly from neighbouring countries via vehicles, whereas cannabis-type drugs are cultivated and consumed locally.¹⁶

Seized drugs consist mainly of marijuana, hashish, opium and heroin. In Armenia, marijuana is consumed mainly by people of middle age. Use of synthetic drugs such as ecstasy in nightclubs or other places of entertainment has never been reported.¹⁶ According to the RAR surveys, use of drugs in nightclubs was common in the 1990s, but has since declined in popularity.

The analysis of the results of the survey among IDUs shows that their mean age of first illegal drug-use is 17.6 years. Forty percent of those surveyed used opium, 4% - 'chernyashka' (a type of opium), 4% - ephedrone, 44% - hashish, 8% heroin. 36% of the respondents had their first injecting drug experience in Armenia, 36% in Russia, 16% in the Ukraine, and 12% in other countries (two individuals in Poland, one individual in Turkmenistan). The table below shows the distribution of IDUs by age at first drug use.

Table 12.
Distribution of IDUs by age at first drug use

Age at first drug use (years)	Absolute number	%
10-14	1	4
15-19	17	68
20-24	7	28
Total	25	100

The mean age of first experience of non-injecting drug use among surveyed DUs is 15.6 years. Eighty percent used hashish, 6% used codeine, and 14% sniffed glue. For 62% of the respondents, their first drug experience took place in Armenia; for 22% in Russia, 10% in the Ukraine and 6% in other countries (one individual in Moldova, two individuals in Georgia). The table below shows the distribution of first non-injecting drug using according to age groups.

*Table 13.***Distribution of first non-injecting drug using according to age groups**

Age at first drug use	Absolute number	%
10-14	19	38
15-19	27	54
20-24	4	8
Total	50	100

The mean age of first drug use among DUs is 15.6, and among IDUs – 17.6 years. Thus, there is a strong argument to be made for aggressive primary prevention interventions targeting EVYP and MARA.

The service providers indicate that in Armenia, 70% of drug addicts smoke their drugs, and 30% inject them. The use of drugs is under control (is preventable) in RA, since there is exact statistic on quantity of drug import to the country and to the region by big producers.

In Armenia, adolescents are absolutely not involved in the illegal drug trafficking, in particular, in manufacturing, transport or trade. The minors' involvement is incomparably low: during the past five years, the number of reported cases of minors' involvement in illegal drug trafficking has not exceeded four¹⁶.

There were no criminal cases of drug use among adolescents registered in the 2004 official statistics. However, the surveys conducted for the RAR indicate that drug users themselves believe that narcotic drugs have become affordable and are commonly used by adolescents. Interviews and focus group discussions have shown that some young drug users know up to 25-30 other injecting drug users.

According to experts, there is a great demand for drugs in the country and the number of drug users has increased. Drug users have become younger and belong to different sectors of the population. There is an increase both in the use of hard injecting drugs and of soft drugs: during the past 5 years, the increase in heroin use has been observed.

According to official data, the prices for drugs on the black market are fixed. One gram of heroin costs USD 120-150; one gram of opium - USD 25-35, one gram of marijuana - USD 1.5-2 and one gram of hashish US\$5.13 The data obtained as a result of the surveys conducted and interviews conducted among IDUs also confirm the above mentioned.

According to service providers, there is a group of drug users among the high-income population using so-called 'safe' and 'easy-to-use' drugs, such as Subutex or Methadone. Usually, these are businessmen, children from well-off families and others who prefer using 'clean' drugs over 'street' drugs. Since heroin and other drugs are not always clean, they use synthetic drugs. Among this group there is an opinion that high quality drugs may even help them to quit drug use.

The National Programme on HIV/AIDS Prevention envisages the following strategies to reduce the spread of HIV/AIDS among injecting drug users: reducing drug availability, providing harm reduction activities for non-medical drug use, although substitution treatment is not envisaged, and providing primary and advanced prevention of drug use. To implement these strategies it is necessary to:

- Strengthen relevant state organizations' control over illicit drug production, transportation, storage and illegal trafficking;
- Raise HIV/AIDS awareness of IDUs to form safer behaviour;
- Establish self-help groups to develop and introduce pilot needle exchange projects;

- Introduce and develop the system of sentinel epidemiological HIV surveillance in a target group of injecting drug users; and,
- Raise awareness on drug prevention among the general population through the mass media to develop and introduce drug use prevention issues into the education programmes; to provide peer education, to build a rehabilitation system for drug users.¹⁷

Though the National Programme envisages activities targeting young people outside the formal education system and those who do not work, it has no specific strategy for reaching IDUs or other MARA communities.

On 10 February 2003, the President of the RA ratified the *Law on Narcotic Drugs and Psychotropic Substances* adopted by the National Assembly in December, 2003. The law defines the legal basis for the national policy on the prevention of trafficking drugs and psychotropic substances as a means to ensuring the health of the citizens and security of the state and society. The law also defines the main strategies to combat drug addiction. The amended Criminal Code of the Republic of Armenia, adopted in 2003, envisages more strict liabilities for drug use and engaging in illicit drug trafficking. Under the new law, the use of drugs without a medical prescription is considered a criminal offence (the previous Criminal Code of RA provided only for administrative liability for similar actions). Possessing of small amounts of narcotic drugs can also be criminally prosecuted.¹⁶

According to amendments to the legislature adopted on 9 July 2003, a person may be held criminally liable for minor trafficking of narcotic drugs and psychotropic substances or their equivalents, as well as for non-adherence to regulations on the turnover of drug-related tools and equipment. Any of the above-mentioned violations made in leisure spots such as night clubs, constitutes aggravating circumstances. Drug addiction treatment is provided free of charge and covered by the state budget.

During interviews and focus group discussions with drug users, there was a commonly-held belief that: *"A drug addict is a patient, not a criminal and only those engaged in drug trafficking should be brought before the court."*

The service providers believe that liberalization of laws regulating drug use and trafficking is not acceptable. In particular, they believe that it is necessary to apply more severe punishment to those dealing with illicit drug trafficking, rather than treating them with more leniency. Those who use drugs episodically and are not addicted should not be forced to mandatory treatment, but they should be provided with relevant counselling, medical examination, treatment and appropriate rehabilitation, according to drug users.

According to the service providers, there should be a harmonized legal package for drug users. The existing law envisages mandatory treatment for drug addicts. At the same time it states that psychotropic substances should not be administered during the treatment, whereas effective treatment cannot be provided without administration of psychotropic drugs. According to the specialists taking immediate strict measures against those who have just started using drugs is not appropriate, since firstly, it will not prevent further usage and secondly, it might push a drug user 'underground,' and make them afraid to seek medical assistance. The service providers share the viewpoint of the service providers regarding the necessity to take strict legal measures against those engaged in drug trafficking.

It is recommended that a legal framework analysis be undertaken to better understand obstacles to optimal treatment of drug users. This will allow improved accessibility of medical services, especially for MARA.

Health and Social Consequences

The state policy on drug addiction came into force through the 2004 Annual Health State Target Programme to combat diseases with social significance, such as alcoholism and drug use. The goals of the programme are to ensure prevention and early detection of diseases having special social significance, to organize medical care and monitoring for patients and to raise awareness on healthy lifestyles and proper hygiene among the target population.

In Armenia, only institutions licensed by the Ministry of Health can provide narcological medical aid and services. Drug addicts receive treatment mainly at the Narcological Clinic of the Psychiatric Centre of the MoH (about 90 % of those provided with treatment) and some receive treatment at Gyumri Mental Health Centre or Vanadzor and Kapan Neurological and Psychotherapy Dispensaries, where there are several beds. The Organisational and Methodological Units has two 25-bed general narcological units, one 10-bed emergency narcology unit, one 10-bed narcological research and expert examinations, one follow-up unit (outpatient medical care and services) and one toxicology and chemical laboratory in the Narcological Branch of the Psychiatric Centre of the MoH, and the number of working places has increased from 78 to 115.¹⁶

Inpatient and outpatient medical services are available for drug addicts. The treatment regimen is chosen by the attending physician, taking into account the stage of addiction and the preferences of the patient. No substitution treatment is provided in the country yet. As of 1 December 2005, a total of 138 VCT sites functioned, whereof five were focused on IDUs.⁴

During the year of 2004, 538 visitors were registered and taken under 'preventive control' at the Narcological Clinic of the Psychiatric Centre of the MoH (last year the number of visitors was 549). The allocation of the visitors according to type of used drug is given below (data from 2003-2004):

Table 14.
Allocation of patients according to type of drug used (data of 2003-2004)

	Cannabis group	Opium type drugs	Ephedrine group
2003	466	55	28
2004	409	121	8

Out of the registered 538 individuals who received in-patient care in 2004, 248 live in Yerevan, and 290 came from different rural regions (in 2003 during the same period, the number of those residing in the capital was 224 and in Marzes was 325). Of opium-users, 98 individuals were from Yerevan and 23 were from different Marzes. It can be observed that hard drugs are abused mainly in the capital, and cannabis drugs are more popular in the Marzes. In 2004, opium-based drug had become very common; in comparison with the same period of 2003 it had increased about twofold. The majority of drug abusers are between 25-45 years old; drug abuse is uncommon among minors. In 2004, 9 men and 1 woman received primary drug abuse treatment (in 2003 three patients received the treatment: one woman and two men). Of those patients provided with treatment, four patients belong to the 25-35 age group, 4 to the 35-45 age group and 2 are older than 45.¹⁶ Official data do not indicate the circumstances under which IDUs sought these health care services.

Over the recent years, the demand for drug abuse treatment has been very low, and according to health sector specialists, only 1% of drug addicts apply to the relevant health care institutions. As a rule, registered drug addicts belong to the 20-39 age group; 66.2% are unemployed, and the rest are employed sporadically.¹⁶

Analysis of the surveys and focus group discussions show that many drug addicts have health prob-

lems, but they do not seek care, due to fear based on past experiences, others are afraid to seek medical care because they fear being arrested as drug users; others lack information about appropriate health care.

Service providers also report that the number of drug addicts receiving care in health institutions is much less than those in need of treatment.

Particular attention should be paid to hidden, underground groups of injecting drug users. Outreach activities should be strengthened, as current programmes do not target drug users from lower-income groups, among others. This is evidenced by the number of visitors to the Narcological Branch of the Psychiatric Centre, which has increased in recent years with mainly upper and middle class patients, while socially vulnerable groups, who by definition may be more at risk for HIV/AIDS, are underrepresented. Priority should be given to providing support, treatment and integration for these socially vulnerable groups.

Current procedures for registration and reporting deaths do not enable proper tracking of deaths resulting from overdose. It is, however, possible to register deaths from AIDS or other infectious diseases. While there is likely a strong link between non-sterile injecting practice and HIV infection.

Out of 6,315 recorded crimes in 2003, 356 crimes were drug-related. Most drug-related crimes were committed in the capital city, border regions (Shirak, Syunik and Lori) and Ararat and Kotayk regions. During 2004, 413 cases of crime and 249 offences were registered related to trafficking of illegal drugs and psychotropic substances (356 cases of crimes and 419 offences were registered in 2003). In most cases, these crimes were related to the manufacture, purchase, storage, use, transport and sale of drugs and psychotropic substances (in 2004, 398; in 2003, 346). Crimes related to the trafficking of drugs and psychotropic substances without intent to sell also represent a significant population (in 2004, 313 and in 2003, 219). The involvement of minors in drug-related crimes has been very small: in 2002, 4 minors were convicted; in 2003, there were none, and there were 3 in 2004.¹⁶

Surveys conducted within the framework of the RAR have revealed that a significant portion of surveyed IDUs (48%) get money to purchase drugs by stealing. Additionally highlighted by the RAR was the fact that DUs and IDUs exist in very different worlds: only 14% of non-injecting drug users stole for drug money. A significant number of surveyed DUs (42 %) also get money to purchase drugs from their friends, as compared to only 2% of IDUs.

Table 15.

The source of finances for purchasing drugs

The source of finances for purchasing drugs*	% IDUs	% DUs
Received salary	12	16
Parents/relatives	28	34
Friends	2	42
Selling drugs	-	2
Stealing	48	14
Other	4	20
*Multiple answers permitted		

More than half (60%) of IDU respondents reported problems with the police because of drug use, of which 37.8% were prosecuted, 18.9% were held by the police, against 18.9% force was used, 12.5% were convicted, 6.3% were blackmailed, 6.3% were registered, and one individual (6.3%) did not respond. 32% of the surveyed IDUs were subjected to criminal prosecution for injecting drug use.

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In contrast, 14% of surveyed DUs reported problems with the police because of drug use, of which 57.2% were held by the police, 28.6% said that force was used against them, 28.6% were registered. Of the surveyed IDUs, 4% had been subjected to criminal prosecution for drug use. When asked where they would seek help if in need, 12% of IDUs reported that they would go to an NGO and 56% would not seek help from anyone. Of the surveyed IDUs, none indicated health and social institutions (district administration, city municipality) or youth-friendly services as potential sources of support for them. This finding may indicate that IDUs are not aware of services and service providers designed to meet their needs, or that they are not accessible. More investigation must be undertaken to identify the root of this disconnect, and to better reach IDUs with services. These findings should be taken into consideration in planning further activities in order to improve the accessibility of services, and better tailor them to the needs of IDUs.

Table 16.
Sources and of services accessed by IDUs

Where would apply in need of support *	Absolute number	%
Medical institutions	-	-
Social institutions	-	-
NGOs	3	12
Parents/relevant	1	4
Friends	2	8
Youth-friendly services	-	-
Do not know	8	32
No one	14	56
Other	1	4
* Multiple answers permitted		

Table 17.
Types of assistance IDUs would like to receive

Type of assistance*	Absolute number	%
Financial	7	28
Methadone	5	20
Leave for abroad	3	12
Drugs	2	8
A job	2	8
To be left alone	2	8
Nothing	2	8
Did not mark	1	8
* Multiple answers permitted		

In total, 36% of surveyed DUs would rely on friends for support in case of need, while 26% said they would not turn to anyone. As in the case with the surveyed IDUs, none of the DUs indicated health care and social institutions as sources of support, again underscoring systemic failure to reach vulnerable populations. As mentioned above, this fact should be taken into consideration while planning and tailoring future activities to ensure accessibility of services and to DUs. That 36% of surveyed DUs would seek support from friends is a strong indication that peer education for DUs would be an effective vehicle for prevention.

Table 18.
Sources of support for DUs

Where would apply in need of support *	Absolute number	%
Medical institutions	-	-
Social institutions	-	-
NGOs	3	6
Parents/relevant	6	12
Friends	18	36
Youth-friendly services	1	2
Do not know	17	34
No one	13	26
Other	3	6
* Multiple answers permitted		

Table 19.
DUs would like to receive the following types of assistance

Type of assistance*	Absolute number	%
Financial	16	32
Leave for abroad	3	6
Drugs	1	2
A job	3	6
Treatment	2	4
Car	4	8
Private house	3	6
Nothing	10	20
Do not know	3	6
Other	2	4
* More than one answer were chosen		

Table 20.

Distribution of DUs according to level of education

Education	Absolute number	%
Incomplete secondary	28	56
Secondary	12	24
Vocational	2	4
Incomplete higher	4	8
Higher	4	8
Total	50	100

Table 21.

