STRENGTHENING THE ADOLESCENT COMPONENT OF THE NATIONAL HIV/AIDS PROGRAMME

ADVOCACY REPORT

Based on the results of the study
'Strengthening the Adolescent Component
of the National HIV/AIDS Programme
through Country Assessment'

unicef

Український інститут соціальних досліджень імені Олександра Яременка
ГРОМАДСЬКА ОРГАНІЗАЦІЯ

Strengthening the Adolescent Component

of the National HIV/AIDS Programme

Advocacy report

Based on the results of the study 'Strengthening the Adolescent Component of the National HIV/AIDS Programme through Country Assessment'

Edited by O.M. Balakireva, PhD in Sociology

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Content

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This document was developed by a team of Ukrainian authors as part of a study entitled **'Strengthening the adolescent component of the national HIV/AIDS programme through country assessment'**, the key goal of which was to conduct an impartial analysis of information about the demographic and epidemiological HIV-related situation among adolescents, including key adolescent populations and the respective cross-sectoral programmes for adolescents, in order to strengthen the adolescent component of the national HIV response programme.

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Glossary

Adolescent	According to the World Health Organization (WHO) this definition covers an age group between 10-19 years (inclusive)
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CSW	Commercial sex worker
DLC	Difficult life circumstances
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HCV	Hepatitis C virus
IDP	Internally displaced people
IDU	Injecting drug users
MARA	Most-at-risk adolescents
MoES	Ministry of Education and Science of Ukraine
MoH	Ministry of Health of Ukraine
MoSP	Ministry of Social Policy of Ukraine
MSM	Men who have sex with men
MYSU	Ministry of Youth and Sport of Ukraine
NAS	National Academy of Science
NGO	Non-governmental organisation
PLH	People living with HIV
STI	Sexually transmitted infection
UN	United Nations Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	UN Children's Fund
WHO	World Health Organization
YFC	Youth-Friendly Clinic

Introduction

During 2015–2016, a Ukraine National Situation Assessment to strengthen the adolescent component of the national HIV/AIDS (response programme was conducted with the application of a conceptual approach 'Strengthening the Adolescent Component of National HIV Programmes through Country Assessments' / Guidance Document. UNICEF. July 2015) (hereinafter: 'Assessment').

The goal of this Assessment was to analyse the demographic and epidemiological situation related to the spread of HIV among adolescents, including most-at-risk adolescents, and the respective intersectoral programmes for adolescents, in order to strengthen the adolescent component in the national HIV response programme.

The assessment was implemented in three consecutive phases. Phase 1: Rapid Assessment, which included a review of existing information on the health status of adolescents, a general evaluation of the inclusion of different adolescent groups in the national epidemic response, and identification of geographic differences. Phase 2: In-depth Analysis, including an assessment of barriers that limit the impact of interventions and HIV epidemic response activities among adolescents. Phase 3: Evidence-informed planning was focused on the development of an intersectoral action plan for HIV epidemic response among adolescents.

Evaluation of the programme environment (Phase 1) was based on the survey of experts to listen to opinions on what constitutes favourable conditions of the adolescent component of the National Targeted Social their Programme on HIV/AIDS for 2014–2018. The survey was based on questionnaires (filled out by 56 representatives of stakeholders, government institutions, NGOs, international partners, representatives of networks of people living with HIV (PLH) and leaders of youth organisations). A focus group interview was conducted with the adolescents and young people to make an evaluation of the programme environment[1]. The rapid assessment was focused on an analysis of the available statistical information, analytical reports, publications on the adolescent health status, the prevalence of HIV within the adolescent population, the characteristics of HIV risk-taking behaviours, the accessibility of medical and social services, the coverage of different adolescent groups with prevention interventions, as well as on the identification of specific characteristics of work with adolescents in different regions of the country. The Phase 1

[1] Seven representatives of youth and volunteer organizations that work with adolescents took part in the focus group discussion: 'Volunteer', Youth Committee of U-Report project (see: U-Report project – questioning through free SMS and Twitter on issues that are important to young people [Online document]. – Available at : https://ukraine.ureport.in/about/), Communal Enterprise 'Kyiv City Left Bank Centre for HIV Infected Children and Youth', Club Eney.

results informed the national consultations with the stakeholders and were then used to coordinate interventions and selected regions for Phase 2.

In depth analysis of barriers and 'bottlenecks' (Phase 2) was conducted with the application of a conceptual approach, according to which the interventions are reviewed as structural determinants of the programme environment (policy, legislation, coordination, available resources and social norms), as well as the dimensions of offer, demand and quality of the selected interventions. These dimensions that are specified as specific determinants and their definitions are provided in Annex A, Table 1. Phase 2 was also aimed at identification of structural barriers (legislation, budget, logistics and social norms) and intervention management weaknesses that need to be addressed. The intervention barriers and bottlenecks identified were taken into account in the development of recommendations and an action plan that were discussed at the stakeholder meetings (Phase 3). This assessment has certain limitations, which are primarily related to the lack of data on the local level [2].

The assessment process involved ongoing interaction with a broad range of stakeholders. For this purpose a number of topical stakeholder meetings were conducted at the International HIV/AIDS Alliance in Ukraine (26 February 2016) UN Country Office in Ukraine (12 April 2016) to validate the obtained results and discuss the proposed recommendations. Key results and recommendations were presented and discussed at a meeting of the Intersectoral Working Group on Monitoring and evaluation of the efficiency of implementation of HIV/AIDS, TB and other socially dangerous diseases response (4 July 2016), as well as at the Third National Conference on HIV/AIDS in Ukraine "For each life together: Fast track to 90-90-90 Goals" (21–23 November 2016).

The results of the Assessment indicated the need for ongoing advocacy activities to preserve and strengthen the adolescent component of the National Targeted Social Programme on HIV/AIDS for 2014–2018. Children from families in difficult living conditions, homeless and uncared-for children and children deprived of appropriate parental care constitute one of the high-risk groups for HIV infection in Ukraine. Taking into account the General Comment No. 20 (2016) on the implementation of the right of the child during adolescence [3], approved by the UN Committee on the Rights of the Child (6 December 2016), related to children in their second decade of life, there is a need to pay special attention to this age group of children, to analyse the correspondence of national legislation to the approaches

[2] An in depth analysis of existing intervention practices, challenges and opportunities that were discussed at 12 focus group interviews in 4 cities – Kyiv, Dnipro, Mykolayiv and Odesa – was conducted to obtain the needed quantitative data (with disaggregation by sex and age).

[3] [Online document]. – Available at : http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=5&DocTypeID=11

suggested in this document, to organize the learning of key principles of ensuring adolescent rights by specialists from respective authorities and institutions; to include the needed provisions and respective activities into the Draft National Programme 'National Action Plan to implement the UN Convention on children's rights for 2017–2021'.

The goal of this publication is to draw the attention of all stakeholders and to confirm that adolescents, in particular most-at-risk adolescents, should be a priority group in the national HIV epidemic response. The most important results of the study 'Strengthening the adolescent component of national HIV programmes through Country Assessments', of other research focused on the adolescent (including Most-at-risk adolescents (MARA) behavioural practices, their needs and characteristics, as well as on the practice to provide targeted HIV prevention services to MARA within the UNICEF projects, and examples of already completed and existing activities for adolescents, have been used as arguments to support this goal.

Section 1. The spread of HIV and risky behaviour trends among adolescents (including most-at-risk populations) in Ukraine

1.1. Adolescents within the context of the HIV/AIDS epidemiological situation

According to the State Statistics Service, as of 1 January 2016 the population of Ukraine amounted to 42,590,879 people [4]. Adolescents aged 10-19 years constituted 9.1 per cent (3,872,069 adolescents) of the overall population, including 1,988,779 boys, who make up 10.1 per cent of the male population. The number of girls aged 10-19 years was 1,883,290 or 8.2 per cent of the total female population (Fig. 1). The number of women of reproductive age (15-49 years) was 24 per cent of the total female population (10,260,831 women).

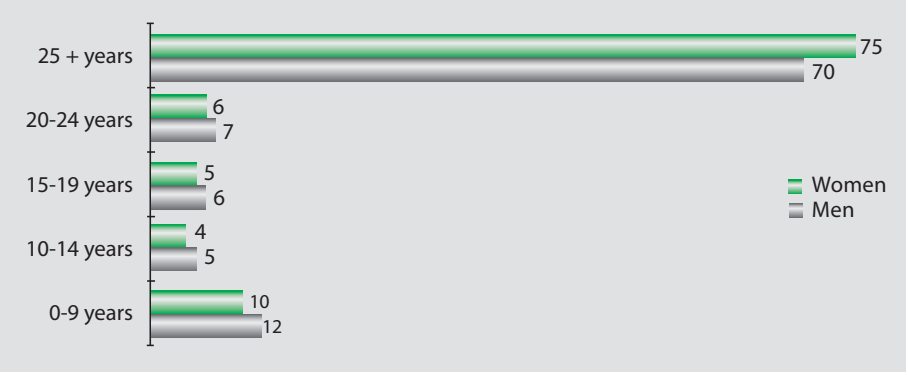

Fig. 1. Sex and age structure of the general population of Ukraine as of 1 January 2016, %

Source: data of the State Statistics Service of Ukraine.

The current HIV epidemic situation in Ukraine gives no grounds to believe that there could be a significant epidemic decrease in the country, as the scale of it continues to grow in the general population due to increased epidemic significance of sexual transmission of HIV, as well as due to a persistent leading role of high risk groups, in particular injecting drug users, commercial sex workers and men who have sex with men and their partners in the spread of infection. Key current trends in the development of the HIV epidemic in Ukraine include: growing sexual transmission

[4] Without taking into account the temporarily occupied territory of the Autonomous Republic of Crimea and Sevastopol city. Calculations (estimates) of the number of people were conducted on the basis of available administrative data from the actual registration system.

of HIV; HIV spread beyond the high risk populations; involvement of reproductive age women in the epidemic process; the predominance of infection in people of working age; the growing number of HIV-infected people identified due to the presence of clinical signs; a growing incidence of HIV/Tuberculosis (TB) co-infection and the growing number of HIV/TB-related deaths; threat of epidemic generalisation in some regions of the country. Forecasting of the further short-term development of the epidemic in the country is becoming ever more complicated due to the critical social and economic conditions and the deterioration of the situation in the eastern regions of Ukraine [5].

Between 1987–2015 there were 479,358 HIV-positive test results in Ukraine, according to laboratory data; 280,358 HIV infection cases were officially registered among the citizens of Ukraine, including 84,045 AIDS cases and 38,457 AIDS-related deaths [6]. In 2015, Ukraine observed a reduction in the number of registered HIV cases by 17.7 per cent compared to 2014; 15,869 people were enrolled in medical care (37.0 per 100,000 of the population), whereas in 2014, there were 19,273 cases (44.8 per 100,000 of population). However, this significant decrease occurred mostly due to the lack of data from the temporarily occupied territories of the Autonomous Republic (AR) of Crimea and Sevastopol city since 2014, and from the conflict zone in eastern Ukraine since 2015 (Fig. 2).

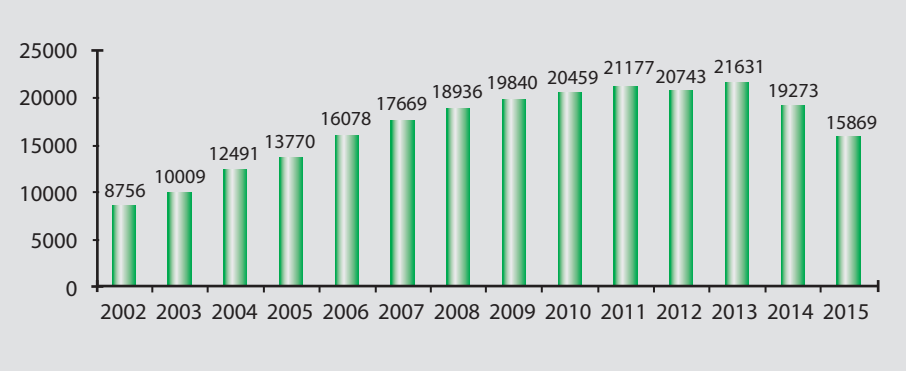

Fig. 2. Dynamics of officially registered new HIV infection cases among Ukrainian citizens, by year, 2002–2015

Source: Ukrainian Centre for Socially Dangerous Disease Control at the Ministry of Health of Ukraine.

[5] HIV Infection in Ukraine: newsletter / MoH of Ukraine, Ukrainian Centre for Socially Dangerous Disease Control at the MoH of Ukraine, Gromashevsky Institute of Epidemiology and Infectious Diseases at the National Academy of Medical Science of Ukraine, Kyiv, 2016. No. 45, p. 19.

[6] Ibid, p. 19.

In 2015, as well as in previous years, the highest prevalence of HIV was found during testing of people who had sexual contact with HIV-infected people (14.6 per cent); in prisoners (5.6 per cent) and in people who died (7.8 per cent). The lowest HIV prevalence was found among people, who have risk of HIV infection through medical manipulations by epidemiological indications (0.1 per cent), blood donors (0.1 per cent) and army recruits/ applicants to military educational facilities (0.3 per cent). Representatives of most-at-risk populations (MARP) amount to one quarter of the total number of people tested for HIV (not taking into account blood donors and pregnant women), and their proportion in the people tested in the regions varies from 5 per cent to 48 per cent [7].

In recent years, up to 30,000 HIV positive cases have been identified annually in Ukraine on the basis of laboratory tests; almost 20,000 people newly diagnosed with HIV were registered and around 12,000 people were taken off the register due to various reasons, including death. Coverage by health registration for HIV-positive people remains low and does not exceed 70 per cent. Every year around one third of HIV-positive people who are identified through testing for HIV are not entered into the medical records. Over 50 per cent of individuals aged 15+ are usually newly identified at the 3rd and 4th clinical stages of HIV infection.