Distribution of IDUs according to level of education

Education	Absolute number	%
Incomplete secondary	2	8
Secondary	13	52
Vocational	2	8
Incomplete higher	2	8
Higher	6	24
Total	25	100

According to service providers, there is no uniform prototype of the drug users. Some beneficiaries have lost everything, including their homes and jobs and have no social safety net, while others live with their families and appear to be socially secure. Still others have children and spouses, and believe that the degree of drug dependency among them is manageable, and that drug use has not impacted on their health. There are also 'elite' drug users who can afford to use pure drugs, such as morphine. IDUs tend to be more isolated than those using non-injecting drugs. IDUs are volatile as they may run out of money and would then switch to using street drugs. *"Today the drugs are available, tomorrow the situation can change, and all depends on money."*

Table 22.
Opinions of IDUs regarding the degree of welfare of their families

Degree of welfare of the family	Absolute number	%
Very well	-	-
Rather well	2	8
Well	1	4
Average	5	20
Lower than average	7	28
Worse than average	6	24
Extremely bad	4	16
Total	25	100

Of those surveyed, 12% of IDUs live alone, 48% with their father, 60% with their mother, 4% with a stepmother, 16% with siblings, 8% with a grandparent, 8% with other relatives, and 8% with other people who are not their relatives (multiple answers were permitted).

All surveyed IDUs were males, with a mean age of 22.5 years.

Table 23.
Distribution of surveyed IDUs by age groups

Age group	Absolute number	%
10-14	-	-
15-19	4	16
20-24	21	84
Total	25	100

Table 24.
Distribution of IDUs by marital status

Marital status	Absolute number	%
Single	17	68
Married	3	12
Divorced	5	20
Widowed	-	-
Total	25	100

*Table 25.***Opinions of DUs regarding the of welfare of their families**

Degree of welfare of the family	Absolute number	%
Very well	-	-
Rather well	-	-
Well	3	6
Average	14	28
Lower than average	18	36
Worse than average	7	14
Extremely bad	8	16
Total	50	100

Of those surveyed, 4% DUs live alone, 58% with their father, 4% with a stepfather, 82% with their mother, 2% with a stepmother, 46% with a sibling, 28% with a grandparent, 10% with other relatives. None of the surveyed DUs lives with other people who are not relatives (multiple answers were permitted).

All the surveyed DUs (50 individuals) were males with a mean age of surveyed DUs was 18.5 years.

*Table 26.***Distribution of DUs by the age group**

Age group	Absolute number	%
10-14	4	8
15-19	27	54
20-24	19	38
Total	50	100

*Table 27.***Distribution of marital status of DUs**

Marital status	Absolute number	%
Single	49	98
Married	-	-
Divorced	1	2
Widowed	-	-
Total	50	100

Health and Risk Behaviour

Injecting Drug Users

In the Republic of Armenia, 54.5 % of HIV positive people have contracted HIV from injecting drug use. This trend and mode of transmission have been steadily increasing in recent years.

The majority of all male HIV carriers (70.2 %), are individuals who inject drugs, whereas the majority of infected women (92.2 %) contracted HIV through sexual contacts.⁴ Interestingly, the number of registered cases of Hepatitis A and B are decreasing, contrary to the usual correlation between HIV and Hepatitis rates.

Table 28.
The number of cases of Hepatitis A and B, 2001-2004

	2001	2002	2003	2004
Viral Hepatitis	1007	948	884	944

Of 884 cases of viral Hepatitis registered in 2003, 755 are cases of Hepatitis B, whereas of 944 cases of viral Hepatitis registered in 2004, 791 are cases of Hepatitis B.¹⁶

Specialists participating in the RAR survey noted that typically, the majority of IDUs contract Hepatitis C six months after continuous injecting drug use. In particular, according to the data from one specialist who treats drug users, 90% of IDUs in his care had a history of Hepatitis C.

Health care workers report many cases of drug overdoses and withdrawal, resulting in suicide, heart attacks and strokes. The number of cases of mental disorders among young drug users and alcoholics has also increased. The number of young people demonstrating what is believed to be hashish-linked psychotic behaviour has also increased. Health care workers indicate that most injecting drug users face a number of health problems, ranging from allergic reactions, vein-related problems, liver-related problems, Hepatitis C, HIV infection, STIs and overdoses. Many young IDUs have mental health problems as well. Young people outside the formal educational system and those who do not work, young people deprived of parental care and control are especially vulnerable. Many young people combat their insecurity or mental health problems by drinking alcohol, taking drugs, fighting, and engaging in other anti-social behaviour. In this context, extending youth-friendly services and involving young people in outreach activities could both reduce vulnerability and prevent or reduce risky behaviour.

It is generally acknowledged that the diagnosis of 'overdose' is not always appropriately recorded, and there are therefore no reliable statistics on the frequency of overdoses.

Survey results revealed that 12% of IDUs had a history of STIs and another 12% did not know whether they had ever had an STI or not. One young person with a history of STIs had visited a health care institution, one of them had treated himself without consulting a doctor, and one of them had sought treatment from a private doctor.

Of those surveyed, 68% of IDUs had been tested for HIV, 8% for Hepatitis B, 8% for Hepatitis C, 4% for STIs and 24% had never been tested (multiple answers were permitted).

During the month prior to the survey, 36 % of IDUs had experienced some sort of skin problems at the place of injection (blush, pain, infection). Eight of the surveyed IDUs had sought treatment for their drug habits and said that they wanted to stop using. However, only one person had visited a doctor to obtain treatment during the year prior to the survey, explaining that he was tired of drugs. The others had not sought treatment, giving the following reasons:

Table 29.

Reasons for not seeing a doctor*	Absolute number	%
Do not trust doctors	3	12.5
Do not believe that treatment could be successful	7	29.2
Do not believe that confidentiality will be maintained	12	50
Have financial problems	12	50
Do not consider themselves to be ill	4	16.7
* Multiple answers permitted		

These rationales demonstrate the need to tailor services provided by health care institution to fit the realities and needs of IDUs. By better targeting their needs, health care practitioners will be able to increase and ensure that IDUs receive the treatment they need.

According to the specialists, raising awareness on HIV transmission modes among drug users has been observed in the country. Specialists believe that young people engage in risky behaviours due to the following:

- low level of awareness on HIV/AIDS;
- indifference and lack of attention by society and adults to the problems of young people;
- deterioration of socio-economic conditions resulting in inability to afford health care;
- negative impact of mass media: aggressive films and television programmes; and,
- negative impact of state of the art multimedia, such as the Internet.

The RAR revealed that young people under the age of 17 do not consider being healthy as an asset; therefore, by their actions, they put their own health and the health of their peers at risk. Many professionals attribute this lack of value for health to a general change in young people's value systems, which now focus on money and material goods as the only true indicator of success.⁹

Using the UNAIDS Guidelines on Construction of Core Indicators, 40% of IDUs could demonstrate a basic understanding of HIV prevention based on the following 5 core knowledge-based HIV prevention questions:

1. Can HIV be avoided by having sex with only one faithful, uninfected partner?
2. Can HIV be avoided by using condom?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

The results reveal that there is a trend on increasing the level of knowledge on modes of HIV transmission in this at-risk group.

- 88% of the respondents consider that limiting sex to one faithful, uninfected partner can reduce risk of HIV transmission.
- 88% indicated that condom use could reduce the risk of HIV, though only 70% of them had used a condom the last time they had sex.
- 44% consider that a healthy-looking person can have HIV.
- 12% believe that a person can contract HIV through a mosquito bite,
- 20% think that HIV can be contracted by sharing a meal with someone who is infected.
- All 25 of the surveyed IDUs think that HIV can be contracted by using a syringe that was already used.
- 80% think that one can avoid contracting HIV by using non-injecting drugs.

Survey results show that all respondents had heard about HIV/AIDS. Of those surveyed, 72 % had received information about HIV/AIDS and STIs from the mass media, 24 % from social/health care workers and 36% from counselling services. There was some concern that having one of the two service-providing NGOs administer the survey might increase the risk for bias. Counselling services are important sources of information on HIV/AIDS, and it is recommended that access to these services be improved by establishing youth-friendly services and using the capacity of existing VCT sites. None of the young people surveyed indicated school as a source of information, underscoring the necessity of expanding and introducing classes on HIV/AIDS and sexual health into the school curriculum.

Table 30.
Sources of Information

Source of information on HIV/AIDS and STIs*	Absolute number	%
Family	-	-
Friends/peers	2	8
Mass media	18	72
School	-	-
Social/health care workers	6	24
Counselling providing services	9	36
None	-	-
Other	1	4
*Multiple answers permitted		

According to surveyed IDUs, the following is necessary to reduce spread of HIV infection: consistent condom use (21 respondents), use of disposable syringes (6 respondents), having one faithful sexual partner (3 respondents), possessing relevant knowledge (2 respondents), and treatment (1 respondent), and using not injecting drugs (one respondent) (multiple answers were permitted).

Of the surveyed IDUs, 8% consider it is likely that they will contract HIV or another STI, 56% thought it was unlikely and 36% rejected the possibility that they may contract HIV. Despite the fact that small number of IDUs eliminates the possibility of HIV transmission for them, manifestation of risky behaviour in this group is high. It is crucial to focus on this 36% of IDUs who think they are not at risk for HIV infection, as they are engaging in high-risk behaviour and therefore pose a threat to themselves and others.

Table 31.
Types of drugs used by IDUs

Substance types*	Absolute number	%
Tobacco	19	76
Alcohol	15	60
Cannabis/marijuana	17	68
Diazepam or other Benzodiazepams	10	40
Relanium	1	
Valium	2	
Ecstasy	-	-
Glue, acetone, petrol or other inhaled substances	-	-
Ephedrine, Ephedrone	8	32
Amphctamines	-	-
LSD	-	-
Heroine	17	68
Methadone	-	-
Cocaine	-	-
Opium (chernyashka)	16	64
Analgesics	2	8
Other drugs	6	24
*Multiple answers permitted		

Before switching to injecting drug use, 32% of those surveyed used drugs by smoking, inhaling or per os for less than one year, another 32% for 1-5 years, 4% did not respond the question, and 32% had used injecting drugs from the beginning of their drug-taking careers. In the month prior to the survey, all the respondents had used drugs.

Of the surveyed IDUs, 64% buy drugs in public parks, 48% on the street, 4% in pharmacies and 16% from other places (multiple answers permitted). Injecting equipment was purchased at pharmacies 12% of the time, and 12% from friends, 52% from health care institutions, 28% from NGOs, outreach workers, or needle exchange sites (multiple answers permitted). In 28% of cases, drugs are injected in the home; 36% use on the street 8% in the park, 4% at school, 24% at a friends' home, and 4% in other places (multiple answers were permitted). That nearly 50% of injecting drug use takes place in public spaces indicates the need for better outreach services to reach IDUs where they are congregating and engaging in risk behaviours.

The results of individual interviews conducted among young IDUs reveals that 80% of those surveyed share injecting equipment 2-3 times a week, because they don't want to try to find clean equipment: *"We share drug equipment with others but we know for sure that they are not ill"*, said one young person who was interviewed.

The results of the survey show that 32% of IDUs shared drug-injecting equipment during the month prior to the survey, and 56% of the respondents indicated that they had injected drugs prepared by someone else.

According to professional opinions, despite the fact that neither the drug use rates or the number of young men having sexual intercourse with non-regular partners hasn't reduced, 'culture of drug use' has changed over the recent years. Thus, the number of those IDUs using disposable syringes/needles and condoms has grown.

Forty eight percent of IDU respondents always disinfect drug-injecting equipment; 8% disinfect from time to time, 20% never disinfect, and 24% use disposable syringes. Of the 13.3% of those who marked, 'I always disinfect it' and 'I disinfect it from time to time'. Disinfection was accomplished through boiling the injecting equipment or disposable syringes are used (80% of those who responded, 'I always disinfect it' and 'I disinfect it from time to time').

During focus group discussions, IDUs stated their belief that if injecting drugs are not used more than once a week, then there is no risk of HIV infection. Clearly, increased education of IDUs must be undertaken to put into context issues such as frequency of drug uses, versus safety.

According to survey results, IDUs regularly engage in high-risk behaviour by sharing injecting equipment. The capacity of harm reduction projects must be strengthened, and IDUs should be involved in their design and implementation whenever possible. By increasing confidence in needle exchange sites and increasing attendance, this risky behaviour may be targeted.

The mean age at first sexual intercourse of surveyed IDUs was 17.7 years. Of the surveyed IDUs, 42.9% of surveyed IDUs had had sex in the 30 days prior to the survey and 38.1% of those surveyed had had sexual intercourse with a non-regular sexual partner during the year preceding the survey. Of the surveyed IDUs 85.7% reported using condoms last time they had sex with a non-regular sexual partner; 71.4% reported that they used condom consistently in the year preceding the survey, 19 % used condoms inconsistently, 4.8% never used condoms, and 4.8% did not answer the question. This is a relatively high rate of condom use by IDUs, which is likely the result of some form of public education that has effectively reached them.

Table 32.
Distribution of ages at first sex by age group

Age at first sex	Absolute number	%
10-14	1	4.8
15-19	11	52.4
20-24	5	23.8
Have not marked	4	19
Total	21	100

Table 33.
Distribution of non-regular sexual partners according to number.

Number of non-regular sexual partners in the year preceding the survey	Absolute number	%
1-5	3	37.5
above 15	2	25
Have not marked	3	37.5
Total	8	100

Table 34.
Reasons Given for Inconsistent Condom Use

Reasons for inconsistent condom use*	%
Too expensive/unaffordable	-
Embarrassed to purchase condom	33.3
Difficult to use	-
Not that easy to obtain	-
Reduces pleasure	66.7
Are embarrassed to ask their partner to use condom	-
Trust their partner	16.7
Unaware of effectiveness of condom use	-
*Multiple answers permitted	

When cross-analysed, survey findings show that only 77.8% of those having comprehensive knowledge on HIV prevention and transmission always use condom. While 70% of all respondents were able to identify condom use as an effective way to protect against HIV sexual transmission, only 72.2% of that population reported consistent condom use. In-depth interviews also show that a large group of injecting drug users are aware that condoms are a means of prevention, yet they do not often use condoms when having sex with non-regular partners.

Drug users

Only 38% of DUs surveyed could demonstrate a basic understanding of HIV prevention: 82% of respondents consider that limiting sex to one faithful, uninfected partner can reduce the risk of HIV transmission, and 92% indicated that condom use could reduce the risk of HIV infection, though only 38% indicated that a healthy-looking person could be HIV-infected. There remain 18% who think that HIV can be contracted through a mosquito bite, and 30% believe that one can contract HIV by sharing a meal with an HIV-infected person. Mass media was the source of HIV and STI prevention information for 64% of those surveyed, and 40% got information from their friends or peers. This indicates that mass media is an effective instrument for educating DUs on risk reduction and health behaviours. Providing peer education to young DUs would also likely be an effective intervention and awareness-raising activity.

Table 35.
Source of information on HIV/AIDS and STIs

Source of information on HIV/AIDS and STIs*	Absolute number	%
Family	-	-
Friends/peers	20	40
Mass media	32	64
School	5	10
Social/health care workers	13	26
Counselling providing services	3	6
None	-	-
Other	1	2
* Multiple answers were permitted		

Surveyed DUs stated that to reduce the spread of HIV, the following is necessary: condom use, 32 individuals (64%), use of disposable syringes, 2 individuals (4%), having one faithful partner 9 individuals (18%), having relevant knowledge, 9 individuals (18%), having a job, 1 individual (2%), relevant radio/TV programs, 1 individual (2%), eradicating commercial sex work, 1 individual (2%), avoiding sex with non-regular partners, 1 individual (2%), and one respondent (2%) answered that he did not know (multiple answers were permitted).

Table 36.

Drug used first	Absolute number	%
Hashish	40	80
Cocaine	3	6
Glue	7	14
Total	50	100

Physicians participating in the survey stated that long-term smokers of cannabis are at risk of developing gynecomastia, psychoses, mainly of schizophrenia nature. Hashish psychoses take an especially grave course in a young, adolescent person; drug user himself/herself and his/her relatives keep back the fact of drug use, and as a result the sick condition of a drug user prolongs and aggravates, and these young people finally become mentally ill, whereas an early intervention and treatment would brought the results. Over the recent years inhaling glue has become common practice among teenagers aged 11-15; it generates hallucinations and, at times, psychosis.

Specialists involved in carrying out the RAR report that inhaling glue has become common among teenagers, especially among ChCL and ChDPC, aged 9-10 to 13-14 years. Some speculate that as many as 60% of these vulnerable children sniff glue.

Table 37.
Drugs that have been used or tried by DUs

Drug types*	Absolute number	%
Tobacco	48	96
Alcohol	33	66
Cannabis/marijuana	45	90
Diazepam or other Benzodiazepams	11	22
<i>Relanium</i>	<i>1</i>	
Ecstasy	-	-
Glue, acetone, petrol or other inhaled substances	4	8
Ephedrine, Ephedrine	1	2
Amphetamines	-	-
LSD	-	-
Heroin	-	-
Methadone	-	-
Cocaine	-	-
Opium (chernyashka)	1	2
Analgesics	10	20
<i>Codeine</i>	<i>6</i>	
<i>Tramadol</i>	<i>3</i>	
<i>Tramal</i>	<i>1</i>	
Other drugs	-	-
* Multiple answers were permitted		

As per survey findings, 90% of surveyed DUs used drugs by smoking, 12% used by inhaling and 28% orally/per os. A reported 84% of DUs used drugs during the month preceding the survey. Drugs were used by 2% in bars, cafes, night clubs or discos, by 16% in their own home, by 66% on the street by 24% in parks, by 2% at school, by 26% in their friends' homes, 8% at parties and 4% used drugs in other places (multiple answers were permitted). Approximately 62% of those surveyed reported using two or three drugs at the same time, including alcohol.

The mean age at first sexual intercourse of those surveyed DUs was 17.9 years.

Table 38.

Distribution of age at first sex according to age groups.

Age at first sex	Absolute number	%
10-14	1	3.7
15-19	16	59.3
20-24	7	25.9
Have not marked	3	11.1
Total	27	100

Nine individuals, or 33.3% of the sexually active DUs had sexual intercourse in the 30 days preceding the survey, and 44.4 % had sexual intercourse with non-regular sexual partners in the year preceding the survey. Of the group of sexually active DUs, 8 had used condoms the last time they had sex.

83.3% had used condoms last time they had sex with a non-regular sexual partner.

Table 39.

Distribution of non-regular sexual partners according to their number

Number of non-regular sexual partners in the year preceding the survey	Absolute number	%
1 partner	6	50
2 partners	5	41.7
7 partners	1	8.3
Total	12	100

In total, 82.5 % of the surveyed DUs used condoms consistently in the year preceding the survey, 11.1 % used condoms inconsistently, 3.7 % never used condoms (see table 40). This shows a relatively high rate of condom use by DUs, once again pointing to effective condom promotion, education and dissemination.

Table 40.
Reasons for inconsistent condom use

Reasons for inconsistent condom use*	%
Too expensive/unaffordable	-
Embarrassed to purchase condoms	-
Difficult to use	-
Not that easy to obtain	-
Reduces pleasure	100
Embarrassed to ask their partner to use condom	33.3
Trust their partner	66.7
Unaware of effectiveness of condom use	-
Other	33.3
* Multiple answers were permitted	

Of the surveyed DUs, 6% had a known history of STIs and 2% did not know their STI status. The most prevalent STIs in this group were gonorrhoea and trichomoniasis. Three of those surveyed had an STI or inflammations of genitals in the year prior to the survey and one had an STI within the six months prior to the survey. All the surveyed DUs sought treatment from health care institutions.

Interventions

Currently, three HIV preventive programmes target IDUs within the framework of the National Programme on HIV/AIDS Prevention in Yerevan, Kapan and Gyumri cities. However, activities did not focus specifically on EVYP. Harm reduction programmes are needed for IDUs should have relevant components targeting EVYP, (which would improve access to syringes and other means of prevention).

According to survey results, the level of knowledge on HIV prevention was low among IDUs (40%) and DUs (38%) and there is a need to raise their awareness. However, mass media was identified by both populations as a significant source of information (72% by IDUs and 64% by DUs respectively). This indicates that mass media should be integral to future interventions, as it has great potential to influence and inform youth and young people on issues surrounding HIV and AIDS. International experience shows that the most effective way to provide information to young people is through peer education. The RAR found that nearly half of all DUs of surveyed (40%) indicated their friends and peers as a source of information, making a strong case for the introduction of a peer education system with this group. Peer education may be less successful for IDUs (8%), however, as only a small minority of IDUs indicated their friends and peers as a source of information. There may be room for innovative peer education to include young people of 15-24 year olds.

According to service providers, combating drug addiction requires early preventive intervention, so that even school-aged children are informed about the consequences of drug abuse. At present, *Life Skills* classes are integrated into the curricula of 384 schools in RA, and *Healthy Lifestyle* classes are taught in 30 schools, which cover a total of 30% of all schools in the country. Among other preventive issues, these classes include topics aimed at preventing drug abuse.

According to service providers, the *Life Skills* classes given in some schools should be administered in all the schools throughout the country. The results of the survey also indicate the necessity for increasing the role of schools in promoting the idea of healthy lifestyles. Only 10 % of the surveyed DUs and none of the surveyed IDUs mentioned school as a source of information, indicating a lost opportunity for information and education. Service providers suggest that schools should provide children with comprehensive, preventive information on drug use, allowing children to make informed decisions.

Taking into account the data obtained, it is recommended that:

- Peer education be provided to IDUs and DUs;
- Mass media be involved in future activities;
- Increase outreach to IDUs and DUs in public areas where they congregate and do drugs; and,
- Relevant programmes on HIV/AIDS-related issues are introduced into school curricula.
- Information-Educational Communication to be realized
- Behaviour Change Communication to be conducted

In interviews, drug users indicated the need for psychological services and support and a rehabilitation centre, preferably outside Yerevan. According to them, they do not know where to go, other than to NGOs, for the information and help they need. Even amongst those who are aware of NGOs, only 12% of IDUs and 6 % of DUs indicated that they would turn to NGOs for support in case of need.

The service providers involved in the RAR survey believe that treatment should be combined with rehabilitation, likely requiring a new form of intervention. More research is needed to identify an appropriate support model for DUs and IDUs.

The survey results reveal that neither IDUs nor DUs have confidence in health care services; there is also lack of information regarding targeted health services for vulnerable groups in the country. Only 2% of surveyed DUs would seek care in YFHS and none of them would go to health care and social institutions. None of the surveyed IDUs would go to YFHS, health care or social institutions. Profound changes are needed to address these weaknesses and ensure that DUs and especially IDUs, are comfortable and encouraged to access the services they need, in non-threatening, confidential and youth-friendly environments. These findings indicate that either not enough is known about YFH and other services, or that even those services which are designed for youth do not give young people a sense that they are accessible and appropriate to their needs. It will be necessary to tailor VCT and health care services to improve and increase accessibility, and meet the needs of the most vulnerable of young people and adolescents.

The RAR survey also show that in addition to drug use, HIV and STIs, primary prevention among IDUs and DUs is needed within health services and outreach services need to be strengthened and, where none exist, established.

During focus group discussions with service providers, it was mentioned that it is necessary to amend the existing laws regarding the prohibition of providing treatment with narcotic drugs and psychotropic substances, allowing more effective treatment. According to service providers, the law should authorize and encourage NGO activities conducted in the area of drug use prevention. For example, the law should authorize implementation of harm reduction projects so that the police do not prosecute drug addicts who are beneficiaries of the projects. This would increase community involvement and raise its role in the implementation of the activities as well as increasing trust and encourage drug users to safely access services.

It is important to involve family members of IDUs and DUs in implemented activities, making them participants of treatment and prevention activities, as demonstrated by the survey results. Only 4% of surveyed IDUs and 12% of surveyed DUs would turn to their parents, relatives or friends for support. Neither IDUs nor DUs indicated family as a source of information or support.

Young Commercial Sex Workers

Contextual assessment

According to official data provided by the Department to Combat Illegal Drug Trafficking and Prostitution of the RA Police, there are approximately 1,800 CSWs registered in the country, of which 900 live in Yerevan. However, experts estimate many unregistered CSWs, totalling 7,000-8,000 CSWs.¹⁸ The police classify prostitution as street prostitution, home prostitution, elite prostitution or case prostitution.

In the process of the RAR the service providers noted that there is no state policy related to commercial sex work in the country. The informal opinion is common within the government structures that the strictest legal and administrative methods should be applied to fight prostitution.

The main factors influencing the expansion of commercial sex in Armenia are believed to be:

- **Weak economy:** About 60% of unemployed individuals registered with employment agencies are women. According to other data, the unemployment rate among women is 73%.
- **Poverty:** According to official statistical data, 55% of the population is poor, and 23% is very poor. The proportion of women in Armenia holding low-paying jobs and the level of poverty among women is higher than that of men.
- **Income stratification;**
- **Economic liberalization:** The market economy has created disposable income for some, and the opening of a number of privately-owned public places in which leisure and commercial sex can be combined;
- **The development of the sex-culture and the sex-industry;**
- **Intensive emigration of men:** For every 1,000 women of reproductive age (20-39) 670-700 men of the same age, and 40-50% of women older than 16 are unmarried.
- **Homelessness and poor temporary shelters:** The substandard quality of temporary shelters and the lack of basic living conditions motivate many young women to take up residence in one of the privately-owned 'leisure clubs.'
- **Lack of family and spiritual upbringing:** There are four-six times more widows and divorced women than men. Due to lack of economically and sexually active men, two-three out of every ten women has practically no chance of getting married, or they may be forced to care for and raise their children by themselves. The decline in the enrolment may be directly linked to the demoralisation of young people.
- **Liberalization of traditionalism.**¹⁸

While there is no legal structure for prosecuting CSWs, some specialists believe that there should be legislative recourse to crack down on prostitution. Within the legal framework, CSWs are not traditionally prosecuted. There are, however, laws against operating brothels or pimping, both of which are punishable by fine or prison sentence. It is a criminal liability to engage in sexual intercourse with a person under the age of 16 years²¹.

Of note, RAR focus group discussions conducted with young CSWs revealed that some young CSWs would like to find legal, non-sex industry work. This may be an indication that employment generation projects have a potential preventive role to play, and such activities should be coordinated when possible.

Health and Social Consequence

Interestingly, commercial sex work is addressed by the Department to Combat Illegal Drug Trafficking and Narcobusiness of the RA Police. This seems to implicitly link sex work with the drug trade. While the number of individuals charged for prostitution continues to rise, those charged with pimping or operating brothels has stayed at the same level, despite an increase in privately-owned leisure clubs.²¹

Table 41.

Individuals Prosecuted for Commercial Sex Code Violations

Article	2002	2003	2004
Article 179/1 of the RA Administrative Violations Code (for prostitution)	72	171	175
Article 262 of the RA Criminal Code (organizing and keeping brothels or pimping)	35	30	43

According to specialists involved in the RAR survey CSWs are perceived as:

- Potential transmitters of infection due to poor hygiene, not using condoms and not undergoing regular medical checkups;
- Providing services to criminals and thereby contributing to increased crime rates; and,
- Involving and morally corrupting minors (those who provide their services at low prices are affordable for minors).

The survey revealed that 54% of young CSWs had problems with the police as a result of their sex work. Of these, 33.3% mentioned that they had not been allowed to walk the streets for work, 18.5% had experienced violence from the police, 7.4% reported being verbally insulted, 14.8 % reported undergoing mandatory STI testing, 11.1% were placed in isolation, and 7.4% were fined (multiple answers were permitted). Commercial sex work is also dangerous: 58% of the surveyed young CSWs reported being threatened, robbed, not being paid or other unpleasant experiences with their clients. In individual interviews, the young CSWs reported that sometimes they are pressured to have sex without a condom, for which they are paid extra.

The survey revealed that 70% of young CSWs would seek care and support from an NGO and 40% would seek help from health care institutions. This indicates a relatively high level of trust by CSWs in NGOs. More research should be undertaken to identify how to strengthen health services.

Table 42.

Sources of support for CSWs

Where would turn for support *	Absolute number	%
Medical institutions	20	40
Social institutions	1	2
NGOs	35	70
Parents/relatives	1	2
Friends	13	26
Youth-friendly services	-	-
Do not know	4	8
Other	3	6
* Multiple answer permitted		

Table 43.

Forms of assistance desired by young CSWs

Type of assistance*	Absolute number	%
Family	2	4
Financial assistance	19	38
Job	14	28
Husband	4	8
Free condoms	1	2
Medical care	3	6
Do not know	2	4
Other	5	10
* Multiple answers were permitted		

Table 44.

Distribution of the surveyed young CSWs according to education level

Education	Absolute number	%
Incomplete secondary	20	40
Secondary	24	48
Vocational	3	6
Incomplete higher	-	-
Higher	2	4
Other	1	2
<i>Have no education</i>	<i>1</i>	
Total	50	100

Only 2% of the surveyed young CSWs consider their family to be rather well-off, 4% indicated that they live well, 42% assess their living conditions as average, 36% as lower than average, 10% as worse than average, 4% as extremely bad, and 2% did not answer the question.

Of surveyed young CSWs, 36% live by themselves, 4% live with their father, 16% with their mother, 4% with siblings, 2% with their grandparents, 6% with other relatives, and 38% with other people who are not their relatives. (multiple answers were permitted).

The mean age of surveyed young CSWs was 21.9 years.

Table 45.
Distribution of young CSWs by age

Age group	Absolute number	%
10-14	-	-
15-19	10	20
20-24	40	80
Total	50	100

Of the surveyed young CSWs, 48% were single, 48% were divorced, 2% were married, and 2% were widows.

Health and Risk Behaviour

Only 8% of surveyed young CSWs had not heard about HIV/AIDS, while 68% received information about HIV/AIDS and STIs from their friends and peers. Expanding peer education can therefore be considered as highly effective means of awareness-raising for young CSWs.

Mass media and social health care workers were other strong sources of information for CSWs. Better utilisation of these information modes should be explored in an effort to better reach CSWs with preventive information.

Table 46.
Source of information on HIV/AIDS and STIs

Source of information on HIV/AIDS and STIs*	Absolute number	%
Family	1	2
Friends/peers	34	68
Mass media	17	34
School	-	-
Social/health care workers	20	40
Counselling providing services	-	-
No	-	-
Other	9	18
* Multiple answers were permitted		

The findings of the survey show that only 30% of young CSWs could demonstrate a basic understanding of HIV prevention. Only 56% of the respondents thought that a healthy-looking person could have HIV, meaning that nearly half of all respondents thought that HIV positive people always exhibit physical and observable symptoms. Of those surveyed, 34% thought that HIV can be contracted through a mosquito bite, and 32% indicated that HIV can be contracted by sharing meals with an HIV positive person. Most CSWs (92%) think that limiting sex to one faithful, uninfected partner can reduce the risk of HIV infection. Almost everybody (98%) noted that condom use could reduce the risk of HIV infection.

Rapid Assessment and Response Analysis

Though all the survey participants (100%) noted that syphilis and gonorrhoea are STIs and 8% identified pneumonia as an STI. Another 14% did not know that HIV can be transmitted through sexual intercourse.