In 2008 the predominant routes of HIV transmission changed in Ukraine from parenteral (through injecting drug use) to sexual, mostly heterosexual transmission, which is becoming ever more epidemically significant. The share of sexual transmission in the structure of HIV transmission routes (taking the frequency of mother-to-child transmission into account) has grown constantly and amounted to 72.5 per cent in 2015. Despite a declining trend in the long term, the relevance of parenteral transmission with injecting drug use still remains high (26.6 per cent taking into account the frequency of mother-to-child-transmission (MTCT); 21.7 per cent excluding children born to HIV-infected mothers). The proportion of this transmission route in the structure of transmission routes grew in 7 regions (Zhytomyr, Zakarpattia, Zaporizhzhia, Ivano-Frankivsk, Kirovograd, Poltava and Chernihiv regions) in 2015. Men who have sex with men (MSM) are acquiring an increasing epidemical significance. Every year the number of new officially registered HIV infections in this group is growing in the country – from 20 cases in 2015, to 262 in 2013; 277 in 2014 and 368 in 2015. Today we observe a serious under-reporting of HIV infection cases related to sexual contacts between men, because MSM usually hide their sexual preferences. Stigmatisation of MSM remains the main barrier to access to HIV prevention, treatment, care and support services for people living with HIV (PLH) [8].

[7] Ibid, p. 77.

[8] Ibid, p. 32–33.

As of 1 January 2016, the number of people, who knew their HIV positive status and were receiving medical follow-up at AIDS services in Ukraine, amounted to 126,604 PLH (58 per cent of the estimated number of PLH) (prevalence was 297.2 per 100,000 of the population). Data about the number of PLH under medical follow-up as of 1 January 2016 were received and summarised on the basis of the results of official statistics from 25 regions of Ukraine, excluding the areas of Donetsk and Luhansk regions not under state control, and do not include a cumulative number of deceased HIV infected people [9]. Before 2012 there was a growing trend in the incidence of AIDS. During the last three years this indicator changed and in 2015 it reduced to 19.8 per 100,000 of the population (giving a rate of reduction of 13.7 per cent). As of 1 January 2016 (as well as in previous years) tuberculosis remained the most common AIDS-indicator disease - found in 4,470 cases (52.8 per cent) of 8,468 new AIDS cases and in 12,566 cases (36.9 per cent) among 34,016 patients with AIDS receiving medical treatment [10].

An analysis of the sex and age structure of individuals with a newly diagnosed HIV infection indicates that women are infected at an earlier age compared to men. The proportion of individuals aged 15-29 years among HIV positive women of reproductive age (15–49 years) was 33.7 per cent, whilst among HIV positive men aged 15–49 it was 18.6 per cent. The population of adolescents who were infected parenterally is gradually growing in Ukraine. Today the average age of HIV infected children is 9.5 years and in 5-10 years they will reach the legal age. The overwhelming majority or registered children were born to HIV infected mothers. As of 1 January 2016, 2,857 HIV infected children born to HIV infected mothers were under medical follow-up, including 74 children with AIDS; another 5,683 were waiting for the confirmation of their diagnosis; 2,932 children were taken off the records due to the lack of HIV infection [11].

The regions of Ukraine can be conditionally divided into three groups by HIV prevalence rates: high prevalence (over 300 cases per 100,000 population); average prevalence (100-300 cases per 100,000 population) and low prevalence (less than 100 cases per 100,000 population). According to the newsletter, the highest HIV prevalence rates were registered in Odesa (821.5 per 100,000 population), Dnipropetrovsk (774.0), Mykolayiv (676.2), Kherson (378.8) regions and in the city of Kyiv (407.0) [12]. The proportion of adolescents aged 10-19 years in these regions varies from 7.1 per cent to 11.4 per cent. Table 1 presents the sex and age structure of the population in the regions with the specified HIV prevalence rates.

[9] Ibid, p. 48.

[10] Ibid, pp. 34–36.

[11] Ibid, pp. 30–31.

[12] Ibid, p. 117. Average HIV prevalence rate among the citizens of Ukraine as of 1 January 2016 – 297.2 per 100,000 population.

According to recommendations from UNAIDS and the World Health Organisation (WHO), identification of HIV infection among younger age groups (15–19 and 20–24 years) provides an opportunity to obtain a more realistic picture of the trends in the development of the epidemic. In 2015 the proportion of people aged 15-24 years with newly registered HIV infections was 5.7 per cent compared to 6.7 per cent and 7.1 per cent in the previous years; that is, it had a declining trend[13]. Reduction in the general prevalence rate had been observed among pregnant women aged 15-24 years (from 0.33 per cent in 2013 to 0.27 per cent in 2015). In the population of pregnant women as a whole, this indicator was 0.33 per cent in 2015[14].

Table 1. Sex and age structure of the population in the regions of Ukraine (without AR Crimea and Sevastopol city), % of the region population (as of 01.01.2016)

Region		Age range, years			
		0–9	10–19	20–24	25+
Vinnytsia	men	12.2	11.4	7.1	69.3
	women	9.6	9.2	5.9	75.3
Volyn	men	14.2	10.5	6.8	68.5
	women	10.8	9	5.9	74.3
Dnipropetrovsk	men	12	9.5	6.6	71.9
	women	9.4	7.4	4.9	78.3
Donetsk	men	10.2	8.7	5.9	75.2
	women	7.9	6.8	4.6	80.7
Zhytomyr	men	12.2	10.3	7.2	70.3
	women	9.8	8.6	6	75.6
Zakarpattia	men	13.4	10.8	7.3	68.5
	women	10.8	9.7	6.6	72.9
Zaporizhzhia	men	10.8	8.9	6.2	74.1
	women	8.3	7	4.8	79.9
Ivano-Frankivsk	men	12.1	10.6	8.1	69.2
	women	10	9.4	6.6	74
Kyiv region	men	12.1	9.9	6.4	71.6
	women	9.7	8.2	5.3	76.8
Kirovohrad	men	12	10	7.2	70.8
	women	10	7.5	5.2	77.3

[13] Ibid, p. 31.

[14] Ibid, p. 26.

Region		Age range, years			
		0–9	10–19	20–24	25+
Luhansk	men	9.3	8.4	5.8	76.5
	women	7.4	6.6	4.6	81.4
Lviv	men	11.2	11	8	69.8
	women	9.2	9.3	6	75.5
Mykolayiv	men	10.7	9	6.3	74
	women	8.2	7.1	4.9	79.8
Odesa	men	10.7	8.8	7.4	73.1
	women	8.9	7.5	5.9	77.7
Poltava	men	10.8	9.4	7	72.8
	women	8.4	7.6	5.3	78.7
Rivne	men	12.8	11.1	7.9	68.2
	women	10.2	9.8	6.2	73.8
Sumy	men	11.7	9.8	6.6	71.9
	women	9.2	8	5.5	77.3
Ternopil	men	13	11.3	6.8	68.9
	women	10.7	9.4	6.2	73.7
Kharkiv	men	9.9	9	8.7	72.4
	women	8.1	7.5	6	78.4
Kherson	men	12	10.1	6.5	71.4
	women	9.1	7.4	4.9	78.6
Khmelnitsky	men	12.1	10.7	7.1	70.1
	women	9.9	9	5.8	75.3
Cherkassy	men	10.7	9	6	74.3
	women	8.4	7.1	5.1	79.4
Chernivtsi	men	11.4	11.7	7.6	69.3
	women	9.1	9.7	6.7	74.5
Chernihiv	men	10.4	8.7	5.4	75.5
	women	8.4	6.9	4.5	80.2
Kyiv city	men	12.7	9.7	7.2	70.4
	women	10.3	8.1	5.8	75.8

Note: **HIV prevalence according to the medical follow-up data in the regions of Ukraine as 1 January 2016. (per 100,000 of population) [15].**

Over 300 cases per 100,000	100–300 cases per 100,000	Less than 100 cases per 100,000

[15] Ibid

As of 1 January 2016, 8,609 HIV infected children aged 0-18 years (8,229 children aged 0-14 years and 380 children aged 15-17 years) were officially registered, including children with unconfirmed HIV status and 809 children living with AIDS[16]. Studies in countries with a more mature HIV epidemic testify to the fact that HIV-infected adolescents adhere poorly to their antiretroviral treatment (ART) and often refuse medical care. It should be noted, that **there is currently no clear plan for monitoring and follow-up of these adolescents when they reach legal age.** There is a need to manage additional services at AIDS centres that would address the needs of adolescents and young people. The existing system of medical follow-up of HIV-infected adolescents with a parenteral transmission route needs to be studied further and reviewed to prevent their loss to appropriate follow-up procedures. Children (between the ages of 0-17, inclusive) receive ART at health care facilities run by the Ministry of Health (MoH) and National Academy of Medical Science of Ukraine exclusively funded by the state budget. In spite of the high level coverage with ART, children and adolescents face problems with the accessibility and quality of social and psychological support services in the majority of regions. In depth analysis helped to determine the real situation and bottlenecks in key interventions - the results are presented in Section 3. In the first six months of 2016, 2,826 individuals were receiving ART, that is, 4.3 per cent of the total number of people on ART [17]; 1,188 adolescents aged 11-18 years were receiving ART [18].

The main mode of HIV transmission among adolescents (as well as in the general population) was through heterosexual sexual intercourse. Drug injection was second by the number of cases and was the predominant transmission route amongst boys aged 15–19 years up until 2010. The number of registered HIV infections through injecting drug use significantly reduced for both sexes during the period 2007–2014. Since 2013 the level of homosexual transmission has surpassed drug injecting transmission for boys aged 15–19 years. So, most-at-risk adolescents are the most vulnerable as they face a higher risk of HIV infection: boys who have sex with men; adolescents who inject drugs; adolescents (boys and girls) who are exploited in the sex business; and adolescents who do not belong to the most-at-risk adolescent (MARA) category, but who are sexually active and do not use any means of protection[19]. Adolescence is

[16] Ibid, p. 30.

[17] HIV Infection in Ukraine: newsletter / MoH of Ukraine, Ukrainian Centre for Socially Dangerous Disease Control at the MoH of Ukraine, Gromashevsky Institute of Epidemiology and Infectious Diseases at the NAMS of Ukraine. Kyiv, 201, No. 45, p. 14.

[18] Ibid, Ch. 36.

[19] Balakireva O. Most-at-risk adolescents: facts and assessment: newsletter [Online document] / O. Balakireva, T. Bondar, Y. Sereda, O. Sakovych; Ukrainian Institute for Social Research after O. Yaremenko, UNICEF, Kyiv, 2014. – Available at : http://www.unicef.org/ukraine/ukr/UA_Buklet_MARA.pdf (original in Ukrainian).

the age when the risk of infection grows among those who become sexually active, among children deprived of parental care, or those under negative peer pressure, who subjectively believe that they are already adults and experiment with drug use, or can embark upon risky sexual practices (sex without condoms, commercial sex, etc.).

HIV prevalence among most-at-risk adolescents. Targeted studies confirm the epidemic trends in the adolescent age cohort and indicate an underestimation in the number of adolescents who practice risky behaviours in the HIV epidemic in the country. The number of HIV infections among MARA has significantly decreased compared to 2008/2009 estimates (Table 2). This reduction is related to the more active involvement of MARA in the available prevention programmes [20]. According to surveys among most-at-risk populations in 2015, HIV prevalence among adolescent injecting drug users (IDUs) aged 15-19 years was 2.7 per cent, among adolescent men having sex with men (MSM) aged 14-19 years it was 3.1% [21]. According to 2014 data, HIV prevalence among street adolescents varied significantly from city to city and increases with age. The available research data indicate that HIV infections among street adolescents were most frequently found in Odesa, where HIV prevalence among street adolescents aged 14-19 years was 11 per cent (Table 3). An estimated HIV prevalence in all MARA was at least 1.9 per cent [22], and in the 15-49 age group it was estimated at 0.9 per cent [23].

[20] Ibid

[21] Calculations were made on the basis of the studies 'Monitoring of behaviour and HIV prevalence among injecting drug users as a component of second generation surveillance' and 'Monitoring of behaviour and HIV prevalence among men who have sex with men, as a component of second generation surveillance' that were conducted within the project on 'The involvement of local organizations in the development of monitoring and evaluation of HIV/AIDS epidemic response' (METIDA project) implemented by the ICF Public Health Alliance with funding from the US Centers for Disease Control and Prevention (CDC) within the framework of the US President's Emergency Plan for AIDS Relief (PEPFAR).

[22] Balakireva O. Most-at-risk adolescents: assessment and dynamics: newsletter [Online document] / O. Balakireva, T. Bondar, M. Khudik, O. Sakovych; Ukrainian Institute for Social Research after O. Yaremenko, UNICEF, Kyiv, 2016. – Available at : https://www.unicef.org/ukraine/ukr/pidlitki_grup_riziku.pdf (original in Ukrainian).

[23] HIV Infection in Ukraine: newsletter / MoH of Ukraine, Ukrainian Centre for Socially Dangerous Disease Control at the MoH of Ukraine, Gromashevsky Institute of Epidemiology and Infectious Diseases at the NAMS of Ukraine, Kyiv, 2016. No. 45, p. 38.

Table 2. Estimated number of HIV cases per 1,000 population*, *individuals*

Most-at-risk adolescents	2008/2009 pp.	2013/2014 pp.	2015 p.
Adolescent IDUs	50	20	59
Adolescent CSW	80	3	0,6
Adolescent MSM	50	10	35

* Estimated on the basis of HIV testing results in bio-behavioural studies (IBBS) and of an estimated size of the MARA population.

Table 3. HIV prevalence rate among street adolescents in three cities, % (2014) [24]

Age, years	Donetsk *(N=HCF)*	Kyiv *(N=334)*	Odesa *(N=324)*
10–13	0	0	0
14–15	0	1	1
16–17	1	1	12,5
18–19	2	7	18
Among those aged 10-19 years	**1**	**3**	**11**

It is important to note that the number of HIV-infected individuals among injecting drug users (IDUs) under 25 years of age is much less than amongst older IDUs (and in the age group 14-19 years their number is considerably less). This is explained by the shorter length of time they have been injecting drugs and by the expansion of harm reduction services [25]. A similar trend is observed among female sex workers and girls lured into sexual exploitation (Fig. 3)[26]. So, a conclusion can be made that adolescent IDUs, adolescent female sex workers (FSW) and other adolescents practicing risky behaviours represent an extremely important target group for prevention interventions, as working with them will reduce the risk of HIV spread in the future.

[24] Balakireva O. Most-at-risk adolescents: facts and assessment: newsletter [Online document] / O. Balakireva, T. Bondar, Y. Sereda, O. Sakovych; Ukrainian Institute for Social Research after O. Yaremenko, UNICEF, Kyiv, 2014. – Available at : http://www.unicef.org/ukraine/ukr/UA_Buklet_MARA.pdf (original in Ukrainian).

[25] Balakireva O.M. Monitoring the behaviour and HIV-infection prevalence among people who inject drugs as a component of HIV second generation surveillance (according to the results of a 2013 bio-behavioural survey) [Online document] / O.M. Balakireva, T.V. Bondar et al., Kyiv: ICF International HIV/AIDS Alliance in Ukraine, 2014, p. 117. – Available at : http://www.aidsalliance.org.ua/ru/library/our/2014/zvit%20IDU_s.pdf.

[26] Balakireva O.M. Monitoring the behaviour and HIV-infection prevalence among female sex workers as a component of HIV second generation surveillance (according to the results of a 2013 bio-behavioural survey) [Online document] / O.M. Balakireva, T.V. Bondar, Y.V. Sereda et al., Kyiv: ICF International HIV/AIDS Alliance in Ukraine, 2014, p. 104. – Available at : http://aph.org.ua/wp-content/uploads/2016/08/Otchet-ZHKS.pdf

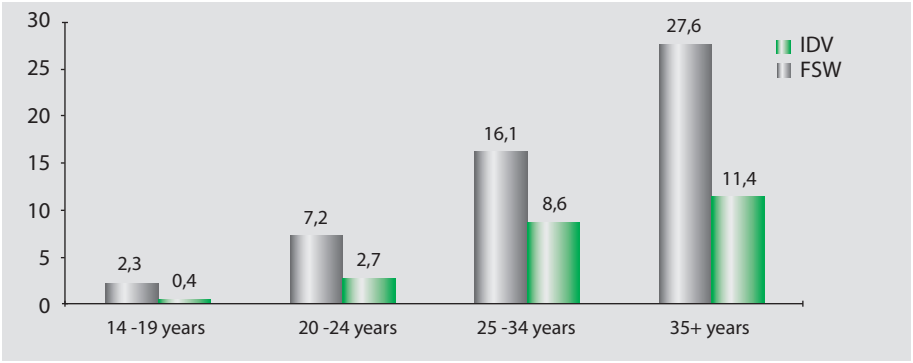

Fig. 3. HIV prevalence among IDUs and FSW, by age group, %

Most-at-risk adolescents and a good proportion of children and adolescents in families experiencing difficult living conditions, with a difficult social and economic situation, have limited access to information and services. In addition to this, the needs of adolescents, in particular MARA, are age- and sex-specific, as adolescents are at different stages of personality development and live in different social conditions. The range of needs is not limited to the list of prevention interventions required to overcome the HIV epidemic in this population.

Children and adolescents ***who arrived from the temporarily*** occupied territories require special attention. The registration of individuals who were under medical follow-up at health care facilities (HCF) of AIDS service in Donetsk and Luhansk regions and who opted for health care in other regions of Ukraine is done on the basis of registration forms 502-1/o and 502-2/o. According to the AIDS Centres located in other regions, in 2015 they registered 572 PLH from Donetsk region, 127 PLH from Luhansk region and 32 PLH from AR Crimea. As of 1 January 2016 the AIDS services of other regions had 1,153 HIV-infected people from the territories of Ukraine not controlled by the state under medical treatment, including 824 people (71.4 per cent) displaced from Donetsk region; 236 people (20.5 per cent) from Luhansk region and 93 people (8.0 per cent) from AR Crimea and Sevastopol city. Among those 1,153 HIV infected people, 575 (49.9 per cent) were women and 578 (50.1 per cent) were men. This group had the following age distribution: 92 children aged up to 14 years (8.0 per cent); 19 adolescents aged 15–17 years, inclusive (1.6 per cent); 28 individuals aged 18–24 years, inclusive (2.4 per cent), 1,014 individuals aged 25 years and above (88.0 per cent). The number of HIV-infected IDUs was 370 individuals (32.1 per cent of the total number of HIV-infected people displaced from the occupied territories), including 238 IDUs from Donetsk region, 86 IDUs from Luhansk region and 46 IDUs from AR Crimea and Sevastopol. Twenty six HIV-infected pregnant women, 110 children born to HIV infected mothers, including 58 children with confirmed HIV diagnosis,

who arrived from Ukraine-uncontrolled territories to AIDS services of other regions, were under medial follow-up as of 1 January 2016 [27].

Taking into account the data about the number of internally displaced persons (IDPs), including children, the total number of ***children from vulnerable families*** covered by the social services should grow quickly. However, according to the Ministry of Social Policy (MoSP), shortly before the conflict in eastern Ukraine, (as of 31 December 2013) the number of children from vulnerable families covered by social services was 1,357,614 children, and as of 31 December 2015 it was half that, i.e., only 675,825 children. This trend is a **consequence of the sacking of social workers in the country**, whose number decreased threefold between the beginning of 2014 until the beginning of 2016.

According to the MoSP, one social worker (SW) has to work with over 1,000 IDPs (this is the average statistic for Ukraine), while in the areas of compact settlement of IDPs the correlation of social workers to IDPs is as follows: in Donetsk region: 1 social worker per 4,917 IDPs; in Luhansk region: 1 SW per 7,274 IDPs; in Kharkiv: 1 SW per 3,715 IDPs and in Kyiv city: 1 SW per 2,161 IDPs.

An abrupt reduction in the number of social workers in the places and areas of compact settlement of IDPs has led to an abrupt growth of number of adults and children in need of social services, which, in turn, has led to an increase **in the workload of specialists and results in psychological trauma and emotional burnout.**

Children in difficult living conditions and children deprived of parental care [28] represent another group at high risk of HIV infection in Ukraine. According to the State Statistics Committee, in 2015 the number of

[27] HIV Infection in Ukraine: newsletter / MoH of Ukraine, Ukrainian Centre for Socially Dangerous Disease Control at the MoH of Ukraine, Gromashevsky Institute of Epidemiology and Infectious Diseases at the NAMS of Ukraine, Kyiv, 2016. No. 45, p. 38.

[28] **Child in difficult living conditions:** A child who has found him or herself in circumstances that affect its life, health and development due to disability; severe disease; homelessness; being in conflict with the law; involvement in the worst forms of child labour; dependence on psychotropic substances and other addictions; violence and abuse in the family, evasion of parents or people who replace them from their parental duties; after-effects of natural disasters, technogenic accidents, catastrophes, acts of war or armed conflicts, etc., which was established on the results of child needs assessment; **Children deprived of parental care:** Children who were left without parental care due to deprivation of their parental rights, or who were taken from parents without deprivation of their parental rights; due to recognition of parents to be missing, or legally incompetent; or if parents are announced dead, or are imprisoned, or are in custody for a period of investigation; or if they are wanted by the National Police due to the lack of information about their whereabouts; or due to a long-term disease of parents that prevents them from performing their parental duties; also children who are separated from the family, or foundlings, children whose parents are not known, unwanted children; children whose parent neglect their parental duties due to unidentified reasons, as these parents stay at temporarily occupied territory of Ukraine or in the anti-terrorist operation zone, or homeless children. Article 1 of the Law of Ukraine 'On Protection of Childhood' [Online document]. Available at : http://zakon3.rada.gov.ua/laws/show/2402-14

orphans and children deprived of parental care amounted to 73,182 children [29].

Orphans and children deprived of parental care receive special attention from the government in comparison with other vulnerable children. By the end of 2015, 66,294 (90.5 per cent) of orphans and children deprived of parental care were under trusteeship and guardianship: 52,938 children were under trusteeship; 7,187 were in foster families and 6,169 in family-type homes for children [30].

In 2015, according to the MoSP, 1,868 orphans or children deprived of parental care were adopted, including 1,489 children who were adopted by the citizens of Ukraine, and 379 children who were adopted by foreign citizens [31]. During the first six months of 2016, 919 orphans and children deprived of parental care were adopted (731 by citizens of Ukraine and 188 by foreign citizens) [32]. A positive trend towards prioritising adoption by Ukrainian citizens has been observed for 10 recent years.

These groups of children and adolescents are vulnerable and require special attention within the context of the HIV epidemic.

The next section focuses in more detail on the risky adolescent practices (including most-at-risk adolescents), which have had an impact on the growth of the HIV epidemic.

1.2. Risky practices of adolescents (including most-at-risk adolescents)

As the sexual transmission of HIV among adolescents is the predominant mode of transmission in Ukraine now, so the existing practices and culture of sexual relations are the key factor in making the work with adolescents within the National HIV/AIDS Programme more efficient. According to a study entitled 'Indicators and social context of adolescent health development' (HBSC project), a quarter of the adolescents (24.3 per cent) aged 13-17 years who were interviewed, had already had some sexual experience. Boys mentioned this much more frequently than girls in all age groups. One out of two (54.9 per cent) 17-year-old boys and one out of three similarly aged girls (33.9 per cent) had already had sexual experience (Fig. 4). One third of the adolescents interviewed indicated that they had started their

[29] Protection of children who require special social attention: Statistical Collection / State Statistics Service of Ukraine, Kyiv, 2016, p. 25.

[30] Ibid, Ch. 12, 17, 18.

[31] Ibid, Ch. 6–7.

[32] Parliamentary Hearing 'Children's rights in Ukraine: ensuring, observance and protection'. 12 October 2016 [Online document]. – Available at : http://static.rada.gov.ua/zakon/new/par_sl/sl1210116.htm (original in Ukrainian)

sexual life at the age of 15 years, and 8.1 per cent had started it at the age of 13 years [33].

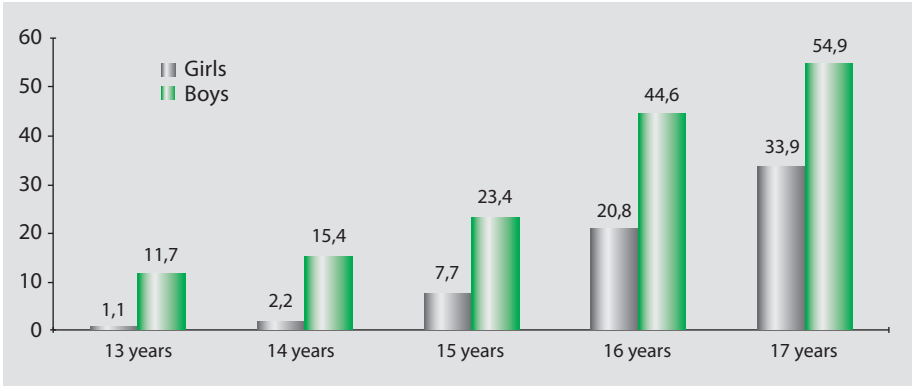

Fig. 4. Distribution of answers of school students about their sexual experience, by age and sex, %

Table 4. Characteristics of MARA involvement in sex practices in 2007–2015, %

	Adolescent IDUs						Adolescent CSW						Adolescent MSM				
	2007	2008	2009	2011	2013	2015	2007	2008	2009	2011	2013	2015	2007	2009	2011	2013	2015
Have experience of heterosexual contacts	83	83	95	89	95	95	100						28	53	36,5	35	37
Boys who practiced anal sex with boys/ men													100				
First sexual contact before reaching 15 years	26	20	29	27,5	38	40,5	50	45	41	35	50	36	–	59	31	28	30
First sexual contact before reaching 18 years	78	73	92,5	88	99	99,5	100	99,5	97	91	100	98	–	89	89	91	93

Most-at-risk adolescents have a rather high level of sexual activity. The proportion of those who become sexually active before the age of 15 years has grown among adolescent IDUs and adolescent MSM. At the same time, the same proportion among adolescent CSW has decreased. Almost all

[33] Balakireva O. M. Indicators and Social Context of Adolescent Health Development: monograph [Online document]. / O.M. Balakireva, T.V. Bondar, D.M. Pavlova et al., edited by O.M. Balakireva; UNICEF, Ukrainian Institute for Social Research after O. Yaremenko, Kyiv, 2014, p. 88. – Available at : http://www.uisr.org.ua/img/upload/files/Analytical_report_HBSC_2015_fin_UA.pdf.

most-at-risk adolescents have sexual relations before reaching the legal age (Table 4)[34].

Adolescent IDUs often have unprotected casual and commercial sex, which increases their risk of infection with HIV and other sexually transmitted infections (Table 5).

Table 5. Characteristics of risky sexual behaviour of adolescent IDUs, %

	2007	2008	2009	2011	2013	2015
Sexual contacts with more than six partners in the last 3 months	25	27	11	9	20,5	17
Sex with a casual partner in the recent 3 months	67	61	56	45	58	67
Transactional sex services (among girls who are IDUs)	25	17	14	8	10	15
Did not always use condoms in the recent 3 months:						
with a casual partner (2009: N=171; 2011: N=93; 2013: N=149; 2015: N= 104)			52	49	59	60
with a transactional sex partner (2009: N=17; 2011: N=15; 2013: N=26; 2015: N=4)			47	73	27	43

The proportion of adolescent CSW who begin providing sex services for remuneration before reaching 15 years of age is decreasing. At the same time, the proportion of adolescents who begin providing transactional sex services before reaching the age of consent has grown (Fig. 5).

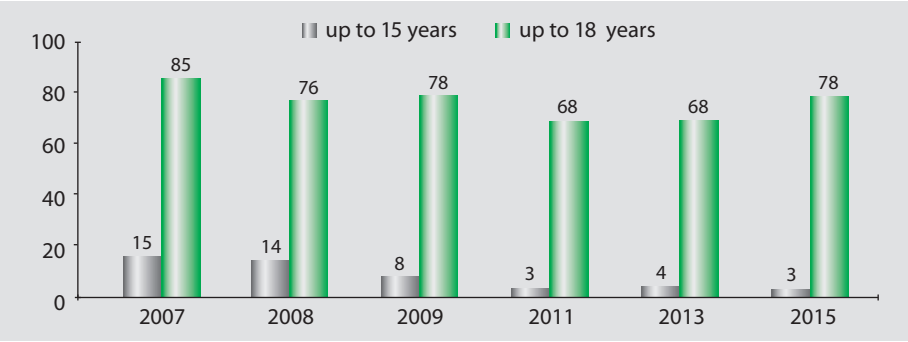

Fig. 5. Age of involvement of girls-CSW in the provision of transactional sex services, %

Adolescent CSW face a high risk of HIV infection due to the non-use of condoms in various sexual contacts (Table 6).

[34] Balakireva O. Most-at-risk adolescents: assessment and dynamics: newsletter [Online document] / O. Balakireva, T. Bondar, M. Khudik, O. Sakovych; Ukrainian Institute for Social Research after O. Yaremenko, UNICEF, Kyiv, 2016. – Available at : https://www.unicef.org/ukraine/ukr/pidlitki_grup_riziku.pdf.