Though 98% of survey participants indicated that condom use could reduce the risk of HIV infection, only 72% used condoms consistently, with 24% using condoms almost every time they had sex and 4% used condom from time to time in the 30 days prior to the survey.

Table 47.
Reasons for inconsistent condom use

Reasons for inconsistent condom use *	%
Too expensive/unaffordable	-
Embarrassed to purchase condoms	14.3
Difficult to use	-
Not that easy to obtain	7.1
Reduces pleasure	14.3
Embarrassed to ask their partner to use condoms	14.3
Trust their partner	57.1
Unaware of effectiveness of condom use	-
Other reasons	14.3
* Multiple answers were permitted	

Individual interviews reinforced that young CSWs do not use condom consistently. Among the reasons for not using a condom a few factors were noted, such as lack of knowledge, client's wish, and unavailability of condom at the moment.

Ninety two percent of the 50 surveyed young CSWs used condom the last time they had vaginal sex. Of all the young CSWs 18 (36%) reported condom use the last time they had oral sex, and 28 (56%) indicated that they do not practice oral sex. However, only 15 (30%) reported using a condom the last time they had anal sex, with 31 (62%) young CSWs indicated that they do not practice anal sex. Therefore, 92% of CSWs are not at risk for contracting HIV through anal sex. This data helps to guide future interventions and the development of appropriate and targeted messaging.

During focus group discussions, young CSWs mentioned that the kind of work they perform put them at risk of infection, and that they try to reduce this risk mainly by using condoms. Eighteen percent of the respondents thought it was very likely for them to get HIV or other STIs, 58% thought it was not very likely, and 24% think there is no risk of infection. During focus group discussions some respondents said that they don't think of their behaviour as risky, and have some understanding of risk reduction: *'I have read a lot about it, 'I take measures to care for my health'*. Interview participants know other girls who do not understand the importance of condom use yet. Many also use alcohol with the clients. The surveyed young CSWs said that they feel they can trust clients, which leads them to engage in risky behaviour.

Eighty two percent of the surveyed young CSWs had been tested for HIV, 2% had been tested for Hepatitis B, 4% for Hepatitis C, 88% for STIs, and only one person (2%) had never been tested for any of the above (multiple answers were permitted). Increased education on STI testing is needed for this population.

Forty six percent of surveyed young CSWs had a history of STIs, of whom 70.8% had STIs or

inflammation of genitals in the year prior to the survey and 73.7% within the six months prior to the survey. Of those who have had STIs, 88.9% of those having STI had visited a health care institution, no one had practiced self-treatment, and one person had not sought treatment (multiple answers were permitted).

Young CSWs said that, to reduce the spread of HIV infection, the following is necessary: condom use (32 respondents), isolation/quarantine (2 respondents), having relevant knowledge (1 respondent), having a faithful partner (5 respondents), receiving relevant treatment (1 respondent), providing relevant testing (10 respondents), and one respondent answered that she did not know (multiple answers were permitted).

Generally speaking, CSWs became sexually active at a young age, and several years passed prior to engaging in commercial sex. The mean age at first sex of surveyed CSWs is 16.6 years, and the mean age at first paid sex of those surveyed CSWs is 19.5 years. **Distribution of age at first sex and first paid sex according to age presented in the tables below.**

Table 48, 49

Age at first sex	Absolute number	%
10-14	6	12
15-19	39	78
20-24	5	10
Total	50	100

Age at first paid sex	Absolute number	%
10-14	-	-
15-19	26	52
20-24	24	48
Total	50	100

Twenty two percent of surveyed young CSWs usually find their clients at bars, cafes and clubs, 6% at parties, 12% in the parks, 72% on the street, 6% in massage salons, and 4% in other places (multiple answers were permitted). More outreach to CSWs in public places is needed.

Eighty eight percent of surveyed young CSWs indicated that their clients are usually local residents, 18 % usually had clients who are foreigners working in Armenia, and 14 % had other types of clients (multiple answers were permitted).

Sixty six percent of surveyed young CSWs had sex with a non-commercial sexual partner in the year preceding the survey (a non-commercial sexual partner is a partner who is neither a spouse, nor a cohabiting person and from whom no payment is received for sex). Of these, 39.4% used condom the last time they had sex with a non-commercial sex partner. None of the young CSWs who had used drugs had ever used injecting drugs.

Table 50.

Distribution of CSWs clients in the week prior to the survey, according to frequency

Number of clients in the last week	Absolute number	%
1-4	13	26
5-9	23	46
More than 9	13	26
Did not mark	1	2
Total	50	100

Table 51.

Distribution of CSWs clients in the month prior to the survey, according to frequency

Number of clients in the last month	Absolute number	%
1-9	3	6
10-19	15	30
20-39	22	44
40-60	8	16
Did not mark	2	4
Total	50	100

Table 52.

Non-commercial sexual partners

Number of non-commercial sexual partner in the last year	Absolute number	%
1-4	30	91
5-8	1	3
9-12	1	3
Did not mark	1	3
Total	33	100

Of those surveyed, five (10%) young CSWs had used drugs. The mean age when drugs were first used was 18.2 years.

The results of the survey have shown that the young CSWs who had used drugs had used cannabis or marijuana (4 CSWs), glue or other inhaled drug (2 CSWs), opium tea (1 CSW), and 1 CSW had used other types of drugs (multiple answers were permitted).

Table 53.
Age at first drug use according to age group

Age at first drug usage	Absolute number	%
10-14	1	20
15-19	2	40
20-24	2	40
Total	5	100

Only one participant of the focus group discussion said that she never used alcohol, while the rest noted that they often used alcohol 'at work' before having sex, but felt they are not alcohol abusers. Only one of the surveyed young CSWs reported having tried glue, and two had tried marijuana once or twice, with friends.

Table 54.
Reasons for starting drug use

Reasons for starting using drugs*	Absolute number	%
Curiosity	4	80
Peer pressure	2	40
Psychological reasons (stress, depression)	2	40
Relieve pain	-	-
Improvement in physical appearance	1	20
Receiving pleasure	2	40
* Multiple answer permitted		

Only one of the surveyed young CSWs having experience in drug use reported having sex under the influence of an illegal drug. None of the young CSWs who had used drugs had ever injected drugs.

Interventions

Currently, HIV prevention programmes targeting CSWs are operated via the National Programme on HIV/AIDS Prevention in Yerevan, Abovyan, Gyumri, Vanadzor, Kapan, Agarak, Gavar and Vardenis cities. There are no activities that specifically focus on young CSWs, however, the fact that none of the young CSWs included in the survey felt comfortable accessing YFHS or VCT services suggests that the current model is not effectively reaching this vulnerable group. Services need to be enhanced and further tailored to address the needs of young CSWs. Based on RAR findings, it is recommended that prevention programmes be modified to target young CSWs. None of the surveyed CSWs indicated readiness to access YFHS, which likely means that YFHS are not reaching out to CSWs. It is recommended that YFHS be expanded and better tailored to the needs of young CSWs and other vulnerable populations. The findings of survey show the necessity to improve access to VCT and health services for young CSWs. This will help to improve access for young CSWs to early diagnosis and treatment of STIs.

Rapid Assessment and Response Analysis

The survey results demonstrate that only 30% of young CSWs could demonstrate a basic understanding of HIV prevention. Awareness-raising must do a better job of targeting young CSWs. This proves, that activities aimed at increasing the level of knowledge on HIV/AIDS related issues among CSWs should be continued, applying Information-Educational Communication and Behaviour Change Communication strategies.

Young Men who have Sex with Men

Contextual assessment

In accordance with UNAIDS estimations, 2-5 % of men aged 15-49 engage in homosexual or same sex sexual relations. Taken to scale, there are estimated 17,000-65,000 men having sex with men (MSM) in the RA.

Prior to 2003, homosexuality was a criminal offence. As of August 2003, homosexuality is not criminally prosecuted. However, according to specialists' observations homosexuality is not considered socially acceptable, and men who have sex with men tend to cluster in small circles, rarely exhibiting their sexual orientation outside of their peer groups. Due to social stigma, there is not one stereotype of a typical MSM, and the MSM population can be difficult to identify: some of are married or do not identify as gay, and many do not inform their families of their sexual orientation. Sex is often limited to small, insular groups, which increases the risk of HIV infection for the group as a whole. Isolation of MSM hinders their access to health and social services and makes it difficult for them to receive information and to increase awareness, increasing their risk to HIV and other STIs.

Because MSM are socially isolated and often engage in risk behaviours in locations that are hidden from the mainstream, ensuring access to information and services is challenging, and increases their vulnerability. This combination of social and physical isolation makes MSM highly vulnerable and among the most hard-to-reach populations.

Health and social consequences

Sixty percent of surveyed young MSM had faced problems due to their sexual orientation (9 with law-enforcement bodies, 4 had suffered from stigma and discrimination, 3 had experienced problems within the family, 3 had experienced violence, 1 had problems at work, and 4 did not specify the nature of their problem). Of the surveyed young MSM, 22.9% had been prosecuted by the law for their sexual orientation prior to statutory changes.

The surveyed young MSM noted during the interviews that before the relevant amendments were made to the law, they had been persecuted by the police. Some young MSM reported the cases of dismissing from work due to their sexual orientation.

The results of the survey show that, 41.2% of the respondents would go to health care institutions for services and information, and 41.2% would go to friends. None of the surveyed young MSM indicated that they would seek help from social institutions.

These responses send a clear signal that young MSM are not sufficiently comfortable with health and social institutions, even when they are designed to be youth-friendly. More must be done to better meet the needs of MSM in institutional settings, and to create systems that young MSM can trust. It is also important to involve parents in preventive activities whenever appropriate and possible, as most of the young MSM still live at home.

Table 55.

Sources of support for young MSM

Where would apply in need of support *	Absolute number	%
Medical institutions	14	41.2
Social institutions	-	-
NGOs	9	26.5
Parents/relevant	7	20.6
Friends	14	41.2
Youth-friendly services	1	2.9
Did not know	2	5.9
No one	2	5.9
Other	3	8.8
*Multiple answers were permitted		

Table 56.

Services desired by Young MSM

Type of assistance*	Absolute number	%
Financial	8	22.8
Psychological	6	17.1
Job	3	8.6
Leave for abroad	3	8.6
Be protected	1	2.8
Tolerance	1	2.8
None	3	8.6
Have not marked	11	31.4
* Multiple answers were permitted		

Table 57.

Distribution of the surveyed young MSM according to the level of their education.

Education	Absolute number	%
Incomplete secondary	3	8.6
Secondary	6	17.1
Vocational	3	8.6
Incomplete higher	7	20
Higher	16	45.7
Other	-	-
Total	35	100

Only 11.4% of the surveyed young MSM consider their family to be *very well-off*, 11.4% *rather well-off*, 28.6% indicated that they live well, 40% think their living conditions are *average*, 8.6% *lower than average*, no one considered their family condition to be worse than average or extremely bad.

Seventeen percent of the surveyed young MSM live alone, 37.1% with their fathers, 54.3% with their mothers, 2.9% with their stepmother, 20% with siblings, 8.6% with their grandparents, 20% with other relatives, and 2.9% with other people who are not their relatives (multiple answers were permitted).

Table 58.
Distribution of young MSM according to age groups

Age group	Absolute number	%
10-14	-	-
15-19	4	11.4
20-24	31	88.6
Total	35	100

The mean age of surveyed young MSM is 15.8 years.

Thirty (85.7%) of the surveyed young MSM were single, two (5.7%) were married, three (8.6%) were divorced.

Health and Risk Behaviour

The findings of the survey show that young MSM are the most knowledgeable risk group, with 48.5% able demonstrate a basic understanding of HIV prevention.

Eighty nine percent of the respondents think that limiting sex to one faithful, uninfected partner can reduce the risk of HIV infection. 85.7% said that condom use could reduce the risk of HIV infection — however only 74.3% used a condom the last time they had sex. Nearly 83% of those surveyed young MSM knew that a healthy-looking person could have HIV; 28.6% thought that a person could contract HIV through a mosquito bite, and 5.7% thought that HIV could be contracted by sharing meals with an HIV-positive person.

All of the surveyed young MSM had heard of HIV/AIDS and 97.1% had heard about STIs. For 51.4% information about HIV/AIDS and STIs comes from their friends and peers, indicating an increased focus on peer education would be effective in raising awareness among young MSM.

Mass media and counselling were also identified as trusted sources of information for young MSMs.

Rapid Assessment and Response Analysis

According to the beliefs of 14.3% of the young MSM surveyed, it is very likely that they will contract HIV or another STI, while 37.1% think the likeliness of becoming HIV positive is average, 40% thought there was no danger, and 8.6% did not mark any answer. Young MSM get tested more often than other groups studied in the RAR: 71.4% of the surveyed young MSM had been tested for HIV/AIDS, 22.9% - for Hepatitis B, 17.1% - for Hepatitis C, 37.1% - for other STIs, and 22.9% had never been tested. (multiple answers were permitted)

Twenty percent of surveyed young MSM had a history of STIs (trichomoniasis, fungal disease, inflammation or a combination of several diseases). A total of 57.1 % of the respondents had experienced an STI or inflammation of genitals during the year preceding the survey, and 28.6% had an STI or inflammation of genitals during the six months preceding the survey. Unlike other risk groups, 71.4% of young MSM with a history of STI or inflammation of the genitals sought treatment in health care institutions, no one had practiced self-treatment, and 28.6% undertook other measures.

According to the opinion of the surveyed young MSM for reducing the spread of HIV infection the following is necessary: 25 said condom use, three said having faithful partner, two said having relevant knowledge, two said avoiding sexual contacts with non-regular partners, one said use of disposable syringes one said having safer sexual intercourse, and one respondent answered that he did not know (multiple answers were permitted).

The mean age at first sex of the surveyed MSM is 14 years.

The sexual partners of 62.9% of the surveyed young MSM are men, 8.6% women, and for 28.6% both men and women. Of those surveyed, 14.3% are active MSM, 14.3% are receptive MSM, and 71.4% both active and receptive MSM. 22.9% of the respondents have sex with regular partners, 2.9% with non-regular partners, 74.2% both with regular and non-regular partners.

Table 61.
Number of sexual partners per day indicated for young MSM

Number of sexual partners per day	Absolute number	%
1	18	51.4
2-5	12	34.3
More than 6	2	5.7
Not indicated	3	8.6
Total	35	100

85.7% (30 individuals) had sexual intercourse with a non-regular partner during the year preceding the survey.

Table 62.
Distribution of non-regular sexual partners in the past according to quantity

Number of non-regular sexual partners in the last year	Absolute number	%
1-6	12	40
7-20	3	10
21-50	2	6.7
Up to 100	7	23.3
Not indicated	6	20
Total	30	100

Individual interviews revealed that some young MSM have sex with multiple partners they do not know.

According to the survey, 82.8% of young MSM used a condom the last time they had sex with a non-regular partner. 34.2% consistently used condoms, 62.9% used condom inconsistently, 2.9% never used condom in the year preceding the survey.

Table 63.
Reasons for inconsistent condom use

Reasons for inconsistent condom use *	%
Too expensive/unaffordable	-
Embarrassed to purchase condoms	-
Difficult to use	-
Not that easy to obtain	8.7
Reduces pleasure	39.1
Embarrassed to ask their partner to use condom	13
Trust their partner	34.8
Unaware of effectiveness of condom use	-
Other reasons	30.4
* Multiple answers were permitted	

During focus group discussions, young MSM indicated that they know how to use condoms properly, know why they should use condoms, always have a condom with them, but do not use condom consistently, since they believe that *'if you suggest to your partner that he use a condom, he may conclude that you have a disease.'*

The results of the survey show that 45.7% of MSM used a condom the last time they had oral sex (however, they used condoms not stipulated for oral sex) before the survey, and 74.3% during the last anal sex, and 20.6% of the surveyed young MSM said that they use condoms for anal sex, 76.5% used any type of condoms, 2.9% do not use condoms. No one reported using condom for oral sex. 67.6% of the surveyed young MSM use lubricants.