Table 6. Condom use by girls involved in the provision of transactional sex services, %

Characteristics of condom use	Years				
	2007	2009	2011	2013	2015
Did not use condom during the most recent sexual contact with a client	24	12	9	5	17
Did not use condoms during sexual contacts with clients during recent 30 days	48	49	47	42	40
oral sex			39	42	37
vaginal sex			23	20	17
anal sex			28	17	23

A significant proportion of adolescent MSM have sexual contact with a casual partner and do not use condoms. Commercial sex is not very common among adolescent MSM, but there were cases where adolescents were paid for sex or paid for it themselves (Table 7).

Table 7. Characteristics of risky sexual behaviours among boys who practice same sex relations (adolescent MSM), %

Characteristics of risky behaviours	Years				
	2007	2009	2011	2013	2015
During the last 30 days they had:					
casual sexual partners	41	54	57	57,5	50,5
commercial sexual partners	11	11	6	13	0,4*
Did not use condoms during the recent anal sex:**					
with a casual sexual partner	17	20	31	22	12,4
with a commercial sexual partner	22	28	20	27	23***

* Proportion of adolescents who paid for sex. A question about commercial sex, when an adolescent was paid for sex, was not asked.
** Among those who had such partners.
*** Among those who were paid for sex.

The results of an international comparative "European School Survey Project on Alcohol and Other Drugs" (ESPAD) among adolescents aged 15-17 years indicated that drugs remain easily accessible (12 per cent confirmed that it was 'very easy' or 'relatively easy' to get marijuana or hashish). Ten per cent of adolescents in this age group said that they had

experienced some type of drug (14 per cent among boys and 7 per cent among girls). Around 1 per cent said that they had injected drugs [35].

Non-injecting drug use is an additional risk factor for adolescents due to possible transition to injecting drugs in the future. Eighteen per cent of adolescent MSM and 9.5 per cent of female CSW confirmed that they had used non-injecting drugs. Among adolescents who live and work on the street, 9 per cent confirmed injecting drug use. Data about the use of non-sterile injecting equipment by adolescent IDUs demonstrate that girls are more inclined than boys to use of non-sterile injecting equipment. Overall, 8 per cent of adolescent IDUs stated that they had used non-sterile injecting equipment in recent 30 days (Fig. 6) [36].

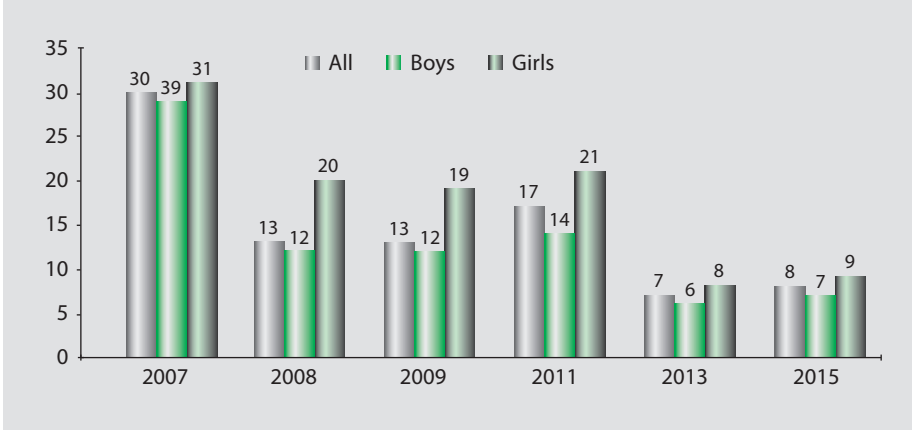

Fig. 6. Proportion of adolescent IDUs who confirmed the use of non-sterile injecting equipment (needles/syringes) in the last 30 days, %

[35] Balakireva O.M. Smoking, alcohol and drug use among adolescent students: prevalence and trends in Ukraine: Based on 2015 study results within the international project "European School Survey Project on Alcohol and Other Drugs – ESPAD" [Online document] / O.M. Balakireva (authors' team leader), T.V. Bondar, Y.Y. Pryimak, D.M. Pavlova, O.V. Vasylenko, O.T. Sakovych, S.Z. Salnikov, S.V. Sydiak, Y.B. Yudin, N.S. Nakhabych, Kyiv: Publishing centre 'Foliant', 2015, 200 p. – Available at : http://www.uisr.org.ua/img/upload/files/ESPAD-ForWEB.pdf (original in Ukrainian).

[36] Balakireva O. Most-at-risk adolescents: assessment and dynamics: newsletter [Online document] / O. Balakireva, T. Bondar, M. Khudik, O. Sakovych; Ukrainian Institute for Social Research after O. Yaremenko, UNICEF, Kyiv, 2016. – Available at : https://www.unicef.org/ukraine/ukr/pidlitki_grup_riziku.pdf (original in Ukrainian).

Most-at-risk adolescents (CSW, IDUs and MSM) practice various forms of risky behaviours that significantly increase their risk of HIV infection. Risky sexual behaviour poses a risk of HIV infection for 77 per cent of adolescent CSW. This risk is double for IDUs, as they can be infected through sexual and injecting modes of transmission (Table 8).

Table 8. Unsafe practices among most-at-risk adolescents (in the last 30 days), % [37]

	Adolescent IDUs	Adolescent CSW	Adolescent MSM
Practice risky sexual behaviours that can lead to HIV infection	48	77	43
Practice unsafe injecting drug use, behaviours that can lead to HIV infection	46		
Take the risk either due to unsafe drug injection or irregular, or incorrect condom use, that can lead to HIV infection	68		

The updated results of an evaluation of the number of children and young people in high risk groups demonstrated an increase in the number of adolescent IDUs, in particular boys, involved in injecting drug use. In addition, data collected indicate a small increase in the number of girls and young women, who provided commercial sex services. At the same time, a reduction in the number of adolescent boys who have sex with men can be considered a positive result (Table 9).

Table 9. Evaluation of the number of most-at-risk adolescents, individuals [38]

	2008/2009	2013/2014	2014/2015
Total MARA	**165 000**	**123 500**	**129 000**
Adolescent IDUs	50 000 (35 000 boys and 15 000 girls)	15 000 (11 000 boys and 4 000 girls)	21 700 (17 500 boys and 4200 girls)
Adolescent CSW	15 000	5 500	6 000
Adolescent MSM	20 000	13 000	11 300
Street adolescents	80 000	90 000	90 000 [39]

[37] Ibid

[38] Ibid

[39] A previous estimate for 2014 was used due to the lack of updated data on this group.

The cumulative number of adolescents in the groups of IDUs, CSW and MSM is 991 per 100,000 of the adolescent population [40] (in 2008/2009 this amounted to 1,602 individuals). This situation substantiated the need to increase the joint efforts of partner organizations for the integration of adolescents in the existing interventions, for introduction of the new targeted projects and for the expansion of the primary prevention programmes to prevent replenishment of high risk groups in an early age. One of the obstacles to the development of interventions for MARA is the lack of evaluation **of the size of MARA population on the level of individual cities or regions.**

An online survey among adolescents entitled 'The voices, values and preferences of adolescents on HIV testing and counselling' conducted in 2015 also created an opportunity to evaluate the spread of certain aspects of risky behaviours. A total of 35.3 per cent of adolescents had sexual contact without a condom with persons of the opposite sex. The largest proportion (54.7 per cent) of them was found in the age group of 18-19 years. The majority of adolescents with an established HIV status have had experience of sex without a condom with persons of the opposite sex (58.3 per cent). Thirteen per cent of boys have had sexual contact without a condom with men; 3.7 per cent of respondents have provided sexual services for remuneration (2.8 per cent of boys and 4.4 per cent of girls) [41].

Three per cent of adolescents confirmed that they had experience of injecting drug use (4.7 per cent of boys and 1.6 per cent of girls). This experience was most frequently found among adolescents aged 18-19 years (4.1 per cent) and young people aged 20–24 years (5.3 per cent) [42]. An integrated indicator of the high-risk group (those who were at risk of HIV infection) among adolescents aged up to 19 years was 14.3% (N=119) and was almost twice higher among boys (19.4 per cent), than among girls (10.3 per cent) [43].

The survey data indicates that the risk group can include adolescents and young people from various strata of society, and not only those who live in unfavourable conditions[44]. Among the surveyed respondents, 26.5 per cent of males and 11.9 per cent of females belonged to the risk groups. 57.6 per cent of those coming from risk groups limited themselves to only one risky practice; 26 per cent practiced two types of risky behaviours and 14.3 per cent three types of risky behaviours [45].

[40] Without taking into account the number of adolescents in AR Crimea and adolescents who live and work in the street.

[41] Balakireva O.M. The Voices, Values and Preferences of Adolescents on HIV Testing and Counselling [Online document] / O.M. Balakireva, T.V. Bondar, K.M Nagorniak, S.Z. Salnikov, O.T. Sakovych; Ukrainian Institute for Social Research after O. Yaremenko, UNICEF, Kyiv: Publishing centre 'Foliant', 2015, 72 p. – Available at : https://www.unicef.org/ukraine/ukr/Report-ForWEB.pdf.

[42] Ibid

[43] Ibid

[44] Ibid

[45] Ibid

The results of a study on *'Estimating female sex workers' early HIV risk and the implications for HIV epidemic control: A multi-country observational and mathematical modelling study'* in Dnipro city [46] demonstrated that there is a hidden group with a high HIV and Hepatitis C (HCV) infection risk among sexually active young women (14-24 years), and that there is an underestimation of the CSW numbers within the general epidemic situation in Dnipro city (the authors believe that it may also be the case in other big cities with high HIV epidemic rates). It can be also presumed that drug use is at a much higher level than is reported by young women (in all study groups) in Dnipro city – Hepatitis C (HCV) test results confirm it, and that there are other negative factors.

The study reveals a number of very important areas within the context of early HIV prevention, which are still insufficiently explored, namely: the age when you start having sex, factors related to involvement in transactional sex, coerced sexual relations, etc. The data obtained contributes to the scientific understanding of the HIV- related risk and of the level of vulnerability of young FSW in the period of transition from the beginning of providing transactional sex service to being provided with prevention services, as well as to the development of efficient prevention programmes in response to the HIV/AIDS epidemic among young women fac ing different degrees of risk (low, average and high), not only in Dnipro city, but in Ukraine in general.

This data demonstrates that further study is needed to identify the driving factors – why such a high level of HIV and HCV is found among young women. Also, it suggests the need to emphasise that bio-behavioural studies should be focused on the 'risk networks' and 'risk environment'. The high level of mobility in the sex business environment (especially among young women involved in commercial sex) requires ongoing mapping as a routine strategy for those NGOs that are working with CSW.

The study results indicate that there are grounds to review the way resources are spent, the design of prevention and treatment activities and the level of existing strategies' coverage of potential hidden groups that face high risk of HIV and HCV infection. **There is a need to strengthen primary prevention:** to implement focused information campaigns on individual protection from HIV and HCV infection; to strengthen the 'get tested' component amongst young people (especially women); to implement the "Say no to violence" campaign; to include the strategy of delaying the sexual debut for adolescents and young adults; to evaluate the quality of programmes at the educational facilities and to develop recommendations of how to improve their efficiency.

[46] The study 'Estimating female sex workers' early HIV risk and the implications for HIV epidemic control: A multi-country observational and mathematical modelling study' was implemented in 2014–2016 by the University of Manitoba (Canada) under a grant from the Canadian Institutes of Health Research (CIHR) (funding reference number(s) MOP-130441, key applicant – Dr. Marissa Becker) in cooperation with the Ukrainian Institute for Social Research after O. Yaremenko. The goal of this study was to characterise HIV infection risks for young women in the transition period from when they first start having sex till the moment of self-reported involvement in sex business; during the first two years of formal sex business employment till the moment of being covered with prevention programmes; as well as to review the importance of early HIV prevention intervention.

It is also relevant **to introduce the focused prevention interventions for young women,** who provide 'transactional sex services'. There is a need to develop standards of work with FSW (for NGOs and CSOs), including standards for the frequency of testing (every six months); to reduce the period of 'lack of access to services'.

This situation reinforces the need **to continue and strengthen the joint efforts of partner organisations aimed at integration of adolescents within the existing interventions**, to introduce targeted projects and to expand the primary prevention programmes to prevent adolescents from getting to the high-risk groups.

A rapid evaluation of HIV epidemic trends among adolescents and risky behaviour practices within the study (Phase 1) showed the limitation of data about certain MARA sub-groups on the sub-national level, but in general, the HIV epidemic in the age group 15-24 years was concentrated in Odesa, Dnipropetrovsk, Donetsk and Kyiv regions and in Kyiv city, whilst in the age group 15-17 years it was concentrated in Dnipropetrovsk, Donetsk, Odesa and Mykolayiv regions. In spite of a reduction in the incidence of HIV and a relative decrease of the general size of MARA, we should take into account the limited access of MARA to HIV services and low rates of HIV testing among adolescent IUDs, adolescent MSM, adolescent FSW and street adolescents. That is why the real HIV infection situation among MARA can only be assessed after a significant improvement of MARA access to, and coverage by, HIV testing. These adolescent groups require help, as do adolescents who do not belong to the MARA population, but who are sexually active, do not use prevention means and do not have sufficient knowledge about HIV. Prevention programmes should therefore be focused on providing a significant increase in the coverage of adolescents to ensure early prevention of an HIV epidemic.

Section 2. Assessment of the programmatic environment for work with adolescents to respond to HIV: Current status and opportunities

2.1. National response to HIV epidemic among adolescents

State policy in the area of HIV/AIDS response

The state policy envisages all necessary activities to reduce specific factors of vulnerability to HIV among children and youth, to eliminate HIV-related discrimination and to ensure equitable and sustainable access to comprehensive HIV services.

Ukrainian legislation, namely the **Law of Ukraine 'On prevention of diseases caused by the Human Immunodeficiency Virus (HIV), and legal and social security of people living with HIV'** [47] states the following:

- Testing of individuals aged 14 and older is provided on a voluntary basis, conditional to the availability of the well-informed consent of an individual received after pre-test HIV counselling;
- Testing of children under 14 years is provided at the request of their parents or legal representatives and with well-informed consent;
- Testing of individuals under 14, deprived of parental care and placed in the custody of special full-time public institutions for children or boarding schools, who are mature enough to understand the consequences and advantages of such testing, is provided at the request of their legal representatives and with the well-informed consent of such individuals with the only purpose to provide them with HIV treatment, care and support.

This Law of Ukraine regulates which information should be provided to parents or authorised representatives of a child with regards to HIV infection, medical follow-up for their child, treatment and prevention of HIV infection. Also, parents or legal representatives of a child shall be responsible for the compliance with all recommendations by a health worker and shall sign the appropriate written consent form. The law also envisages certain additional rights of the parents of HIV-infected children, including the right to stay together at an in-patient clinic with their children under 14 years of age, with a release from work and receipt of a temporary disability allowance; as well as the right to have additional annual leave for 10 days in summer or at any other convenient time until their children reach 18 years of age. The Law also provides governmental guarantee to HIV-infected children and children with HIV-related diseases, to receive

[47] [Online document]. – Available at : http://zakon3.rada.gov.ua/laws/show/2861-17.

a monthly state allowance of the amount established by the Cabinet of Ministers of Ukraine.

The Law of Ukraine 'On approval of the national targeted social programme on HIV/AIDS for 2014–2018' [48] of 20 October 2014 No. 1708-VII envisages a number of activities for children and youth, including:

- Implementation of sociological and epidemiological research among the population and especially most-at-risk populations, which include homeless and uncared-for children, children from the families in difficult living conditions, and children who do not receive appropriate parental care;
- Expansion of informational and educational programmes promoting the development of tolerant attitudes towards people living with HIV, and representatives of populations that have higher risk of HIV infection, as well as on the issues of protection of human rights of such individuals to prevent them being discriminated against;
- Provision of teachers, students and pupils with the necessary educational and learning materials, including videos, to introduce an interactive approach to improve the level of knowledge about HIV prevention;
- Support to the planning activities of the programmes on sexual education of youth related to HIV/AIDS, taking into account a gender-based approach, and implementation of these programmes;
- Facilitating the provision of social and prevention services to children from families in difficult living conditions; children, who do not have appropriate parental care, homeless and uncared-for children, and their involvement in the informational and prevention activities, including through the operationalisation of multi-disciplinary street teams and Youth Friendly Clinics;
- Ensuring provision of social services to children, who may be in contact with HIV-infected people, at their personal request (HIV positive children, children born to HIV positive parents, from families in difficult living conditions (orphans, children under guardianship or deprived of parental care);
- Ensuring early detection of infection in children born to HIV positive mothers with the use of innovative diagnostic technologies.

[48] [Online document]. – Available at : http://zakon5.rada.gov.ua/laws/show/1708-18.

Resolution of the Cabinet of Ministers of Ukraine of 15 February 2006 No. 148 'On the approval of the standard provisions on the centre for HIV-infected children and youth' [49] envisages provision of social services to HIV-infected children and their parents or persons who replace them (including children with an unconfirmed status born to HIV-infected mothers), and to HIV infected young people.

The Order of the Ministry for Youth and Sport (MYS) of 18 January 2008 No. 4941 'Standards of the minimal package of social services to children living with HIV and children born to HIV-infected mothers and members of their families' establishes the list of social services to children living with HIV (including HIV-infected orphans placed in boarding schools); children born to HIV infected mothers, their parents (legal representatives) and other close family members.

The Resolution of the Cabinet of Ministers of Ukraine of 27.08.2014 No. 389 'On approval of the norms of nutrition for children living with HIV or AIDS' [50] regulates the norms of nutrition for children living with HIV and AIDS, and norms of replacement of food products by calorific value.

Orders of the MoH of Ukraine of 12 July 2010 No. 551 'On the approval of the clinical protocol for antiretroviral therapy of HIV infection in adults and adolescents' [51] **and of 24 February 2015 No. 92 'Unified clinical protocol for primary, secondary (specialised) and tertiary (highly specialised) health care for children with HIV infection'** [52] specify the procedures for medical follow-up and treatment of HIV infection in children and adolescents.

Strategy of working with most-at-risk adolescents as an HIV epidemic response

At the present time, most-at-risk adolescents still remain one of population sectors most vulnerable to HIV/AIDS epidemic in Ukraine; they are highly sexually active, often change sexual partners and have risky sexual practices. In the context of low social adaptation and poor protection most-at-risk adolescents are vulnerable to external factors, which lead to high rates of HIV and other infections.

[49] [Online document]. – Available at : http://zakon2.rada.gov.ua/laws/show/148-2006-%D0%BF

[50] [Online document]. – Available at : http://zakon3.rada.gov.ua/laws/show/389-2014-%D0%BF

[51] [Online document]. – Available at : http://moz.gov.ua/ua/portal/dn_20100712_551.html

[52] [Online document]. – Available at : http://www.moz.gov.ua/ua/portal/dn_20150224_0092.html

Implementation of the United Nations Children's Fund (UNICEF) multi-country project on 'HIV prevention in most-at-risk adolescents in Ukraine and South-Eastern Europe' (which started in 2007) helped to collect an evidence base [53] on the epidemiological situation among adolescents, on the risk factors for HIV transmission and AIDS, on the HIV/AIDS prevention programmes implemented and provided advocacy for the interests of adolescents on the national and regional levels in order to prove that adolescents (including MARA) should be a priority group for the national HIV epidemic response [54]. One of the most significant achievements of the MARA project included the development and approval of the National strategic action plan for HIV prevention among children and high risk youth who are vulnerable to HIV, and for care and support to children and youth affected by HIV/AIDS [55], approved by a resolution of the National Council on Response to Tuberculosis and HIV/AIDS of 26 May 2010.

It should be noted that most-at-risk adolescents were successfully integrated into the National Targeted Social Programme on HIV/AIDS for 2014–2018 [56], the goal of which is to reduce HIV/AIDS- related incidence and mortality, to provide quality and accessible HIV prevention and diagnostic services primarily to most-at-risk populations, treatment, medical and care and support services to people living with HIV, within the framework of health care system reform.

In accordance with the goals of the National Programme, an information campaign among adolescents, including MARA, service providers and the general public is being implemented to inform them about HIV transmission routes, healthy life styles, combating stigma and discrimination on other issues. Knowledge hubs are in operation, and prevention programmes are being implemented among MARA on the local and national levels. This programme is expected to cover 100 per cent of pupils and students in the process of implementation of HIV/AIDS prevention programmes and development of healthy life styles.

According to sub-clause 2 of the Objective 2, Section I 'Organizational objectives and activities' of Amendment 2 to the Law of Ukraine 'On approval of the national targeted social programmes on HIV/AIDS for 2014–2018', the State Service of Ukraine on Response to HIV/AIDS and other socially dangerous diseases has approved the *Strategy to ensure*

[53] Most-at-risk adolescents: the evidence base for strengthening the HIV response in Ukraine : analytical report / UNICEF, Ukrainian Institute for Social Research after O. Yaremenko, Kyiv : K.I.C., 2008, p. 192.

[54] Most-at-risk adolescents: challenges and time to act : advocacy document / UNICEF, Ukrainian Institute for Social Research after O. Yaremenko, Kyiv: Verso 04, 2011, p. 56.

[55] Approved by the Order of the Ministry of Family, Youth and Sport of Ukraine of 30.07.2010 No. 2533.

[56] [Online document]. – Available at : http://zakon5.rada.gov.ua/laws/show/1708-18.

access of most-at-risk populations to HIV prevention services for 2014–2018 (order No. 6 of 22 January 2015) [57].

This strategy recognizes the goals of government policy and key objectives of the central and local executive power bodies and local self-governments, aimed at ensuring access of target groups to the prevention services in 2014–2018, and envisages the alignment of the governmental regional policy with other state-run interventions designed to curb the spread of HIV among the representatives of these target groups.

The strategy also contains a government policy component on MARA: children from families in hard living conditions, homeless and uncared-for children and children who do not have appropriate parental care:

- Counselling and provision of information about prevention of HIV, STI, TB and viral hepatitis (B and C) (from the age of 14 years).
- Syringe distribution and exchange (from the age of 14 years).
- Distribution of condoms and lubricants (from the age of 14 years).
- HIV counselling and testing (from the age of 14 years).
- Testing for STI (from the age of 14 years).
- STI treatment (from the age of 14 years).
- Social follow-up (from the age of 14 years).

The strategy takes into account the goals of a joint UNAIDS and UNICEF 'All-In' initiative, which Ukraine joined – the only country in the region to do so – to put an end to AIDS epidemic among adolescents, and to ensure children and young people living with HIV have access to diagnostic, treatment, high quality care and support, as well as access to social benefits they need (support with shelter, protection, social adaptation and reintegration).

Programmes and partners focusing their activities on adolescents in the context of the HIV epidemic

The Ukrainian Centre for Socially Dangerous Disease Control (UCDC) at the MoH of Ukraine plays a leading role [58]. UCDC cooperates with the Global Fund, USAID, UN agencies and other international and regional organizations working in the area of response to HIV, TB and other infectious diseases. UCDC is a recipient of two Global Fund to Fight HIV, Tuberculosis and Malaria (GFATM) grants till December 2017. In addition,

[57] On approval of the new edition of the Strategy to ensure access of most-at-risk populations to HIV prevention services for 2014–2018 [Online document]. – Available at : http://zakon4.rada.gov.ua/laws/show/1708-18.

[58] [Online document]. – Available at : http://ucdc.gov.ua

UCDC has all the statistical information on the epidemiological situation, disaggregated by age group.

Changes in the governmental bodies and processes of restructuring of national and local administrations threaten the continuity and quality of response activities for MARA and the respective reforms [59]. In Phase 1 of the study 'Strengthening the adolescent component of the national HIV/AIDS Programme through country assessment', experts evaluated the functioning of **the coordinating body on HIV among adolescents** and came to the conclusion that **there is no** such formal body. There are individual discussion platforms that convene representatives of different organizations, institutions and funds to discuss certain topics, but they are not institutionalised, because such platforms do not have any impact mechanisms.

There are some individual cases where regional coordinating councils on HIV conduct some specific activities aimed at MARA. So, there is a need to create such a body with clearly defined composition and authorities. It can be done on the basis of a multisectoral working group on MARA issues, the activities of which should become systemic. At the same time, there is a need to establish collaboration of this body with the respective ministerial departments, the range of responsibilities of which include adolescents as a target group.

The Ministry of Social Policy of Ukraine has established the Intersectoral Working Group on Protection of Childhood [60], headed by the Minister of Social Policy of Ukraine. The commission also includes the Minister of Health (Deputy chairman of the commission), the Minister of Education and Science (Deputy chairman of Commission), representatives of other ministries, and also, concurrently, the Ukrainian Parliament Commissioner for Human Rights, the Commissioner of the President of Ukraine for Children's Rights, Members of Parliament of Ukraine, the Deputy head of the Trade Union Federation, of the M.V. Ptukha Institute of Demography and Sociological Research at the NAS of Ukraine, first vice-presidents of the National Academy of Medical Sciences of Ukraine, the National Academy of Pedagogical Sciences of Ukraine; the Executive director of the National Fund for Social Protection of Mothers and Children 'Ukraine to Children', the representative of the UN Children's Fund (UNICEF) in Ukraine, the national correspondent of International Labour Organization in Ukraine, head of the National Council of the Federation of Children's Organizations of Ukraine, and other persons. Meetings are held at least once every three months to discuss a broad range of issues related to childhood.

[59] Review of the MARA Programme of UNICEF Country Office in Ukraine (July 2011 – June 2014): Summary Report, December 2014.

[60] [Online document]. – Available at : http://zakon5.rada.gov.ua/laws/show/1200-2000-%D0%BF

Now **it would be expedient to create a working group to deal with health issues relating to children and adolescents, as an alternative to creation of a working group on HIV.** For adolescents, HIV is nothing else but a risk related to behaviour and sexual practices, as well as alcohol and drug use. That is why it is necessary to create a working group that will lobby for the issues of adolescent and children's health, including prevention of HIV/AIDS.

Optimisation of the interaction between governmental bodies with all other stakeholders on the issues of adolescent health and HIV prevention with the involvement of NGOs, science, schools and private sector remains relevant.

Ukraine has a policy of partnership between governmental and non-governmental organizations *(the non-governmental organizations include civil society organizations, international partner organizations and charitable foundations)*. Within the context of an HIV epidemic, the government has the best leverage and governmental institutions are formally leading the HIV response activities among adolescents, though tit is he non-governmental sector, primarily international organizations, which play the real leadership role in the area of work with MARA. The programmes for targeted prevention and harm reduction among MARA were essentially scaled up due to an ongoing advocacy and technical support from UNICEF, and financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and from other international donors [61].

On 7 October 2015, a memorandum on HIV prevention among the general population was signed in Kyiv [62]. This document was signed between the Ministry of Health of Ukraine, the Ukrainian Centre for Socially Dangerous Disease Control, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the company Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ) GmbH in Ukraine. Signing of these documents provides an opportunity to strengthen cooperation and ensure international support to overcome the HIV epidemic in Ukraine. The goal of this document is to prevent HIV infection in the general population through the participation of international partners.

The GIZ project 'HIV/AIDS Advisory Services and Institutional Capacity Building' has been functioning successfully in Ukraine since 2007 within the Ukraine-Germany Intergovernmental Agreement. In addition, since 2009, as part of its cooperation with the Ministry of Health of Ukraine, GIZ has been implementing a Ukraine-wide campaign called 'Don't Give

[61] Review of the MARA Programme of UNICEF Country Office in Ukraine (July 2011 – June 2014): Summary Report, December 2014.

[62] [Online document]. – Available at: http://health.unian.net/country/1145877-v-kieve-podpisan-memorandum-po-profilaktike-vich-infektsii-sredi-naseleniya.html.

AIDS a Chance', focused on HIV prevention in the general population, which was developed on the basis of a similar successful campaign in run in Germany.

The best practices projects in this Campaign include innovative projects such as 'Fair Play' and 'Safety Route' based on the best international practices of preventive education and aimed at the promotion of healthy life styles and HIV/AIDS prevention among young people and adolescents. In particular, GIZ conducts free education and training for volunteer educators to implement the project in educational, sports and recreational institutions, as well as providing the project participants with football gear and outfits. The projects envisage interactive classes as part of the educational curricula approved by the Ministry of Education and Science of Ukraine, sports competitions and festivals, and topical contests in a form that is interesting and understandable to children and adolescents. So, for example, the 'Fair Play' project alone has covered more than 115,000 children at schools in all regions of Ukraine since 2012. Several organizations and charitable foundations (including international ones) focused on young people and adolescents are now working in the area of HIV/AIDS.