Rapid Assessment and Response Analysis

Twelve young MSMs (35.3%) have had sex in exchange for money, drugs or a job, of whom, 25% had been providing paid sexual services for 1-4 years prior to the survey, 33.3% for 5-9 years, 8.4% for 10-14 years and 33.3% did not indicate the period. The mean age at first paid sex is 17.5 years.

Table 64.
Distribution of first paid sex according to age

Age at first paid sex	Absolute number	%
10-14	1	8.3
15-19	6	50
20-24	3	25
Not indicated	2	16.7
Total	12	100

For 91.2% of young MSM their sexual partners were mainly local residents, 14.7% were military men, 32.4% were foreigners, and 2.9% others (multiple answers were permitted) This was reinforced during the individual interviews with young MSM.

Of all young MSM surveyed, 31.4 % had been forced to have sex against their will.

Some 42.9% of the surveyed young MSM usually find a sex partner on the street, 31.4% in bars, cafes and clubs, 25.7% at parties, 42.9% in the parks, 2.9% in public bathhouses, 40% through the Internet, 22.9% in public toilets, and 8.6% in other places (multiple answers were permitted). Outreach must be improved to target young MSM who are engaging in risk behaviours, much of which occurs in public places. During the individual interviews the young MSM indicated that they usually meet at certain parks and a number of night clubs, known within in the MSM culture.

Three of the surveyed young MSM (8.6 %) had taken drugs. The mean age of first drug use among young MSM is 18.7 years.

Table 65.
First drug use according to age

Age when first used drugs	Absolute number	%
10-14	-	-
15-19	2	66.7
20-24	1	33.3
Total	3	100

The results of the survey show that those young MSM who had used drugs had used cannabis, marijuana, diazepam or other benzodiazepams (apaurin), ecstasy, heroin, cocaine, or other drugs. No one reported using glue or other inhaled drugs, amphetamines or opium tea. The young MSM using drugs indicated that usually they use drugs in bars, cafes and clubs, in nightclubs, discos, at their own homes, at their friends' places or at parties.

Table 66.
Reasons for starting to use drugs

Reasons for starting using drugs*	Absolute number	%
Curiosity	1	33.3
Peer pressure	-	-
Psychological reasons (stress, depression)	-	-
Relieve pain	2	66.7
Improvement in physical appearance	-	-
Receiving pleasure	2	66.7
* Multiple answers were permitted		

During the individual interviews drug-using young MSM indicated that they use drugs because *'it is interesting to feel how it can be.'* For others, fear was cited a reason for not using drugs. Among those using drugs, 66.7 % reported having had of sexual contact under the influence of drugs. Two of the three young MSM using drugs injected heroine or morphine.

One of the young MSM who used injecting drugs reported sharing injecting equipment during the month prior to the interview. He also reported using drugs prepared by someone else. Usually he obtains injecting equipment from a drug supplier, always disinfects it himself and always uses disposable syringes. He also reported having skin problems at the site of injection (blush, pain, infection) in the month preceding the survey.

One of the two young MSM who inject drugs sought care from a physician to obtain treatment to quit injecting drugs. He and was provided with socio-therapy (social, group therapy) during the year preceding the survey.

Interventions

An HIV prevention programme targeting MSM is carried out within the framework of the National Programme on HIV/AIDS Prevention in Yerevan. About 150 MSM have been involved in programme activities. However, the implemented activities are not focused on young MSM and do not address their particular needs.

Such programmes should be expanded to include concrete activities specifically involving young MSM into their implementation, to raise the level of relevant knowledge of young MSM through realization of Information-Educational Communication and Behaviour Change Communication strategies and improve their access to means of prevention and risk reduction. At the same time it is necessary to implement activities on the community level aimed at reducing stigma and discrimination against this group.

Children in Conflict with Law and Children Deprived of Parental Care

A Contextual Assessment

International and Domestic Legal Framework

The Republic of Armenia joined the International Convention on the Rights of the Child in 1992. For the first time ever, state policy is being informed by the best interests of children, pursuant to the principles of a social state. Ratification of the Convention of the Rights of the Child was followed by adoption of the RA Law on the Rights of the Child in 1996, which promotes children's entitlement to fundamental human rights and the right to human dignity.

Children without parental care are recognised as the most socially vulnerable group, and receive special protection and care from the State.

According to the RA Article 24 of the Law on the Rights of the Child, every child deprived of parental care has the right to state-sponsored protection, care, upbringing and assistance. The state and its relevant agencies ensure these rights through adoption, guardianship, trusteeship and foster care when possible, and placement in orphanages when not possible. To protect the rights of children deprived of parental care, on 24 September 2002 the RA National Assembly adopted a law on the social protection of children deprived of parental care. At present, about 1,150 children deprived of parental care in Armenia are in orphanages under the full care of the government.¹⁹

According to official data about 200 'street children' lived in the country in 2003, though others estimate this number at 2,500. Such a big discrepancy between the numbers is must be remedied by focusing attention to obtain reliable data on this vulnerable population³

Children with special educational needs, including children deprived of parental care, attend special boarding or extended-day educational institutions. Five of the 54 public boarding institutions are for children deprived of parental care or for children from socially vulnerable families. There are no private residential special education institutions in the country.

The Ministry of Education and Science Collegium approved the Reform Programme of the Boarding Institutions System of the Armenian Education Sector on 13 June 2000. By decree, special education system reforms have the following objectives:

- mainstreaming of the children with special needs into general educational institutions;
- structural adjustment;
- improvement of admission system;
- decentralization of special education services;
- introduction of new management and functioning system; and,
- improvement of child care and education quality.²⁰

Service providers participating in the RAR project believe that the needs of youth and how they are raised are not being adequately addressed by the State, furthering their vulnerability. The local mentality creates obstacles for implementing awareness raising activities. Part of the society also hinders the implementation of activities.

Some specialists believe Government has yet to clearly define its strategy there is clear-cut system of values within the education system and school curricula. Also, the dramatic decrease of the national values has been observed. The specialists think that young people today are neglected, and no educational public activities are conducted, which in its turn has increased risk in this group. As a matter of fact children start inhaling glue (it is easy to get and is cheap) from the age of nine and using drugs of cannabis group from the age of 12-13 and afterwards they switch to injecting drugs. The findings of the surveys conducted among the ChDPC and ChCL prove that. 12% of the

surveyed ChDPC and 40% of the surveyed ChCL have experience in drug use. Mean age when first used drugs ranged from 10 to 14 years.

The service providers indicate that knowledge, attitude and behaviour contribute to vulnerability in the target groups. However, information does not always transform into knowledge and, later, into relevant behaviour. Teenagers often do not consider their family members as authorities, but instead rely upon their peers: 'whatever their peers do they follow them.' RAR surveys suggest that 67.3% of ChCL and 43.8% of ChDPC indicated their friends and peers as a reliable source of information. RAR surveys show that 53.1% of ChCL and 45.8% of ChDPC identified the mass media as a source of information. The service providers also expressed concern that TV programs distort children's way of thinking and understanding. In this context, it is important that information on HIV/AIDS provided by the mass media be reliable.

The National Programme on HIV/AIDS Prevention does not envisage targeted activities for ChCL and ChDPC and they are not specifically targeted by other preventive programmes implemented within the framework of the National Programme on HIV/AIDS Prevention. Effectively, these two highly vulnerable groups slip through the cracks of mainstream prevention efforts.

Health and Social Consequences

According to Article 9 of the RA Law on Medical Aid and Services, 'Everyone, including adolescents, shall be entitled to access information on maintenance of their sexual health, on sexually transmitted infections and their complications and consequences.'

Specialists believe that the general public's attitude towards health and healthcare is low. There is poor supervision of health by parents, which creates an environment in which children more freely enter into risky behaviours. Surveys show that despite the fact that 8.2% of ChCL and only 4.2 % of ChDPC indicated parents as source of information, 56% of ChCL and 36% of ChDPC would ask their parents for assistance. Parents need to be included in preventive activities whenever possible and appropriate. Young labour migrants, who sometimes end up in conflict with the law, often find themselves engaging in risk behaviour.

The findings of interviews conducted among the ChDPC revealed that 34% would seek support from health care institutions, 36% from their parents/relatives, and 26% from their friends. None of the interviewed ChDPC would go to an NGO for support, indicating that the NGO sector is not widely associated with activities targeting ChDPCs.

Table 67.
Sources of Support

Where would ChDPC apply in need of support *	Absolute number	%
Health care institutions	17	34
Social institutions	3	6
NGOs	-	-
Parents/relative	18	36
Friends	13	26
Youth-friendly services	1	2
Do not know	17	34
No one	2	4
Other	6	12
Multiple answers were permitted		

Table 68.
Types of support

Type of support (for ChDPC)*	Absolute number	%
Financial	17	34
None	3	6
Job	5	10
Family	7	14
Psychological	3	6
Education	2	4
Friends	7	14
Social	2	4
Apartment	3	6
Leave for abroad	1	2
Marriage	1	2
Have not marked	1	2
Other	3	6
Don't know	2	4
Multiple answers were permitted		

Table 69.
Distribution of surveyed ChDPCs according to education

Education	Absolute number	%
Incomplete secondary	36	72
Secondary	12	24
Vocational	2	4
Incomplete higher	-	-
Higher	-	-
Total	50	100

Table 70.
Socioeconomic status of Families

Degree of welfare of the family	Absolute number	%
Very well	-	-
Rather well	3	6
Well	7	14
Average	26	52
Lower than average	9	18
Worse than average	3	6
Not indicated	2	4
Total	50	100

Fourteen percent of surveyed ChDPC live with their father, 48% with their mother, 4% with a step-mother, 42% with siblings, 16% with grandparents, 10% with other relatives, 12% with other people who are not their relatives, and 4% did not answer the question (multiple answers were permitted)

Forty percent of interviewed ChDPC were male and 60 % were female. The mean age of the interviewed ChDPC was 15.3 years.

Table 71.
Distribution of ChDPC according to age

Age group	Absolute number	%
10-14	17	34
15-19	32	64
20-24	1	2
Total	50	100

Forty eight (96%) of the ChDPC were single, and 2 (4%) did not specify their marital status.

The interviews conducted with ChCL revealed that 56% of them would turn to their parents or relatives for support, 30% to health care institutions, and 26% to their friends. (multiple answers were permitted) These findings indicate that all of these networks should be further developed to provide improved and increased support to ChCL.

Table 72.
Sources of Support (ChCL)

Where would apply in need of support *	Absolute number	%
Health care institutions	15	30
Social institutions	1	2
NGOs	2	4
Parents/relative	28	56
Friends	13	26
Youth-friendly services	2	4
Do not know	2	4
No one	-	-
Other	3	6
* Multiple answers were permitted		

Table 73.
Types of Support (ChCL)

Type of support*	Absolute number	%
Financial	12	24
None	11	22
Work	9	18
Family	6	12
Psychological	3	6
Education	2	4
Health	2	4
Legal	1	2
Other	4	8
Did not mark	1	2
* Multiple answers were permitted		

Table 74.
Distribution of ChCL according to education

Education	Absolute number	%
Incomplete secondary	43	86
Secondary	7	14
Vocational	-	-
Incomplete higher	-	-
Higher	-	-
Total	50	100

Table 75.
Socioeconomic status of ChDPC families

Degree of welfare of the family	Absolute number	%
Very well	1	2
Rather well	1	2
Well	11	22
Average	21	42
Lower than average	6	12
Worse than average	8	16
Not indicated	2	4
Total	50	100

Two percent of surveyed ChCL live alone, 28% live with their father, 2% with their stepfather, 76% - with their mother, 2% with their stepmother, 60% with siblings, 10% with their grandparents, 4% with relatives, 4% with people who are not their relatives (multiple answers were permitted)

Fifty two percent of the interviewed ChCL were male and 48% were female. The mean age of the interviewed ChCL was 15.8 years.

Table 76.
Distribution of ChCL according to age group

Age group	Absolute number	%
10-14	10	20
15-19	38	76
20-24	1	2
Did not indicate their age	1	2
Total	50	100

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Of those interviewed, 49 ChCL, (98%) were single, and 1 (2%) were divorced.

The service providers note that many ChCL are not provided with routine medical care such as immunization, which makes them vulnerable to different diseases in addition to their behaviour, which puts them at risk for HIV and other STIs.

Through focus groups, service providers expressed concern over the vulnerability, loneliness, hopelessness and general sense that they don't belong which drives ChCL to risky behaviours. Often, these children are afraid to tell their parents about their anxiety and, at times, about the disease revealed in them, and thus they do not receive appropriate treatment. Minors, unable to get answers to the interested questions in their families, try to find them outside the family, and if the children are left without proper supervision and consistency, most probably they become commercial sex workers, tramps, etc.

According to official data, 14-24 year olds comprised 31.4% of all law-breakers in 2003, a 3.4% increase from 2002.⁵

Table 77.
Crime stratified by age

Age group	2001		2002		2003	
	Quantity	%	Quantity	%	Quantity	%
14-17	251	4.6	201	4.2	198	4.3
18-24	1333	24.3	1148	23.8	1239	27.1
Total	5492	100	4821	100	4567	100

Health and Risk Behaviour

Children Deprived of Parental Care

Service providers participating in the RAR do not believe that young people consider their health to be an asset or perceive it as something they can preserve or destroy. Parents in Armenia do not believe that their children may become sexually active at an early age and do not prepare their children for responsible sexual behaviour. That results in increasing vulnerability of EVYP and MARA. Thus, it is necessary to make relevant interventions to address this issue.

The RAR surveys show that only 12% of ChDPC could demonstrate a basic understanding of HIV prevention. Seventy four percent of surveyed ChDPC believe that limiting sex to one faithful, uninfected partner can reduce the risk of HIV transmission; 56% indicated that condom use can reduce the risk of HIV transmission; 70% indicated that a healthy-looking person can have HIV; 38% think that HIV can be contracted through a mosquito bite, and 44% think that HIV can be transmitted by sharing meals with someone who is HIV-infected.

Twelve percent of surveyed ChDPC consider the likeliness of becoming HIV-positive or contracting other STIs to be very high for them, 38% don't consider it a strong likelihood, and 50% eliminated the possibility that they could become infected. This data indicate that more education is needed to ensure that ChDPC have a realistic understanding of the consequences of engaging in risky behaviour.

Interviews revealed that ChDPC think that sexual contact with non-regular sexual partners does not increase risk of HIV infection, reasoning that *'One can have sex with three partners and not get HIV-infected, while another can become infected having only one partner.'*

Eight percent of surveyed ChDPC had never heard of HIV/AIDS, however 76% had heard about STIs. For 43.8%, information about HIV/AIDS and STIs comes from their friends and peers, 45.8% from the mass media. Peer education is recommended as an effective means of awareness raising among ChDPC

Table 78.
Sources of information

Source of information on HIV/AIDS and STIs*	Absolute number	%
Family	2	4.2
Friends/peers	21	43.8
Mass media	22	45.8
School	11	22.9
Social/health care workers	9	18.8
Counselling providing services	-	-
None	1	2.1
Other	7	14.6
* Multiple answers were permitted		

The results of the survey conducted among ChDPC show that a small proportion of them had been tested for HIV, Hepatitis B and C. Only 2% of the surveyed "street" children had been tested for HIV, 8% for Hepatitis B, and 8% had been tested for STIs. None had been tested for Hepatitis C. The majority of the surveyed "street" children (82%) had never been tested for any infection (multiple answers were permitted)

Two percent of surveyed ChDPC had a history of STIs and 9% did not know whether or not they had a history of STIs or not. However, the service providers indicate that, as a rule, girls aged 14-15 apply to health care institutions seeking for STI treatment.

Table 79.

ChDPC's understanding of how to reduce the spread of HIV

Opinions regarding the ways of reducing spread of HIV*	Absolute number	%
Condom use	9	18
Have a faithful partner	4	8
Have relevant knowledge	1	2
Treatment	11	22
Does not know	9	18
Not communicate with people with HIV	5	10
Be tested/screened	1	2
Isolate patients	2	4
Be careful	5	10
Not to engage in commercial sex work	1	2
Proper hygiene	4	8
Reducing number of sexual contacts	4	8
Not to have sexual intercourse with HIV+ people	2	4
Have not marked	2	4
Other	3	6
* Multiple answers were permitted		

The mean age at first sexual intercourse for ChDPC is 13.1 years. A focus on delay of first sexual encounter and abstinence may be an effective strategy for ChDPC. Two of the sexually active ChDPC had sexual intercourse in the 30 days preceding the survey, and one had used a condom during last sexual intercourse.

Table 80.

Distribution of ChDPC by age of first sexual intercourse according to age groups

Age at first sex	Absolute number	%
10-14	8	100
15-19	-	-
20-24	-	-
Total	8	100

Three (37.5%) of the sexually active surveyed ChDPC had had a sexual intercourse with a non-regular partner in the year prior to the survey, of whom one had sexual intercourse with 1-5 non-regular partners, two had had sex with up to 15 non-regular partners. Of these, 66.7% had used a condom the last time they had sex with non-regular sexual partner.

Table 81.

Frequency of condom use among sexually active ChDPC in year prior to survey

Condom use	Absolute number	%
I always use condom	3	37.5
I do not always use condom	-	-
I never used condom	5	62.5
Total	8	100

Table 82.

Reasons for inconsistent condom use (ChDPC)

Reasons for inconsistent condom use*	%
Too expensive/unaffordable	20
Embarrassed to purchase condoms	-
Difficult to use	-
Not that easy to obtain	-
Reduces pleasure	-
Embarrassed to ask their partner to use condom	-
Trust their partner	-
Unaware of effectiveness of condom use	40
Other reasons	40
<i>I did not know about them</i>	
<i>No need</i>	
Total	5 children
* Multiple answers were permitted	

Access to and promotion of condoms for ChDPC must be increased. Of those surveyed, 12.5% of ChDPC had exchanged sex for money, drugs or a job, and 25% had at some point been forced to have sex against their will.

The service providers note that socially unprivileged young people are vulnerable also because they use services provided by the most affordable sex workers. Surveys concur with expert opinions that socially underprivileged young people are especially vulnerable, and require interventions tailored to meet their specific needs.

One (12.5%) of surveyed ChDPC indicated that his sexual partners are mainly commercial sex workers, and 7 (87.5%) indicated other non-regular sexual partners.

Six (12.5%) of surveyed ChDPC had used drugs. The mean age at first drug use was 13.2 years. Drug prevention efforts for ChDPC must target grammar school-age children in order to reach ChDPC before they first take drugs. Primary prevention of drug use among ChDPC at early age would reduce their risky behaviour. The ChDPC who had used drugs indicated that they have used cannabis, marijuana (4 individuals, 66.7%), glue or other inhaled drugs (4 individuals, 66.7%),

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opium tea (1 individuals, 16.7%), other reported using other drugs (prepared from manure). One ChDPC (16.7%) started using drugs from cannabis, three (50.1%) from opium tea, and two (33.3%) from glue. One (16.7%) indicated that drugs are usually taken in a bar, cafe, night club, disco; one (16.7%) on the street, one (16.7%) in the park, one (16.7%) at the homes of their friends, one (16.7%) at parties and three (50%) used drugs in other places (multiple answers were permitted).

Only one of those ChDPC using drugs reported having sexual contact under the influence of drugs. None of the 6 drug-using ChDPC had ever injected drugs.

Table 83.

Distribution of ChDPC by age at first sexual intercourse

Age at first drug use experience	Absolute number	%
10-14	5	83.3
15-19	1	16.7
20-24	-	-
Total	6	100

Table 84.

Reasons for starting to use drugs

Reasons for starting using drugs*	Absolute number	%
Curiosity	3	50
Peer pressure	1	16.7
Psychological reasons (stress, depression)	-	-
Relieve pain	-	-
Improvement in physical appearance	-	-
Receiving pleasure	2	33.3
* Multiple answers were permitted		

During focus groups discussions, ChDPC indicated that peers often use glue as well as combining Dimedrole and vodka; they also indicated that almost everybody in their environment used alcohol, and stated that drugs and alcohol are easily available.

The service providers think that young people become more vulnerable to HIV as a result of alcohol and especially injecting drugs use, as well as due to unprotected sex and unperceived sexual behaviour. The risk factors are: the social situation, lack of information, and the lack of sex culture. Pernicious habits of young people, especially smoking, drug addiction, toxicomania and alcoholism constitute the most serious danger today. One of the common reasons for alcohol use is unemployment. 'Playing cards for vodka' is a common practice among the young people. According to some specialists' opinion, psychological problems and curiosity are among the major reasons for alcohol and drug use among children.

Children in Conflict with the Law

RAR surveys show that only 16% of ChCL could demonstrate basic knowledge on HIV prevention. Seventy eight percent of surveyed ChCL believe that limiting sex to one faithful, uninfected partner can reduce the risk of HIV transmission; 64 % indicated that condom use could reduce the risk of HIV transmission; 64 % indicated that a healthy-looking person could have HIV; 52 % think that one can get HIV through a mosquito bite and 42 % noted that one could get HIV by sharing meals with someone who is HIV-infected.

Ten percent of the surveyed ChCL had never heard about HIV/AIDS, but 88% of respondents had heard about STIs. Information about HIV/AIDS and STIs for 67.3 % of ChCL came from their friends and peers, and 53.1 % got their information from the mass media. The findings of the survey show that peer education and targeted mass media would be very effective among ChCL, as well as among ChDPC.

Table 85.
Source of Information

Source of information on HIV/AIDS and STIs*	Absolute number	%
Family	4	8.2
Friends/peers	33	67.3
Mass media	26	53.1
School	6	12.2
Social/health care workers	2	4.1
Counselling providing services	1	2
No	-	-
Other	7	14.3
Not indicated	1	2
* Multiple responses were permitted		

Four percent of surveyed ChCL consider the likeliness of becoming HIV-positive or contracting other STIs to be very high for them, 50% not high, and 46% thought it was not possible for them to become infected. Eight percent of the surveyed ChCL had a history of STI, 34% did not know whether they had a history of STI or not. Three (75%) of those having STI history had had gonorrhoea; 4 had gone to a health care institution seeking the treatment. The surveys show that there is a need to raise awareness on STI and other reproductive health-related issues among ChCL.

The results of the survey show that a very small proportion of ChCL had been tested for HIV or Hepatitis B and C. In particular, 6% of surveyed ChCL had been tested for HIV, 2% for Hepatitis B, 16% had been tested for STIs, and none had been tested for Hepatitis C. Fully, 80% had never been tested for any infection. (multiple answers were permitted)

Interviewed ChCL indicated that they had not undergone medical checkups, since they do not prioritise their own health care. The survey shows that low levels of testing applicability among ChCL are consistent with low levels of their knowledge. Therefore, awareness-raising is a critical intervention for this group and should be achieved through both IEC and BCC.

Table 86.

What is needed to reduce the spread of HIV

Opinions regarding the ways of reducing spread of HIV*	Absolute number	%
Condom use	9	18
Know partner	1	2
Have relevant knowledge	2	4
Treatment	10	20
Does not know	8	16
Not communicate with anyone	11	22
Be tested/screened	2	4
Isolate patients	6	12
Be careful	5	10
Prohibit commercial sex work	1	2
Exercise control over commercial sex work	1	2
Have not marked	2	4
Other	3	6
* Multiple answers were permitted		

The mean age at first sexual intercourse of ChCL was 14.4 years. Six (20.7%) of sexually active ChCL had had sexual intercourse in the 30 days preceding the survey, of which 66.7 % had used a condom during last sexual intercourse.

Table 87.

Distribution of ChCL by age at first sexual intercourse

Age at first sex	Absolute number	%
10-14	13	44.8
15-19	15	51.8
20-24	1	3.4
Total	29	100

Of the sexually active ChCL surveyed, 51.7% (15 individuals) had had sexual intercourse with a non-regular partner in the year prior to the survey.

Table 88.

Distribution of non-regular sex in past year prior to survey, by frequency

Number of non-regular sexual partners	Absolute number	%
1-5	10	66.7
Up to 15	3	20
Not indicated	2	13.3
Total	15	100

Of those sexually active ChCL, 66.7% had used a condom the last time they had non-regular sex.

Table 89.

Frequency of condom use

Condom use	Absolute number	%
I always use condom	7	24.1
I do not always use condom	7	24.1
I never used condom	15	51.8
Total	29	100

Table 90.

Reasons for inconsistent condom use

Reasons for inconsistent condom use*	%
Too expensive/unaffordable	-
Embarrassed to purchase condoms	13.6
Difficult to use	4.5
Not that easy to obtain	4.5
Reduces pleasure	22.7
Embarrassed to ask their partner to use condom	22.7
Trust their partner	13.6
Unaware of effectiveness of condom use	18.2
Other reasons	18.2
* Multiple answers were permitted	

Focus group discussions show that half of the male ChCL are sexually active, whereof the majority are aware of their risky sexual behaviour and of the ways to reduce the risk. However, their level of awareness is rather low due to irregular provision of information.

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Of the sexually active ChCL, 10.3% had exchanged sex for money, drugs, or a job, and 10.3% had been in situations in which they were forced to have sex. Five ChCL (17.2%) of the surveyed ChCL indicated that their sexual partners are mainly commercial sex workers, 6.9% (2 individuals) usually had sex with foreigners, 79.3% (23 individuals) had sex with other categories of people (multiple answers were permitted)

Twenty (40%) of surveyed ChCL had used drugs. The mean age at first drug use was 13.1 years. Provision of primary prevention of drug use among ChCL at early age would be an effective form of reducing risk of exposure to HIV among ChCL.

Table 91.
Distribution of ChCL by age at first drug use

Age when first used drugs	Absolute number	%
10-14	17	85
15-19	2	15
20-24	-	-
Not indicated	1	5
Total	20	100

Three ChCL (15%) who had taken drugs indicated that they usually use drugs at their homes, 5 (25%) on the street, 4 (20%) in the park, 5 (25%) at school, 3 (15%) in the homes of their friends, 2 (10%) at parties. Three (15%) started using cannabis, 1 (5%) first used opium tea, and 17 (85%) began with glue. Four ChCL reported having sexual contact under the influence of drugs. None of the 20 drug-using ChCL had ever injected drugs.

Table 92.
Types of drugs used by ChCL

Drug types*	Absolute number	%
Cannabis/marijuana	6	30
Diazepam or other benzodiazepam (apaurin)	-	-
Ecstasy	-	-
Glue or other inhaled drugs	18	90
Amphetamines	-	-
Heroin	-	-
Cocaine	-	-
Opium tea	1	5
Other	-	-
* Multiple answers were permitted		

Table 93.
Reasons for starting to use drugs

Reasons for starting using drugs*	Absolute number	%
Curiosity	14	70
Peer pressure	4	20
Psychological reasons (stress, depression)	1	5
Relieve pain	-	-
Improvement in physical appearance	-	-
Receiving pleasure	7	35
* Multiple answers were permitted		

Interventions

According to the State secondary education system, a graduate student of a secondary school must:

- know rules of healthy life style and safer behaviour and apply those rules
- know his/her rights and obligations
- have his/her thinking, to be able to act in different situations
- express mutual understanding and be able to cooperate
- realize the necessity of starting family, be prepared for domestic life
- be able to adequately evaluate his/her capacities and be self-confident.

These issues are being addressed through the secondary education system. The curricula of 414 secondary schools in Armenia include HIV/AIDS prevention. In particular, *Life Skills* classes are given in 384 secondary schools, and *Healthy Lifestyles* classes are given in 30 schools with UNICEF support. It is envisaged that a course on HIV/AIDS prevention and forming safer behaviour be developed during the first phase of the National Programme, and be introduced in 400 secondary schools. These classes are not incorporated into the curricula of special educational institutions, increasing the vulnerability of students who may already be socially isolated. It is strongly recommended that special educational institutes be included in these efforts.

As per specialists' opinion, awareness on sexual life among youth is one of the major factors increasing the vulnerability of youth, which is conditioned by indifferent attitude of school. The majority of teachers consider it inadmissible to discuss the topics related to or give lessons on sexual issues with schoolchildren. They think that in most cases adolescences receive information from unreliable sources.

RAR survey results show that awareness on HIV prevention of ChCL and ChDPC is significantly lower than all other surveyed EVYP. It should be noted that the scope of activities implemented among these group of young people is very limited; activities aimed at raising awareness and forming safer behaviour must include and specifically target ChCL and ChDPC. It is recommended that future interventions incorporate HIV/AIDS-related classes into curricula of special educational institutions, in particular to incorporate 'Life Skills' and 'Healthy Life Style' classes and provide peer education to ChCL and ChDPC, not only in the special educational institutions, but also involve in these activities children living or working on the streets

The survey also revealed that only 32% of ChCL and 40% of ChDPC would go to health and social services institutions when in need, and only 4% of ChCL and 2% of ChDPC would go to youth-friendly health services, proving that there is insufficient trust in institutions and lack of information about services they provide. According to the survey, fundamental changes are needed, including

Rapid Assessment and Response Analysis

the expansion of VCT and other health services, and tailoring them more to the needs of adolescents. More youth-friendly clinics are needed, and all services should target and be accessible to children living or working on the streets as well as other vulnerable groups.

While drug abuse prevalence among ChDPC is only at 12%, it reaches 40% among ChCL. The mean age when first used drugs among ChCL and ChDPC groups is nearly the same at 13.1 and 13.2 years respectively, understating the urgent need to strengthen early drug and STI prevention among ChCL and ChDPC. To achieve this, the capacity of primary health and educational services must be strengthened by engaging relevant specialists to address healthy lifestyles and preventive health issues.

The survey showed that ChCL and ChDPC place importance on the support of parents and relatives. The revealed that 56 % of ChCL and 36 % of the ChDPC would turn to their parents and relatives for support when in need. In this case, it is also important to involve family members in preventive activities.

The population at large should be targeted with awareness-raising on the vulnerability faced by ChCL and ChDPC. Ultimately, increased community awareness and support, will engage entire communities to play a role in risk-reduction and HIV prevention.

Response Analysis

What is being done and what needs to be carried on

The response analysis shows that the preventive projects implemented among the most vulnerable of the HIV population groups (IDUs, CSWs, MSM) are of great importance in the process of reducing HIV prevalence rates. In general, the projects' implementation could be considered as effective, since they ensure and provide VCT services, STI diagnosis and treatment, means of prevention (condoms, disposable syringes) and skills on their proper use. However, the interventions conducted within the framework of these projects do not involve MARA, are not focused on their special needs, and do not provide for YFHS for the target groups.