The international charitable foundation 'Alliance for Public Health' (Alliance-Ukraine) has been operating since 2000. The goal of this foundation is to reduce the spread of the HIV/AIDS epidemic in Ukraine. Many of the foundation's projects are aimed at adolescents from key populations [63]. At the present time, the Alliance is implementing a project called 'Harm reduction for children and young people who use drugs in Ukraine: Reaching the underserved', targeted at adolescents aged between 10-18 years, who use drugs and psychoactive substances (PAS), and their sexual partners.

The Organization HealthRight International [64] began working in Ukraine in 2005. It is implementing programmes focused on HIV positive, drug addicted women, their children, street children and youth, and cooperates with the All-Ukrainian Network of People Living with HIV/AIDS (PLH), the Ministry on Family, Youth and Sport, Ministry of Health and other organizations.

The UNICEF Ukraine MARA Programme [65] is being implemented on the national level and in seven demonstration (pilot) sites (Kyiv city, Bila

[63] [Online document]. – Available at : http://www.aidsalliance.org.ua/ru/library/our/2014/children%20risk%20rus.pdf

[64] [Online document]. – Available at : http://www.healthright.org.ua/

[65] Review of the MARA Programme of UNICEF Country Office in Ukraine (July 2011 – June 2014): Summary Report, December 2014.

Tserkva, Odesa, Mykolayiv, Dnipro, Donetsk and Mariupol [66]). Evaluation of this programme indicates that in 2014 there were more HIV-servicing organizations and Youth-Friendly Clinics (YFC) providing services to most-at-risk adolescents than at the beginning of the MARA Programme [67]. Since 2009 this programme has provided medical and social services to 19,000 MARA (i.e. every fifth adolescent in the high-risk groups who participated in the UNICEF prevention programmes in various cities). The level of satisfaction with the services received by MARA at the pilot UNICEF sites was very high, reaching an average of 85 per cent. The proportion of MARA tested for HIV in the cities included in the programme cities increased two-and-a-half times (from 30 per cent in 2011 to 70 per cent in 2014) [68].

UNICEF also provides assistance to the Ministry of Health of Ukraine to improve health care services for children and young people aged up to 18 years through the support of the Youth Friendly Clinics network, which included 139 YFC as of 1 January 2016 (not counting YFCs located on the temporarily occupied territory of AR Crimea, Sevastopol city and in the territory of Donetsk and Luhansk regions not under state control); 22 YFCs were established with the UNICEF support [69].

In order to increase motivation for HIV testing among adolescents within the information campaign 'Get Tested!', UNICEF is conducting an awareness-raising campaign supplemented by a number of special studies to evaluate its efficiency; a baseline study (2013) and a secondary evaluation (2015). Monitoring and evaluation of the efficiency of this campaign is being carried out by the Ukrainian Institute for Social Research after O. Yaremenko.

The 'Get Tested' information campaign may create the background for a communication strategy on HIV among adolescents and young people. HIV information and education lead to behaviour change, when people start to understand the risks and personal benefits of other types of behaviour. Websites such as 'Date' and 'Risky Relations' contribute to the development of such understanding through the direct communication and increase the efficiency of key messages. Information products developed within this campaign can be used in prevention interventions for adolescents and young people in other cities and in HIV prevention activities in educational and health facilities.

[66] The Programme was suspended in the two last-mentioned cities due to the armed conflict eastern Ukraine.

[67] Review of the MARA Programme of UNICEF Country Office in Ukraine (July 2011 – June 2014): Summary Report, December 2014.

[68] Ibid

[69] Analysis of activities of centres, departments and health care rooms for adolescents and young people at 'Youth-Friendly Clinics' in 2015 (O.M Meshkova, L.V. Romanenko), Kyiv, 2015 (original in Ukrainian).

In 2016 UNICEF piloted an international tool to evaluate the living standards of adolescents (Adolescents country tracker – ACT), which measures the level of adolescent development in five areas: health care, education, safety, economic opportunities and participation in social life. The indicators developed create a platform for identification, evaluation and monitoring of progress in various spheres of adolescent life throughout the world. Regular monitoring of these indicators provides the opportunity to develop action plans aimed at improving social and economic conditions for adolescents on both the national and international levels. This tool is based on existing national and regional monitoring systems, and activities to improve the measurements and analysis of available data. The piloted indicators will be further used to monitor the progress of living standards of adolescents and to compare it on the national, regional and global levels.

Since 2013, the USAID RESPOND project has been actively implementing activities to map the services on the regional level and has been contributing to strong capacity-building in the country through the organization of training on the development of various types of maps for regional and national partners.

In 2015, in order to ensure transparency and optimize access to key information in the area of HIV response, the Ukrainian Centre for Socially Dangerous Disease Control at the MoH of Ukraine commissioned the establishment of a National Strategic Information Portal in the area of HIV/AIDS response (hereinafter: National Portal) with the technical support of the USAID RESPOND project. The National Portal is a separate website which combines several interactive Internet resources in the sphere of monitoring and evaluation (M&E) and strategic information on HIV/AIDS response: 'Regional Profiles Online', 'Mapping', 'DevInfo – e-database of HIV/AIDS indicators', 'Compendium of HIV/AIDS Response Interventions', 'Registry of HIV Service Organizations and Donors in HIV/AIDS Response in Ukraine', 'M&E Centres in Ukraine', 'E-library of Publications, 'Research Plan' and 'Training Plan'.

Information resources on the adolescent component of HIV response deserve special attention. The website TEENERGIZER[70] was created with the support from East Europe and Central Asia Union of PLWH, where adolescents and young people can find certain information about HIV/AIDS, receive specialist counselling and communicate with other adolescents living with HIV. The Information and Educational Knowledge Centre[71], which is being implemented with technical support from the UNICEF on the basis of the Ukrainian Institute for Social Research after O. Yaremenko

[70] The online platform Adolescent and Youth Association «Teenergizer», created by adolescents for adolescents [Online document]. – Available at : http://teenergizer.org

[71] Online platform 'Knowledge Centre' – informational and educational resource on work with adolescents [Online document]. – Available at : http://knowledge.org.ua.

in cooperation with ICF AIDS Foundation East-West has been designed to build the capacities of specialists working with adolescents, in particular in HIV prevention, including the most-at-risk adolescents. The platform is bringing together powerful informational, analytical and educational resources; webinars, workshops and training for different target groups are being conducted on its basis.

Also important is the global youth project U-Report, which takes the opinions of young people into account and covers the whole of Ukraine. Its rapid surveys through free SMS or Twitter help to learn the opinions of young people about important social issues. UNICEF is studying the results and cooperating with partners, so that these public opinion polls will be used in practice in future programmes. U-Report is one of the easiest tools with which young people can influence changes in the important areas of social life [72].

At the Third National Conference on HIV/AIDS (21-23 November 2016), a special topical sectional meeting 'Youth and Teenagers: Priorities and challenges of the HIV epidemic response' was held. It sparked the interest of a broad range of partners and stakeholders as it discussed relevant issues related to teenagers (including MARA) in the context of HIV epidemic and key activities aimed at preventing the spread of HIV.

HIV prevention in the educational system

A school curriculum on reproductive and sexual health and on the development of HIV prevention skills is being introduced in the secondary education system in all schools throughout Ukraine [73]. In 2015 the educational course 'Fundamentals of Health ' is being taught at 15,498 state-run and 141 private general educational institutions of the II–III degrees in grades 5-9 [74]. The MoH of Ukraine also recommended introducing extracurricular 'Protect yourself from HIV' classes for the development of healthy life styles and HIV/AIDS prevention in 10th-11th (senior) grades to ensure the continuity of prevention education in school [75].

[72] Project U-report survey through the free SMS and Twitter on the topics important to youth [Online document]. – Available at : https://ukraine.ureport.in/about/

[73] Educational curricula for grades 5-9 of the general educational institutions (according to the new State Standards for Basic and Complete Secondary Education) [Online document]. – Available at : http://mon.gov.ua/activity/education/zagalna-serednya/navchalni-programy.html

[74] Ibid, General educational institutions of Ukraine at the beginning of 2015/16 academic year : statistical bulletin, Kyiv, 2016, p. 21.

[75] Fundamentals of Health [Online document]. – Available at : http://mon.gov.ua/content/Освіта/osn-zdor.pdf

In 2012–2013 the project 'Capacity building of teachers to ensure effective HIV/AIDS Prevention' was implemented with the objective of developing training curricula and training of trainers for postgraduate pedagogical institutes on HIV/AIDS prevention, development of healthy life styles, counteracting stigma and discrimination of people living with HIV (PLH); to develop and distribute educational materials to train teachers of general educational (middle and senior school), vocational training and higher pedagogical institutions; to develop and distribute materials for regional departments of education and science on large-scale advocacy activities, HIV/AIDS prevention, development of healthy life styles, counteracting stigma and discrimination of PLH [76].

As a result, 216 regional trainers were trained to conduct special courses on HIV prevention, promotion of tolerance, integration of HIV positive children into the educational environment; the government supported training for 16,000 teachers to conduct special courses for 8,000 educational institutions; 10 study guides were published to train teachers to conduct special courses; educational institutions (including schools, vocational training schools and higher educational institutions of the I and II levels of accreditation) were provided with educational materials with a total circulation of 328,300 copies; 160,000 students of schools, vocational training schools and higher educational institutions aged 15–17 years attended the 'Protect Yourself from HIV' training course [77]. The goal of the project was to achieve the indicator of 50 per cent of adolescents aged 15–17 years being able to correctly identify the methods for preventing sexual transmission of HIV and knowing how it is not transmitted. One of the target indicators of the Plan for Monitoring and Evaluation of Efficiency of the National Targeted Social Programme on HIV/AIDS till 2018 is for 70 per cent of young people aged 15-24 years, to have the correct knowledge about HIV transmission modes and individual ways of protecting themselves [78]. Those with this knowledge accounted to 48 per cent of young people in this age bracket in 2012 [79]. Among adolescents aged 13–17 years old this indicator was met by only 24.1 per cent (2014) [80]. So, the youngest adolescents are less aware of HIV transmission methods and this can be improved through the introduction of a school curriculum on

[76] Project 'Capacity Building of teachers to ensure effective HIV/AIDS prevention' [Online document]. – Available at : http://network.org.ua/projects/current_projects/proekt-posylennya-spromozhnosti-pedagogiv-u-zabezpechenni-dievoyi-profilaktyky-vil-snidu-protydiyi-s/

[77] Ibid

[78] Order of the State Service of Ukraine on socially dangerous diseases as of 15 January 2015 p. № 2 [Online document]. – Available at : http://document.ua/pro-zatverdzhennja-planu-monitoringu-ta-ocinki-efektivnosti--doc218090.html

[79] Ukraine. Multi-indicator cluster household survey, 2012 / State Statistics Service of Ukraine [et al.], Kyiv : K.I.C., 2013, p. 198–199.

[80] Indicators and social context of adolescent health development: monograph [Online document] / O.M. Balakireva, T.V. Bondar, D.M. Pavlova et al., edited by O.M. Balakireva; UNICEF, Ukrainian Institute for Social Research after O. Yaremenko, Kyiv, 2014, p. 113.

reproductive and sexual health and by the development of HIV prevention skills.

Table 10 presents an expert evaluation of the inclusion of adolescents into the national HIV response programme, provides a generalized description of barriers and bottlenecks in the work with adolescents in the area of HIV/AIDS response, and identifies the next steps.

Table 10. Programme environment components on the national level: existing problems and next steps

Programme environment components (expert evaluation /evaluation by representatives of the regional AIDS Centres) *	**Facts**	**Steps**
National policy and strategy (4.8/3.4)	• Negative social attitude to MARA and adolescents living with HIV; • Threat of exclusion of MARA problems from the political agenda; • Insufficient resources.	• On-going advocacy; • Creation of favourable environment for MARA; • Further integration of medical and social services on the community and health facility levels; • Improvement of resource provision.
Coordination (4.5/3.5)	• Lack of coordination body on MARA problems; • Resulting threat to continuous and coordinated activities; • Restructuring of central and local governments.	• Creating and ensuring the functioning of a coordination body on the basis of a national intersectoral working group on MARA issues; • Optimising intersectoral collaboration and a referral mechanism to keep track of clients in various systems; • Establishment of cooperation between the government bodies of different levels as a result of decentralisation.
Consultation process (4.3/3.3)	• Poor cooperation between partners; • Insufficient discussion of HIV prevention issues among adolescents.	• Improvement of communication between the government bodies and NGOs, scientific institutions, schools and health care facilities; • Organization of regular meetings of the national intersectoral working group on MARA issues.
Legislation (5.5/3.6)	• Quality assurance by providers of services to MARA; • Uncoordinated legislation on HCT for adolescents; • MARA discrimination and limited access to certain services; • Insufficient legal knowledge among service providers.	• Introduction of the standards of service for MARA as a component of the national standard operating procedures for medical and social services; • Analysis of legislation to improve it; • Removal of contradictions in the norms on HCT between the Law on HIV and HCT Procedures; • Training of specialists and improvement of knowledge of the legislation for service providers.

Programme environment components (expert evaluation /evaluation by representatives of the regional AIDS Centres) *	**Facts**	**Steps**
Adolescent participation (4.8/2.1)	• Insufficient information about adolescents' views about their needs, programmes and services; • Low awareness of infection risks and importance of prevention among adolescents; • Lack of monitoring of adolescent networks.	• Involvement of adolescents in decision making and evaluation of programmes and services; • Regular monitoring of adolescent networks; • Application of new technologies and social networks to attract adolescents and disseminate information about HIV through social networks.
Resource distribution (4.8)	• Insufficient funding and risk that it will be reduced; • Weak regional programmes; • Irregular service availability at the local level; • Insufficient resources in most regions to provide social and psychological support services to adolescents living with HIV.	• Attraction of donor funds; • Development of strategies to attract private sector funds; • Support to regional programmes; • Attraction of funds for the city and regional social programmes to provide social and psychological support services to adolescents living with HIV.
Monitoring and evaluation (5.0)	• Lack of single governmental body responsible for monitoring and evaluation of efficiency of implementation of the National Targeted Social HIV Response Programme and further national programmes, which would be implemented in response to HIV/AIDS in Ukraine; • Lack of single database of health and social well-being indicators for adolescents; • Insufficient information on the regional and local levels; • Optionality of some indicators for the target group of adolescents and youth for the programme monitoring and evaluation.	• Identification of a responsible body that would coordinate implementation; • Development of monitoring plan and conducting evaluation of efficiency of implementation of the National Targeted Social HIV Response Programme and further national programmes, which would be implemented in response to HIV/AIDS in Ukraine; • Control over adherence to the plan for monitoring and evaluation of programme efficiency; • Development and regular updating of the single database of health and social well-being indicators for adolescents; • Regular control of the quality of services, especially on the subnational level; • Control of discrimination cases; • Attachment of mandatory status to indicators No. 3 and No. 18 of the M&E plan for the National Programme **

* **The evaluation uses a 10-point scale, where '1' is the lowest, and '10' the highest score. The expert evaluation involved 56 experts including 29 people who represented state institutions, 19 representing NGOs/Charitable Funds, two international partners and 6 governmental bodies. In order to evaluate the components of the programme environment by adolescents and young people, an additional focus group interview was conducted with 7 representatives from youth and volunteer organizations. Evaluation by the representatives of regional AIDS Centres was calculated based on answers given by 28 participants of the National Meeting of Heads of Regional AIDS Centres (in February 2016).**

** **Indicator No. 3 'HIV prevalence among young people aged 15-24 years'. Indicator No. 18 'Percentage of young people aged 15-24 years, who correctly identify methods to prevent sexual transmission of HIV and know how it is not transmitted'.**

2.2. Regional context of HIV response programmes for adolescents in Ukraine

Only half of the regions included indicators on adolescents in their plans for monitoring and evaluation (M&E) of the region HIV/AIDS response programmes for 2014–2018. At the same time, region programmes are poorly oriented to working with most-at-risk adolescents (an average estimate of the region programmes by the representatives of regional AIDS centres was 3.1 points on the 10-score scale). The lowest estimates were related to accessibility of HCT services for street adolescents (2.6 points), adolescent FSW (2.7 points), adolescent MSM (2.8 points) and adolescent IDUs (3 points). The estimates of policy and legislation on protection of adolescents from key risk populations from discrimination in the access to services of combination HIV therapy were also low (3.1 points for all risk populations). HIV prevention among adolescents, provision of HCT, treatment and care services to HIV positive adolescents are rather seldom discussed on the level of regions, cities and districts.

Participation of adolescents. The worst situation was found with the involvement of adolescents and young people in the region councils on HIV/AIDS response, involvement of adolescents in the coordination bodies on various issues and with taking into account adolescent opinions in the development and implementation of epidemic response programmes and activities. An average estimate of adolescent participation was 2.1 points out of 10. The majority of experts involved in the evaluation believe that adolescent opinions in the process of development of HIV response programmes on both national and region levels are insufficiently taken into account. Cases where adolescents and young people are involved in the discussion of HIV-related problems remain rare. There are no effective mechanisms and procedures that would ensure representation of adolescents and youth in the work of intersectoral consultation councils. The experts estimated the representation of interests of adolescents from vulnerable populations in HIV response programmes as low. This is particularly the case with most-at-risk adolescents. MARA do not have their own community-based associations which would represent their interests, and this undermines their capacity to demand fulfilment of their needs and observance of their rights by the government and local governments [81].

According to the mapping of services by the informational and educational platform Knowledge Centre [82], operating with UNICEF technical support on the basis of the Ukrainian Institute for Social Research after O. Yaremenko, in cooperation with ICF AIDS Foundation East-West,

[81] Review of the MARA Programme of UNICEF Country Office in Ukraine (July 2011 – June 2014): Summary Report, December 2014.

[82] Online platform 'Knowledge Centre' – informational and educational resource on work with adolescents [Online document]. – Available at : http://knowledge.org.ua/

the majority of HIV prevention services (medical and social, social and psychological, informational etc.), including for the most-at-risk adolescents and adolescents living with HIV, are concentrated in Kyiv city, Central and Southern regions (see Fig. 7); in general this coincides with the regions where the HIV epidemic is concentrated among adolescents.

In addition to treatment, social and psychological support to children and adolescents living with HIV and their families is important. Five communal social service facilities operate in the regions of Ukraine; they are Centres for HIV Infected Children and Youth, two of them in Kyiv city and three others in Odesa, Kharkiv and Dnipro [83].

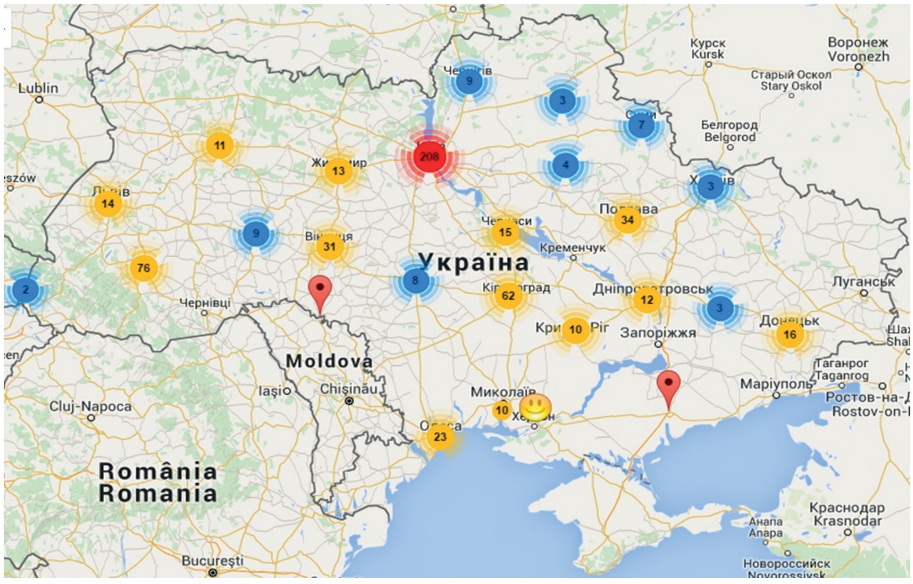

Fig. 7. Map of HIV-related services for adolescents and young people in Ukraine (excluding AR Crimea, Sevastopol city and territories of Donetsk and Luhansk regions not under state control) [84]

Coverage of adolescents with these support services was negatively impacted by the suspension of the Global Fund funding for psychosocial support programmes in 2015 [85]. However, in the previous period qualified

[83] Analytical report on the results of the study 'Development of integrated medical and social services for HIV positive adolescents: current challenges, needs and opportunities'. HealthRight International, Kyiv, 2015, p. 9.

[84] Online platform 'Knowledge Centre' – informational and educational resource on work with adolescents [Online document]. – Available at : http://knowledge.org.ua/uk/karta-poslug/

[85] Access to continuous care for HIV positive adolescents in Ukraine. Eastern Europe and Central Asia Union of People Living with HIV within the UNICEF supported project Strengthening of Service Providing Community Networks and Leadership Skills of Adolescents Affected by HIV/AIDS, Kyiv, 2015.

specialists were trained to provide psychosocial support to children and adolescents. In particular, in 2014–2015 the ICF Ukrainian Public Health Foundation, with financial support from UNICEF made a training visit to the United Kingdom and conducted two training workshops (in Kyiv and Mykolayiv) for members of multidisciplinary teams and partners of the project 'Development of integrated medical and social services for HIV positive adolescents' on the basis of international experience and WHO best practices [86]. Also, in 2012–2013, with the participation of the All-Ukrainian Network of PLH, 11 regional multidisciplinary teams including 32 specialists (psychologists, social workers of HIV servicing organizations and physicians of the regional AIDS Centres) were trained[87].

Due to the above-mentioned suspension of funding and lack of local government resources, the number of care and support centres was reduced and, correspondingly, the territorial accessibility of social and psychological services for children and adolescents living with HIV also decreased [88].

Studies conducted in 2013–2015 as part of the project of the Eastern Europe and Central Asia Union of People Living with HIV, supported by UNICEF in 19 regions of Ukraine [89] demonstrated that regular support groups for adolescents operated only in 7 of 19 regions (37 per cent) – including Poltava, Kyiv, Donetsk, Odesa, Cherkassy, Khmelnitsky and Mykolayiv regions; NGO specialists in only 9 out of 19 regions (Poltava, Kyiv, Chernivtsi, Donetsk, Odesa, Cherkassy, Khmelnitsky, Mykolayiv and Volyn regions) have experience of working with HIV positive children and adolescents; none of the regions studied involved adolescents as leaders or peer counsellors [90].

[86] Analytical report on the results of the study 'Development of integrated medical and social services for HIV positive adolescents: current challenges, needs and opportunities'. Health Right International, Kyiv, 2015, pp. 10-11.

[87] Ibid, p. 11; Project 'Improvement of the quality of life of HIV positive adolescents in Ukraine' [Online document]. – Available at: http://network.org.ua/projects/current_projects/proekt-pokrashchennya-yakosti-zhyttya-vil-pozytyvnykh-pidlitkiv-v-ukrayini-/ (original in Ukrainian).

[88] Analytical report on the results of the study 'Development of integrated medical and social services for HIV positive adolescents: current challenges, needs and opportunities'. HealthRight International, Kyiv, 2015, p. 12.

[89] Chernihiv, Ivano-Frankivsk, Chernivtsi, Poltava, Kyiv, Donetsk, Odesa, Khmelnitsky, Volyn, Mykolayiv, Cherkassy, Rivne, Lviv, Ternopil, Zakarpattia, Vinnytsia, Kirovograd and Zhytomyr regions and Kyiv city.

[90] Access to continuous care for HIV positive adolescents in Ukraine. Eastern Europe and Central Asia Union of People Living with HIV within the UNICEF supported project Strengthening of service providing community networks and leadership skills of adolescents affected by HIV/AIDS, Kyiv, 2015, p. 13.

The network of Youth-Friendly Clinics is an important component of the regional and local HIV response programmes for adolescents in Ukraine. Their task is to promote the value of a healthy life style among young people and to ensure comprehensive medical, social and psychological support to adolescents and youth. As of 1 January 2016, Ukraine had a network of 139 YFCs (not including those located on the temporarily occupied territory of AR Crimea, Sevastopol city and uncontrolled territory of Donetsk and Luhansk regions)[91]. In 2015, with UNICEF support, Ukraine continued the creation and development of network centres, departments and rooms to provide health care to adolescents and young people (starting from 1998 a total of 22 YCF and an informational and resource centre in Kyiv have been created with the UNICEF support), and the number of YCFs has increased in rural areas (the proportion of rural YCFs is now 39.4 per cent, the majority in Chernivtsi, Mykolayiv and Lviv regions)[92].

Over 90 per cent of representatives of the regional AIDS Centres believe that the adolescent component should be significantly strengthened in both the National Targeted Social Programme on HIV/AIDS for 2014–2018 and in the region HIV/AIDS response programmes for 2014–2018. At the same time, they singled out a variety of aspects that could have a positive impact to attract the attention of the adolescent population: the educational sector should be included into the principal programme implementers, specific indicators should be identified and funded; specific interventions focused on MARA should be included in the region programmes; an evaluation should be conducted into the efficiency of school curricula in HIV prevention and development of healthy life styles; the human resource capacity of AIDS Centres for work with adolescents and monitoring of this activity should be strengthened; the responsibility of persons who disclose HIV positive status should be increased; collaboration and coordination of work between the government bodies, state institutions and NGOs should be strengthened; mechanisms should be developed through NGOs to ensure that the opinions of adolescents are taken into account; MARA should have opportunities for feedback on the services received and should be involved in the planning and implementation of prevention programmes and projects (both with service providers and with government bodies) so that these services meet their needs and observe their rights[93]. It is very important to involve adolescents and children at the local level. That is why adolescents and young people should be involved in the development

[91] Analysis of activities of centres, departments and health care rooms for adolescents and young people at "Youth-Friendly Clinics" in 2015 (O.M. Meshkova, L.V. Romanenko), Kyiv, 2015, p. 5 (original in Ukrainian).

[92] Ibid, p. 7.

[93] Prevention models within the UNICEF project 'HIV prevention among most-at-risk adolescents' / Ukrainian Institute for Social Research after O. Yaremenko, UNICEF, Kyiv, 2015; Review of the MARA Programme of UNICEF Country Office in Ukraine (July 2011 – June 2014): Summary Report, December 2014.

of local programmes, and permanent mechanisms for cooperation should be developed, and on the basis of this experience it will be possible to evaluate the efficiency of programmes and services with the participation of adolescents. Ongoing advocacy is needed to preserve and strengthen the adolescent component of the National Targeted Social Programme on HIV/AIDS and regional or local programmes. Work with adolescents, especially with MARA, is an efficient method of early prevention of an HIV epidemic. Due to the age specifics compared to the adults, adolescents have more complex needs and are less protected. At the same time, adolescents have a worse experience of access to services, first of all, due to their legal status as underage persons.

Section 3. Assessment of key HIV prevention interventions among adolescents

3.1. Review of key HIV prevention interventions among adolescents

In recent years, several prevention interventions have been implemented in various regions of Ukraine focusing on children, adolescents and young women (particularly from most-at-risk populations), and have proved to be effective. A number of studies have been conducted on the accessibility of HIV counselling and testing, the prevalence of high-risk practices, awareness levels, as well as needs assessments, reviews of the regulatory and legal framework, risk factor simulations, and the like.

As the HIV epidemic in the general population and among adolescents in Ukraine has a concentrated character, an in-depth analysis within the study 'Strengthening the adolescent component of the national HIV/AIDS Programme through country assessment' implied the selection of the four large cities in the most affected regions [94], with the largest number of interventions for MARA: These are Dnipro, Kyiv, Mykolayiv and Odesa. The selection criteria included the presence of organisations working in the area of HIV/AIDS with the experience of implementing prevention models aimed at changing risky behaviours, improving HIV/AIDS knowledge, and seeking social services and medical assistance (e.g. prevention models of health and social service provision, implemented in 2013–2015 [95]).

During the study, the researchers identified key interventions that may strengthen the adolescent component within the National Targeted Social Programme on HIV/AIDS for 2014–2018:

1. *Treatment and support programmes for adolescents living with HIV, specifically social and psychological follow-up of adolescents on ART.*
2. *HIV counselling and testing services (HCT) for adolescents.*
3. *Syringe exchange programmes for adolescents who are IDUs.*
4. *Programmes for MARA to increase safer behaviour regarding HIV/STI, particularly for adolescent MSM and adolescent FSW.*
5. *School curriculum on reproductive and sexual health, and development of HIV prevention skills.*

[94] Donetsk, the city with one of the highest HIV prevalence rates, was excluded from the analysis as it is currently located on non-government controlled territory.