However, appropriate approaches and strategies are used in the implementation of all the above-mentioned projects targeted to the population groups with the greatest risk of HIV. Thus, the implementation of the projects is due to be continued with more focus on MARA during the future interventions.

What is being done and what needs expansion

By the end of the second year of implementation of the GFAMT-supported National Programme on HIV/AIDS Prevention, about 1,800 teachers from 1,420 educational institutions had been trained. Twenty-four hours "HIV/AIDS Prevention and Forming Safer Behaviour" course was developed, which is to be introduced in 400 schools. The course is to be given during lessons of form master. At the same time, this course will be given in the eighth and ninth grades of thirty schools as part of the "Healthy Lifestyles" pilot project.

Besides the RA Police suggested incorporating in educational programmes the manual "Legal mosaic" developed within the framework of legal socialization programme "Development of justice promoting ideas" financed by International Bureau on the Issues of Combating Trafficking and Rights Protection. This manual includes five topics. The fourth one is "Pernicious Habits", where etiology and consequences of HIV are given with the assistance of a policeman and a teacher to senior students of secondary schools.

It is necessary to broadly integrate the HIV/AIDS-related issues into the educational programmes of the educational institutions, and to also incorporate them into the curriculum of the special educational institutions throughout Armenia.

What has not been done

The preventive measures envisioned by the National Programme on HIV/AIDS Prevention and HIV/AIDS preventive activities implemented by separate NGOs do not cover the following especially vulnerable groups of adolescents aged ten to fifteen:

- Children in Conflict with the Law
- Children Deprived of Parental Care

The work with the above-mentioned groups requires new strategic approaches. It is necessary to develop effective responses and new technical solutions to prevent HIV/AIDS in these especially vulnerable groups, which should be incorporated into the Country Specific Strategic Plan.

The results of Situation and Response analyses give an opportunity to develop a strategic plan on HIV/AIDS prevention among Especially Vulnerable Young People and MARA in Armenia.

Recommendations

The Response Analysis has revealed the strengths and weaknesses of implemented HIV/AIDS prevention interventions. Recommendations to solve revealed problems are given below.

- It is critical to encourage involvement and participation of central and local governmental and community representatives in preventing HIV/AIDS. Coordination of government and civil society activities must be improved at the community and national levels.
- HIV/AIDS-related issues must be integrated into the special education system. Peer education, which is already provided in mainstream secondary schools, higher educational institutions, among uniformed services, in penitentiary institutions, as well as among number of HIV vulnerable populations, must be target EVYP and MARA and should also be expanded to special education.
- While the role of parents and the extended family is changing in Armenia, it is still critical to include family members in the promotion of safer behaviours and accurate HIV prevention information for MARA and EVYP.
- Activities and services to meet the needs of EVYP and MARA, and current services must be made more youth-oriented, to encourage health-seeking behaviour among EVYP and MARA.
- Harm reduction strategies must be implemented, including outreach work, improving accessibility, conducting IEC and BCC, mobilizing communities, tailoring existing services to meet the needs of EVYP and MARA.
- It is necessary to implement activities at the national and community levels to minimize indifference and discrimination towards EVYP and MARA to reduce stigma that hinder their greater involvement into HIV/AIDS prevention activities.
- Young girls engaged in commercial sex require urgent, targeted interventions and promotion of healthy lifestyles. Complimentary activities aimed at young boys should seek to reinforce healthy behaviours.
- A review of all current services should evaluate efficacy of reaching EVYP and MARA, and relevant amendments to current strategies should be made. EVYP and MARA should be integrated into existing HIV surveillance efforts

Conclusions and Recommendations

This rapid assessment evaluated the level of knowledge on HIV prevention, risk behaviour, vulnerability and accessibility to services among EVYP and MARA. The RAR findings present an opportunity to identify and respond to the needs of EVYP and MARA, and to plan targeted interventions to reduce their risk and vulnerability to HIV infection. Cumulative data of behaviour features and knowledge level on HIV prevention, sources of support, sources of HIV/AIDS information are given below.

Table 94.

Cumulative: data risk behaviour and HIV knowledge

<i>Cumulative data of risk behaviour and HIV knowledge level</i>							
N	Behaviour features and knowledge on HIV prevention	IDUs	DUs	Young CSWs	Young MSM	ChCL	ChDPC
1.	The level of correct knowledge on HIV prevention	40%	38%	30%	48,5%	16%	12%
2.	Drug use	100%	100%	10%	8,6%	40%	12%
3.	Consistent condom use	71,4%	85,2%	72%	34,2%	24,1%	37,5%
5.	STI history	12%	6%	46%	20%	8%	2%

Table 95.

Cumulative: sources of support

<i>Cumulative Sources of Support</i>							
N	Sources of Support	IDUs	DUs	Young CSWs	Young MSM	ChCL	ChDPC
1.	Medical institutions	-	-	40%	41,2%	30%	34%
2.	Social institutions	-	-	2%	-	2%	6%
3.	NGOs	12%	6%	70%	26,5%	4%	-
4.	Parents/relevant	4%	12%	2%	20,6%	56%	36%
5.	Friends	8%	36%	26%	41,2%	26%	26%
6.	Youth-friendly services	-	2%	-	2,9%	4%	2%
7.	Do not know	32%	34%	8%	5,9%	4%	34%
8.	No one	56%	26%	-	5,9%	-	4%
9.	Other	4%	6%	6%	8,8%	6%	12%

Table 96.

Cumulative sources of information

<i>Cumulative Source of HIV/AIDS Information</i>							
N	Source of information on HIV/AIDS	IDUs	DUs	Young CSWs	Young MSM	ChCL	ChDPC
1.	Family	-	-	2%	8,6%	8,2%	4,2%
2.	Friends/peers	8%	40%	68%	51,4%	67,3%	43,8%
3.	Mass media	72%	64%	34%	37,1%	53,1%	45,8%
4.	School	-	10%	-	8,6%	12,2%	22,9%
5.	Social/health care workers	24%	26%	40%	8,6%	4,1%	18,8%
6.	Counselling providing services	36%	6%	-	22,9%	2%	-
7.	None	-	-	-	-	-	2%
8.	Other	4%	2%	18%	22,9%	14,3%	14,3%
9.	Not indicated	-	-	-	-	2%	-

According to survey results, none of the vulnerable groups possessed even 50% correct knowledge on HIV/AIDS prevention and transmission. MSM had the highest level of knowledge, at 48.5% answering correctly, and ChDPC had the lowest level, with a mere 12% answering correctly. It is recommended that this be addressed through IEC and BCC activities as well as group-specific targeted interventions. None of the surveyed groups identified school as a main source of information, highlighting the missed potential schools has in HIV prevention. *Healthy Lifestyles* and *Life Skills* should be taught in all schools, and educators should be trained and supported to be able to communicate better with their students on these sensitive and important issues. *Healthy Lifestyles* and *Life Skills* must also be expanded to cover all special education institutions.

Peer education networks should be expanded and developed as an effective means of awareness-raising for all vulnerable groups. Special peer-based interventions should be developed for IDUs, who were the only group that did not use peer networks as a source of HIV and reproductive health information.

Most of the targeted groups identified mass media as an important source of information. Mass media must therefore be oriented and engaged in promoting preventive and information with group-specific messages designed to reach all EVYP.

The survey revealed very little confidence by youth in what are supposed to be youth-friendly health institutions. In particular, none of the CSWs, IDUs or DUs would consider seeking help from a health institution, and no IDUs or DUs would go to youth-friendly health institutions. The survey also revealed that in case of need rather small part of the surveyed MSM would apply to health care institutions (41.2%) or to youth-friendly service (2.9%); 30% of ChCL and 34% of ChDPC would apply to health care institutions; 4% of ChCL and 2% of ChDPC would apply to youth-friendly services in case of need. At the same time no one of the surveyed young CSWs would go to youth-friendly health services and 40% would go to health care institutions. So, few adolescents access youth-friendly health services that monitoring of STI prevalence among the young people through YFHS is not possible. This represents a huge flaw in the YFHS programme and indicated the need for improvement in reaching out to all sectors of youth.

ChCL and ChDPC first begin using drugs when they are quite young, at a mean age of 13.1 and 13.2 years respectively. The mean age at first drug use among IDUs, DUs, CSWs and MSM is high-

er, at 17.6, 15.6, 18.2 and 18.7 years respectively. The mean age at first sexual intercourse of ChCL, ChDPC and MSM was 14.4, 13.1 and 14 years respectively, lower than that of the IDUs, DUs and young CSWs, who began at 17.7, 17.9 and 16.6 years, indicating the need for drug prevention and sex education to be focused at children under 13 years of age.

While IDUs, DUs and CSWs don't turn to their families for help, ChCL, ChDPC and MSM consider their families as sources of support. None of the groups named their families as significant sources of information, however family members of EVYP and MARA should be given the opportunity to actively participate in the preventive and treatment processes whenever possible and appropriate.

Interviews revealed that communities are not actively engaged in preventive activities. Activities aimed at changing the attitude of community leaders and community representatives toward ChCL and ChDPC as well as other EVYP are also critically needed and interventions at the community level should target the elimination of stigma and discrimination against IDUs, DUs, CSWs and MSM. The level of involvement and role of communities in the implementing activities must be increased. While CSWs, IDUs and MSM feel comfortable seeking services from NGOs, almost no ChCL or DUs would do the same.

To provide effective drug addiction treatment it is necessary to:

- Combine existing treatment with rehabilitation.
- Make the amendments to the existing law referring to the prohibition of using drugs and psychotropic substances in drug addiction treatment.
- Study possible obstacles which can arise when representatives of the surveyed groups apply to the services providing institutions and monitor confidentiality maintenance.

GUIDE FOR A FOCUS GROUP

Topics:

1. Presentation of the interviewee
2. Family
3. Social context (communications)
4. Standards (rules) of the group
5. Attitudes and rules about sex
6. Healthy/risky sexual behavior
7. Alcohol and drugs
8. Needs

Detailed review of the topics:

1. Presentation of the interviewee:

- How old are you?
- What do you study/work?
- Where do you live, and with whom?

2. Family

- What are the relations within the family like? (how much time do you spend with your family?)
- Do you feel safe and loved?
- Can you talk about your feelings? With whom?
- Whom of your closest ones would you confide in?

3. Communications:

- What does your day look like, what do you do in your spare time, where do you spend your spare time, with whom?
- How would you like to spend your spare time and with whom?
- Where do you go out most often?
- What do you usually talk about, and what do you do together?
- Who do you address for help if you have a problem and why?
- Who has the greatest influence on you?

4. Standards (rules) of the group

- What is acceptable for your peers (how do you make decisions about what is bad and what is good)?
- Are you complying with the rules of your peers that you associate with?
- What will happen if you break those rules?
- How do you respond to peer interventions?

5. Attitudes and rules about sex

- Who did you learn from (and how) about sex-related matters?
- Since when have you been interested in these matters?
- Do you talk with anybody about your sexual life? With whom?

6. Healthy/risky sexual behavior

- What kinds of sex do you know about?
- Do you feel forced to do things that you don't want to do (sex without condom, sex for money, drugs, religion)?
- Do you know what risky sexual behavior is?
- Are there cases of risky sexual behavior among friends (in the institution)?
- What are the factors that are conducive to this kind of behavior?
- Does your group do something about risky behaviour?
- Does your group provide information and education on prevention of risky sexual behavior on a continuous basis?
- Have you ever heard about condoms and what kind of condoms do you know about?
- Do you use condom, and what kinds do you use (who takes care of that)? If not, why?
- Does your partner use condom?
- Do you know how to protect yourself from unwanted pregnancy?
- What do you know about Sexually Transmitted Infections (STIs)? When are they dangerous?
- How can you get infected by HIV? What do you know about AIDS?
- Are you afraid that you may get infected with HIV, and what measures do you take in order to protect yourself?
- Do you feel ready for an open conversation about condoms with your partner?
- Do you feel ready to start a family?

7. Alcohol and drugs

- Do you drink? In what situations? How often?
- Have you ever smoked grass (marijuana) or taken another kind of drugs (tablets with alcohol, sniffing, injecting); when you do that, how are you feeling?
- What is your opinion regarding this phenomenon prevalence?
- Are those people different from the others who do not use drugs or alcohol?
- Is there anything that bothers you in the communication with them?

The following questions are only for drug users:

- What do you think about the drug problem among the young people?
- Is it easy to get drugs in the place where you live?
- Are drugs expensive or cheap?
- Do you know many people that take drugs?
- Do you take drugs intravenously? For how long?
- Do you inject drugs more often when you are alone or in a company of other people?
- Who are you usually with when you take drugs intravenously?
- Has it ever happened to you to take drugs in a company of unknown people?
- Have you visited a place where drug users get together in order to take drugs (where they don't know each other)?
- Has it ever happened to you to use needles and syringes that somebody else had used before you?
- Has it happened to you to use drugs already prepared by somebody else?
- Is it easy for you to get new needles and syringes?
- Is it easy for you to get a social, health or another service if people know that you are a drug user?
- What do you think that needs to be done in order to improve the living conditions for drug users?
- Do you think that with your behavior of an intravenous drug user you are more susceptible to diseases?
- Would you like to give in drug use?

8. Needs

- Do you have enough information on HIV/AIDS, alcohol and drugs?
- Do you have a place (school, clinic, NGO, friend) where you can go and find information about the issues you are interested in (sexually transmitted diseases, protection, testing, drugs) anonymously?
- In which of the areas that we mentioned so far you would change something, and what?

QUESTIONNAIRE FOR CSWS, ARMENIA

Questionnaire No: _____

City: _____

Place of the interview: _____

Date: _____ (dd/mm/year)

Completed by (member of the team, initials): _____

Checked by (initials): _____

Hello, my name is _____. I am helping to UNICEF in the research that's focused on issues of youth and their health in your _____ (name of the institution, country, city). The objective of the study is to identify the health issues young people face today and to develop responses to deal with these issues. As part of this study, we are interviewing a large number of vulnerable young people across the region. I would like to ask you a few questions to assist us with this study. It will take about 20 minutes. We are not taking down any names or addresses and all information is completely confidential.

[NOTE for Interviewer: At this stage respond to any queries that the interviewee has. If he/she agrees, record their age to ensure they meet study criteria. If they do not, thank the respondent and terminate interview.]

1. Have you heard of HIV/AIDS?

- a. Yes
- b. No

2. Have you heard of STIs?

- a. Yes
- b. No

We define STI as a genital herpes, gonorrhoea, syphilis, chlamydia, genital herpes, inflammation of genital organs, trichomoniasis, hepatitis B and C.

3. Where do you get information on HIV/AIDS and STIs?

- a. Family
- b. Friends/peers
- c. Media (TV, newspapers, radio shows...)
- d. School
- e. Social/health workers
- f. STI counseling service
- g. Nowhere
- h. Other (please specify) _____

4. Please, answer the following statements with “YES” or “NO”

Statement	YES	NO
Can the risk of HIV transmission be reduced by having sex with only one faithful, unprotected partner?		
Can the risk of HIV transmission be reduced by using condoms?		
Can a healthy-looking person have HIV?		
Can a person get HIV from mosquito bites?		
Can a person get HIV by sharing a meal with someone who is infected?		

5. In your opinion what are STIs of the mentioned below?

- a. Syphilis
 b. HIV/AIDS
 c. Pneumonia
 d. Gonorrhea
 e. All

6. What is your risk for HIV or other STI?

- a. High
 b. Moderate
 c. Without any risk

7. Have you ever been tested for the following?

- a. HIV/AIDS
 b. Hepatitis B
 c. Hepatitis C
 d. STIs
 e. I have never been tested

If you mentioned “e” go to the question 11.

8. If you have been tested for HIV, where have you undergo testing?

- a. VCT site
 b. NCAP
 c. Polyclinic
 d. Other

9. If you have been tested for HIV, you have done it:

- a. On a voluntary basis
 b. On a mandatory basis

10. Have you been informed about the results of the testing?

- a. Yes
 b. No

11. Have you ever had STIs?

- a. Yes
 b. No
 c. I do not know

If the answer is no, go to question 16.

12. Which STI did you have? (name infection) _____**13. Have you had STI or inflammation of genital organs in the last year?**

- a. Yes
 b. No

If the answer is no, go to question 16.

14. What did you when you became infected with STI?

- a. Went to hospital (polyclinic, other health care institution)

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- b. Self treated
- c. Other (please specify) _____
- d. Did nothing

15. How do you think HIV can be prevented? _____

16. Were you given any counseling and information before or after the test?

- a. Yes
- b. No

17. Do you think that you are at risk for HIV or other STIs?

- a. Yes
- b. No

We will ask you some questions in regards to the sexual behavior. We understand how these questions are personal but we would like to mention one more time that your identity is fully protected and that we are asking all respondents the same questions. We define sexual intercourse as oral, vaginal and anal sexual intercourse.

18. At what age did you have your FIRST sexual intercourse? _____

19. At what age did you start providing commercial sex? _____

20. Where do you usually find your clients?

- a. Bars / cafés / clubs
- b. Party
- c. Parks
- d. Street
- e. Schools
- f. In massage salon
- g. Other place (please specify)

21. Are your clients usually:

- a. Locals
- b. Foreigners who work here
- c. Other (please specify)

22. In the last week, how many sexual partners have you had? _____

23. In the last month, how many sexual partners have you had? _____

24. Have you had sex with non-commercial partner in the last year (a non-commercial sexual partner is a partner who is neither a spouse, nor a cohabiting person and from whom no payment is received for sex)?

- a. Yes
- b. No

If no, go to Question 26

25. If yes, how many non-commercial partners have you had in the last 12 months _____

26. Did you (or your partner) use condom last time you had sex with non-commercial partner?

- a. Yes
- b. No

27. How often have you (or your clients) used condom during the last 30 days?

- a. Always
- b. Almost always
- c. Sometimes
- d. Never

If your answer is "always" go to Question 28.

28. What are the reasons for not using condoms always?

- a. Too expensive/not affordable
- b. Embarrassed to buy
- c. Difficult to use
- d. Not easily available
- e. Reduces pleasure
- f. Embarrassed to ask partner to use
- g. Trust in clients
- h. No knowledge about condom's positive effects
- i. Other (please specify) _____

29. Have you ever had sexual intercourse with someone in return for money, drugs, employment etc.?

- a. Yes
- b. No

30. Did you use condoms last time you had oral sex?

- a. Yes
- b. No
- c. I do not have oral sex

31. Did you use condoms last time you had vaginal sex?

- a. Yes
- b. No
- c. I do not have vaginal sex

32. Did you use condoms last time you had anal sex?

- a. Yes
- b. No
- c. I do not have anal sex

33. What kind of condoms do you use?

- a. condoms for anal sex
- b. condoms for vaginal sex
- c. condoms for oral sex
- d. female condoms
- e. any kind of condom
- f. do not use condom

34. Have you had problems with the police related to commercial sex?

- a. Yes
- b. No

35. If yes, so what kind of problems did you have?_____**36. Have you ever prosecuted by the law for being engaged into commercial sex?**

- a. Yes
- b. No

We would like to ask you a few questions connected with drug use. Please be assured that the confidence will be maintained, since we do not know your names. We are asking all respondents the same questions and we are not going to lay special emphasis on you.

37. Have you ever used drugs?

- a. Yes
- b. No

If the answer is no go to question 57

38. How old were you when you FIRST used drugs? _____**39. In your life did you use any of the following?**

- a. cannabis/marihuana

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- b. diazepam or other benzodiazepam (apaurin)
- c. ecstasy
- d. glue or other inhalants
- e. amphetamine
- f. heroin
- g. cocaine
- h. opium tea
- i. other (please specify) _____

40. What drug did you start with (name drug)?

41. Where do you usually use drugs?

- a. Bar/café/disco club
- b. Home
- c. Street
- d. Parks
- e. Schools
- f. Toilets / WC
- g. During parties
- h. Other (please specify) _____

42. Why did you start to take drugs?

- a. Curiosity
- b. Persuasion of friends
- c. Psychosocial problems (stress, depression)
- d. Pain release
- e. Improvement in physical appearance
- f. For pleasure
- g. Other _____

43. Have you ever had sexual contact under the influence of drugs

- a. Yes
- b. No
- c. Do not remember

44. Have you ever used drugs by injecting?

- a. Yes
- b. No

If the answer is no go to question 57

45. What kind of drugs do you use by injecting? _____

46. How old were you when you FIRST used injecting drugs? _____
years old

Questions 46, 48 and 49 are about drug injecting equipment and how it may be used. We define "drug-injecting equipment" as needles and syringes. We define "sharing" as using a needle or syringe for injecting drugs when you knew or suspected that someone else (including your sexual partner) had used it before.

47. Did you share drug-injecting equipment in the last month?

- a. Yes
- b. No

48. Have you ever used drugs prepared by somebody else?

- a. Yes
- b. No

49. Where do you usually get your equipment for injecting drugs?

- a. Sharing equipment with others
- b. From pharmacy
- c. From friends
- d. From health institutions

- e. From drug distributor
 f. Other (please specify) _____

50. Do you clean equipment before you use it?

- a. Yes, always
 b. Sometimes
 c. Never

51. If yes, or sometimes, how do you clean? _____

52. During the last month, did you have any problems with skin (blush, pain, infection) at the place where you inject drugs?

- a. Yes
 b. No

53. Have you ever seek for treatment related to drug use?

- a. Yes
 b. No

If "no", go to Question 56.

54. During the last one year did you visit a doctor because of drug injecting?

- a. Yes
 b. No

If no, go to Question 54

55. If yes, please explain why?

- a. To stop addiction
 b. Overdose
 c. Skin infection
 d. Other infection
 e. Other (please specify) _____

56. What kind of treatment have you received?

- a. Isolation
 b. Psychotherapy
 c. Socioterapy (social, group therapy)
 d. Other (please specify) _____

57. If no, please explain why

- a. Do not trust doctors
 b. Do not believe in the effective treatment
 c. Do not believe that confidentiality would be maintained
 d. Have financial problems
 e. Do not consider myself to be ill

58. If you need support to whom would you like to apply?

- a. Health care institutions
 b. Social institutions
 c. NGOs (specify) _____
 d. Parents/relatives
 e. Friends
 f. Youth Friendly Services
 g. Do not know
 h. No one
 i. Other (please specify) _____

59. What kind of support would like to receive for improving your life?

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60. Your education?

- a. Incomplete secondary
- b. Secondary
- c. Vocational
- d. Incomplete higher
- e. Higher
- f. Other _____

61. To what extent is your family well-off (compare with other families living in Armenia)?

- a. Very well
- b. Rather well
- c. Well
- d. Average
- e. Lower than average
- f. Worse than average

62. With whom do you live?

- a. By their own
- b. With a father
- c. With a stepfather
- d. With a mother
- e. With a stepmother
- f. With a brother (brothers) or a sister (sisters)
- g. With a grandmother (grandmothers) or a grandfather (grandfathers)
- h. With other relatives
- i. With other people who are not their relatives

63. Age _____

64. Your marital status

- a. Single
- b. Married
- c. Divorced
- d. Civil marriage
- e. Widowed

THANK YOU

Thank the respondent and terminate interview. Give out information leaflets if appropriate and answer any questions that the respondent asks. Also, check that the questionnaire is fully and accurately completed.

65. Please state how you think the interview went:

- a. very well
- b. moderately well
- c. not very well.

If "not very well" please state why. Add any other comments you might have.

66. Where are you completing this questionnaire?

- a. bar/cafe/disco club
- b. school
- c. street
- d. park
- e. home
- f. needle exchange site (place or project, where you can discard old/used needles or syringes and exchange them with new ones)
- g. other places (please specify)

ANNEX 3A

GUIDE FOR AN INTERVIEW WITH THE KEY SOURCES OF INFORMATION

Topics:

1. Presentation of the interviewee
2. Presentation of the institution
3. Characteristics of a target group
4. Social context (communications)
5. Family
6. Standards (rules) of the group/institution
7. Alcohol and drugs
8. Healthy and risky sexual behavior
9. Needs

Detailed review of the topics:

1. Presentation of the interviewee:

- Age/gender
- Since when he/she has been working in the institution
- Position in the institution

2. Presentation of the institution:

- Characteristics (type of institution, location, capacity)
- How many people are employed? Their education.
- Activities of the institution.
- What are the social relationships like in the institution?
- Are there any obstacles to interventions and personal initiatives?

3. Characteristics of a target group

- Number, age, gender, education.
- How do they spend their free time?
- Are they local residents or not?

4. Social context (communications)

- Who do they communicate with most of the time in the institution?
- Who do they address for help most often?
- How openly do they communicate amongst each other
- Who do they communicate with most of the time outside of the institution?
- Who has the greatest influence on them?
- How openly do they communicate with you?
- Do they address you in person in given situations?
- What kind of help do they ask from you most often?
- How do you personally build the confidence between you and them?

5. Family

- What kind of family do they originate from – a complete/incomplete one, how many members (several member family means a family with more than 4 members), social and economic status of the family?
- Do they have contacts with any family member?
- Is anybody else interested in them?

6. Standards (rules) of the group/institution

- Do they comply with the rules of the institution?
- What happens if they violate the rules of the institution?

- How do they respond to interventions?
- Do they have their own group rules?
- Do they abide by the group rules?
- Do the groups have leaders?
- What happens if they violate the group rules, i.e. what kinds of measures are taken?

7. Alcohol and drugs

- What is your knowledge on alcohol use inside and outside of the institution?
- What is your knowledge on drug use inside and outside of the institution?
- What are the reasons for them starting to take drugs and alcohol?
- Do you as institution provide continuous information and education about prevention of alcohol and drugs use?
- What do you personally do about this?

8. Healthy – risky sexual behavior

- What is your knowledge on the sexual behavior of the groups inside and outside of the institution?
- Are there cases of risky sexual behavior?
- What are the factors that are conducive to such behavior?
- Do you as institution do anything about it?
- Do you as institution provide continuous information and education about prevention of risky sexual behavior?
- Do they have knowledge on HIV/AIDS and STIs?
- Do they know how to take care of their health, and what kind of measures do they take for protection of their health?

9. Needs

- with regard to the above-mentioned topics/health services/obstacles.

ANNEX 3B

MANAGERS OF HEALTH INSTITUTIONS PROVIDING STI TREATMENT

HEADS OF INSTITUTIONS PROVIDING PRIMARY OUT-PATIENT HEALTHCARE SERVICES

Name of institution -----

Name of ward -----

Name of service -----

Interview structure

- How long have you been engaged into this field?
- How would you assess sex business development in our country?
- What other changes do you find based on your institution's regarding the spread of this phenomenon?
- What are the biggest problems that you encounter during your demanding work ?
- If things at your institution depended solely on you, if you were to make decisions exclusively, what changes would you introduce ?
- Do you follow patterns of risk behaviour related to HIV transmission of your patients?
- Are any measures undertaken to prevent such behaviour? Which?
- What therapeutical programmes applied are the most effective?
- How can you confirm it?
- What do you consider to be inefficient and in need of change ? What would you eliminate?
- What therapy efficiency indicators do you use
- How long is a patient followed-up?
- After discharge, are there any planned controls?
- Are there problems with personnel at your institution, and what kind of problems?
- Where and how do you inform the staff on work specifics, therapy options, methods, and similar?
- Could you enumerate all activities that your institution deals with?
- What out-of-institution activities and programmes is your institution involved with?
- What preventive activities do you propose?
- Anything to add, not included in this interview
- What is your opinion on STI syndromic treatment? Do you apply this approach?
- Do you think that the preventive activities you carry out have an impact on STIs spread?

ANNEX 3C

NGOS REPRESENTATIVES INTERVIEW

Title of institution -----

1. **Is your institution carrying out an activity (programme) aimed at CSWs , related to HIV infection prevention¹.**
 NO YES

2. **For those who answer YES²**

Please describe the activity as follows :

- a) Name of activity – programme -----

 b) Programme started ----- ended ----- still on
 c) Who are target groups (who is it aimed at) -----
 d) What is the planned scope -----
 e) Basic activity contents -----

 f) Activity carriers -----
 g) How is the activity carried out -----
 h) Was there any assessment made before this activity started ?
 No
 Yes – by whom was it done -----
 i) Was there an evaluation at the end ?
 No
 Yes – by whom was it done ? -----

3. **Do you know of any programme of the same or similar character undertaken in any other institution (organization)?**

- NO YES
 If YES, please state :
 a. Name of institution -----
 b. Name of activity -----
 c. Any other data -----

Questionnaire filled by :

- Name and surname -----
 (mark as necessary)
 Member of the National Support Board
 Member of the City Advisory Board
 School Principal or authorized person (function)-----
 Director of health institution or authorized person (function)-----
 Else (who)-----

Supplement

Please describe other activities, if any, at your institution³

- j) Name of activity – programme -----

 k) When did the programme start -----When did it end ----- Is it still on
 l) Who are target groups (who is it aimed at) -----
 m) What is the planned scope -----
 n) Basic activity contents -----

 Activity carriers -----
 o) How is the activity carried out -----
 p) Was there any assessment made before this activity started ?

¹This includes activities and programmes aimed at drug addiction prevention; activities in sexual and reproductive health fields; sexually transmittable diseases or HIV prevention.

²
³

No
 Yes – by whom was it done

q) Was there an evaluation at the end ?

No
 Yes – by whom was it done ?

ANNEX 3D

Draft of RAR interview with Policy makers:

1. Parliamentarians (specific committee).
2. The Police
3. Programme on Trafficking
4. Open Society Institute

National and Local Field Coordinators are to take this interview.

Interview structure:

- Many information sources point to an increase CSWs' risk behaviour. What is your opinion?
- How would you describe such behaviour (i.e., according to you, what are the most serious health threatening risks for CWSs)?
- What causes, according to you, such behaviour?
- Could you divide the causes according to "origin"?
- Drug addiction, no doubt, is per se a very serious phenomenon among young people, and coupled with HIV infection threat it gets a new dimension. What is your opinion?
- Do you believe the phenomenon to be big and serious enough as to require prompt intervention?
- Who do you think should initiate the intervention, and how to realize it?
- Besides the mentioned risks, would you care to add any others, specific for drug addiction?
- Is anything undergoing in the department you manage related to prevention/change of risk behaviour of CSWs? What is it, can you elaborate?
- Is anything planned for the future?
- Anything to add (not included above)?

ANNEX 4

Timeframe RAR in Armenia

May-November 2005

Timeframe RAR in Armenia

May-November 2005

Activities	05	06	07	08	09	10	11
• Preparatory period.							
• Establishing national and Field RAR coordinators and Consultants							
• Establishing NST							
• Initial community consultations							
• Selection of candidates for work in LFT							
• Train RAR teams (training workshop)							
• Build Local Field RAR Teams							
• Establish CSBs							
• Fieldwork							
• Analyze data and report writing							
• Dissemination of findings							
• Development of Strategic plan							
• UN TG and CCM meetings							
• Monitor and evaluation							

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