[95] Balakireva O.M. HIV prevention among most-at-risk adolescents: Models of medical and social / O.M. Balakireva, T.V. Bondar, K.M. Nahornyak, O.T. Sakovych, Y.V. Sereda, A.V. Sudakova; Ukrainian Institute for Social Research after O. Yaremenko; United Nations Children's Fund (UNICEF), Kyiv : Publishing centre 'Foliant', 2015, 151 p. (Original in Ukrainian).

The focus group method was used to determine key barriers and bottlenecks for interventions in the context of structural determinants for primary data collection. In each of four territorial zones (the cities of Dnipro, Kyiv, Mykolayiv and Odesa) the researchers conducted three focus groups on the following topics: the educational programme on reproductive and sexual health and development of HIV prevention skills; health services and adjacent counselling for HIV testing, treatment and support of adolescents with HIV, who receive ART; preventive syringe exchange services for adolescent IDUs and safer behaviour of MARA regarding HIV/STI (12 focus group discussions overall).

All identified interventions are available in the selected cities (Table 11). Mykolayiv currently does not have a centre which would offer social and psychological services to adolescents living with HIV on ART.

Table 11. The number of facilities where selected HIV prevention interventions are being implemented, by city:

		Kyiv	Dnipro	Odesa	Mykolayiv
Health facilities offering ART		2	2	1	1
Centres for HIV positive youth and children		2	1	1	0
NGOs offering harm reduction services (condom distribution and syringe exchange)		8	4	5	3
Facilities providing HCT services		14	20	10	12
Educational establishments	*Schools of general education, levels I–III*	353[96]	163[97]	175	63[98]
	VTS	24[99]	13[100]	12	7

Sources: SyrEx databases of ICF 'Alliance for Public Health'; Educational establishments providing general education in Ukraine at the beginning of academic year 2015/16: Statistical bulletin, Kyiv, 2016, p.21; Continuing education and mastering a profession: Statistical bulletin / The State Statistics Service of Ukraine, Kyiv 2015, p.15; The National Strategic Information Portal for HIV/AIDS, Interactive maps of services / the State Institution 'Ukrainian Centre for Socially Dangerous Disease Control' within the USAID RESPOND project [Online resource]. – Available at: http://hiv.ucdc.gov.ua/mapping/#Part:id.EQ.3; the data validated during the surveys in the cities of Dnipro, Kyiv, Mykolayiv and Odesa.

[96] Educational establishments of general education in Ukraine at the beginning of the 2015/2016 academic year: Statistical bulletin, Kyiv, 2016, p. 21. (Original in Ukrainian).

[97] [Online document]. – Available at: http://www.osvita.com.ua/schools/dnepropetrovsk/

[98] [Online document]. – Available at: http://osvita-mk.org.ua/index/derzhstandarti/0-30

[99] Continuing education and mastering a profession: Statistical bulletin / The State Statistics Service of Ukraine, Kyiv, 2015, p. 15 (Original in Ukrainian).

[100] [Online document]. – Available at: http://uon.dnepredu.com/uk/site/profesiino-tekhnichni-nav.html.

Table 12. Organisations offering harm reduction services to MARA, by city

City / Organisation	Target groups of adolescents receiving services from the organisation		
Dnipro			
NGO 'Doroha Zhytya' (The Road of Life)	IDU		MSM
Charitable Fund 'Virtus'	IDU	FSW	
Dniprodzerzhynsk city CF 'Impulse'	IDU	FSW	
Dnipro region NGO 'Perehrestya' (Crossroads)	IDU		
Kyiv			
CO 'Dopomozhy Zhytiya' (Help Life)			MSM
NGO 'Convictus Ukraine'	IDU	FSW	
Charitable Fund 'Drop-In Centre'	IDU	FSW	
NGO 'Gay Alliance'			MSM
NGO 'The Centre for Psychosocial Rehabilitation of Chemically Dependent Youth "Krok za Krokom"' (Step by Step)	IDU		
NGO 'Club Eney'	IDU	FSW	
ICF Vertical	IDU		
CO Tochka Opory (Foothold)			MSM
Mykolayiv			
Mykolayiv CF 'Vykhid' (Exit)	IDU		
NGO 'LGBT Association 'LIGA'			MSM
Mykolayiv CF 'Unitus'	IDU	FSW	
Odesa			
NGO 'Youth Development Centre'	IDU		
Citizen Movement 'Vira, Nadiya, Liubov' (Faith, Hope and Love)	IDU	FSW	
NGO 'Era Myloserdya' (Era of Mercy)	IDU		
Youth movement 'Partner'			MSM
Odesa CF 'Shlyakh do Domu' (Way Home)	IDU	FSW	

Sources: **SyrEx databases of ICF 'International HIV/AIDS Alliance in Ukraine'; The National Strategic Information Portal for HIV/AIDS, Interactive maps of services / the State Institution 'Ukrainian Centre for Socially Dangerous Disease Control' within the USAID RESPOND project [Online resource]. – Available at: http://hiv.ucdc.gov.ua/mapping/#Part:id.EQ.3; the data validated during the surveys in the cities of Dnipro, Kyiv, Mykolayiv and Odesa.**

Some organisations offer services to all adolescent groups, including harm reduction (most organisations work with IDUs; see Table 12). However, the assessment findings show that MARA are not adequately covered with

prevention services in all cities. The proportion of MARA aged 14-19 years among all clients of harm reduction services in 2015 across all selected cities is minuscule (Table 13). Only 178 adolescent IDUs of 14-19 years of age took part in syringe exchange programmes; similarly, only 403 FSW aged 14-19, and 363 adolescent MSM of the same age received condoms in 2015.

According to the assessment data (Phase 2), all facilities providing ART to children and adolescents under 18 years of age in all four cities are child/youth-friendly (in line with the national standards), with an adequate supply of recommended ARV drugs accumulated in the past three months. All facilities employ specialists trained in the provision of ART counselling to adolescents. In general, the same is true about facilities offering HCT, even though not all of them have staff trained in adolescent-specific testing and counselling.

The coverage of young people aged 20–24 years from key populations with services is much better, but still insufficient. In almost all cases the proportion of such individuals reached by harm reduction interventions (as the proportion of MARA aged 14–19) is lower than their share in the overall population of IDUs, FSW and MSM of the relevant city (Table 13).

Therefore, the level of coverage of both age groups (14–19 years and 20-24 years) with syringe exchange and condom distribution interventions is insufficient. Being of minor age (under 18 years) is a notable barrier to inclusion in harm reduction programmes, so MARA aged 14–17 need particular attention, especially adolescent MSM and FSW. The causes of such a situation are well known: HIV service organisations do not work with adolescents as a separate target group, while donors do not view them as a key population in terms of HIV spread; donors and HIV service organisations often try to avoid legal problems related to legal uncertainty of work with underage risk groups; the effectiveness of NGOs' collaboration with each other and with social services is low, with almost no cooperation with law enforcement agencies.

Table 13. Coverage of at-risk adolescents and young people (IDUs, FSW and MSM) with harm reduction services in four cities [101]

City	Total coverage in all age groups	14–19 years			20–24 years		
		Number	% of covered with services	Proportion of the age group in relevant at-risk group, % [102]	Number	% of covered with services	Proportion of the age group in relevant at-risk group, %
The number of IDUs who received syringes and condoms in NGO network in 2015							
Kyiv	24,675	85	0.3	1.6	1,373	5.6	9.6
Odesa	16,252	61	0.4	3.0	903	5.6	15.2
Mykolayiv	4,677	8	0.2	0.8	113	2.4	4.8
Dnipro	9,583	24	0.3	0.9	324	3.4	4.2
The number of FSW who received condoms / femidoms in NGO network in 2015							
Kyiv	6,809	169	2.5	2.4	1,585	23.3	26.3
Odesa	4,565	190	4.2	13.1	1,752	38.4	32.5
Mykolayiv	2,734	14	0.5	1.6	242	8.9	15.1
Dnipro	1,624	30	1.9	4.8	423	26.0	43.2
The number of MSM who received condoms / femidoms in NGO network in 2015							
Kyiv	12,612	294	2.3	10.0	2,941	23.3	31.0
Odesa	2,554	41	1.6	7.0	581	22.7	27.0
Mykolayiv	1,591	21	1.3	11.0	258	16.2	36.0
Dnipro	855	7	0.8	5.0	107	12.5	42.0

[101] SyrEx databases of ICF 'International HIV/AIDS Alliance in Ukraine'; 'Monitoring the behaviour and HIV-infection prevalence among people who inject drugs as a component of HIV second generation surveillance'. Report on the results of 2013 bio-behavioural survey / O. Balakiryeva, T. Bondar, et.al. Kyiv: ICF 'International HIV/AIDS Alliance in Ukraine', 2014; "Monitoring the behaviour and HIV infection prevalence among female sex workers as a component of HIV second generation surveillance'. Report on the results of 2013 bio-behavioural survey / O. Balakiryeva, T. Bondar, Y. Sereda, et.al. Kyiv: ICF 'International HIV/AIDS Alliance in Ukraine', 2014; 'Monitoring the behaviour and HIV-infection prevalence among men who have sex with men as a component of HIV second generation surveillance'. Report on the results of 2013 bio-behavioural survey / Y. Bolshov, M. Kasyanchuk, et.al, Kyiv: ICF 'International HIV/AIDS Alliance in Ukraine', 2014.

[102] For MSM – 16-19 years.

3.2. Treatment and support programmes for adolescents living with HIV

Situation assessment:

- HIV positive adolescents receive ART out of State Budget funds.
- Doctors adapt treatment regimens in case of counter-indications or side effects.
- Accessibility of ART for children and adolescents is 100 per cent, but the quality of treatment depends on the willingness of adolescents (parents, guardians) to arrive on time for their treatment.

The goal of intervention:

- Coverage – 100 per cent of adolescents aged 10-17 living with HIV/AIDS who remain on ART 12 months after its initiation.
- 100 per cent of adolescents aged 10-17 living with HIV, are covered with care and socio-psychological support services.

An assessment of interventions related to treatment and support of adolescents living with HIV made it possible to distinguish barriers and bottlenecks, and to formulate proposals regarding further steps towards their reduction (Table 14).

Table 14. Barriers and bottlenecks of interventions and further steps to tackle them

Barriers and bottlenecks	Further steps
Access to resources	
• **Newer ARV drugs and those of better quality are not available. Systematic, daily administration of several pills wear a person down psychologically.**	• To expand a list of ARV drugs and to lobby for registration of new, combination ARVs.
Competence of staff	
• **The lack of specialists for prescribing ART; treatment is largely provided in AIDS centres.** • **Notable staff turnover, especially among psychologists working with adolescents.**	• To improve the professional competence of staff regarding provision of comprehensive services to adolescents on ART. • To shift towards online courses; to organise webinars for staff. • To consider the possibility of delegating the responsibility of prescribing ART to adolescent doctors and paediatricians at health facilities other than AIDS centres.

Intake and adherence to ART	
• **Untimely initiation of ART due to:** ◦ **The lack of the protocol for follow-up and ensuring treatment;** ◦ **Ineffective cooperation of health facilities with social services and NGOs;** ◦ **Parental refusals to follow doctor's orders and to initiate treatment;** ◦ **The lack of knowledge among parents (guardians) about HIV infection and ART; failure to understand treatment prognosis.**	• To improve the protocol to ensure adequate treatment and follow-up of HIV positive adolescents from single-parent families or families in difficult life circumstances. • To introduce case management algorithms in social services. • To apply the 'peer education' method for adolescents, if there is a risk of refusal or interruption of ART. • To work with parents to ensure adequate support of treatment of HIV positive children and adolescents. • To disseminate information about modern ARV drugs and the effectiveness of ART, aimed at reducing the stigmatisation of people living with HIV.
• **Interruption of ART due to:** ◦ **Frequent intake of drugs that cause psychological fatigue;** ◦ **Parents (guardians) who are late for appointments (or skip visits);** ◦ **Age-specific peculiarities of teenagers, who may not be serious about their health, or who misunderstand the importance of taking their drugs carefully;** ◦ **The lack of fully-fledged psychosocial support of adolescents on ART (since 2015 the programme of psychosocial assistance to children[103] is no longer being financed by the Global Fund);** ◦ **Ineffective mechanisms to address crisis situations linked to interruption of treatment by adolescents;** ◦ **Ineffective cooperation between health facilities providing ART and social services and NGOs.**	• To introduce more strict norms to hold parents (guardians) responsible for inadequate provision of treatment of children and adolescents on ART. • To introduce psychosocial follow-up for adolescents on ART, funded from local budgets. • To establish cooperation with non-governmental organisations regarding the delivery of comprehensive services to children and adolescents on ART. • To establish cooperation between health facilities providing ART and NGOs to deliver comprehensive psychosocial support to adolescents. • To establish cooperation between health facilities and social protection and law enforcement agencies to accelerate the initiation of ART in case of parental refusal. • To lobby for funding for the socio-psychological follow-up of children and adolescents from international donors and local authorities in regions with large numbers of HIV positive children and adolescents.

[103] 'Access to continuous care for HIV positive adolescents in Ukraine' / East Europe and Central Asia Union of People Living with HIV within the UNICEF supported project 'Strengthening of service-providing community networks and leadership skills of adolescents affected by HIV/AIDS', Kyiv, 2015.

3.3. HIV counselling and testing services (HCT) for adolescents

Situation assessment:

- A network of Youth Friendly Clinics (YFC) has been established, offering services such as HIV counselling and testing.
- HCT standards (protocol) have been developed.
- HCT services are being provided in full measure (pre- and post-test counselling) not only in specialised AIDS centres, but also in drop-in centres and YFCs.
- A network of HIV service non-governmental organisations continues to expand, including the development of multidisciplinary teams and mobile outpatient clinics.
- HIV testing promotions are being regularly organised during mass public events, in educational establishments, and in outlets of the "Auchan" retail chain.
- In case of a positive test result, an adolescent is referred to the AIDS centre.
- Almost all adolescents in need of ART initiate their treatment.

The goal of intervention:

- To achieve 20 per cent [104] coverage of adolescents aged 14–19 years with HCT services (Table 15).

[104] The rate of 20 per cent was established in consultations with stakeholders, but it is disputed and not defined by any official document (Authors' note).

Table 15. Barriers and bottlenecks of interventions and further steps to tackle them

Barriers and bottlenecks	Further steps
Access to resources	
• **Irregularity of provision of test kits (the lack of state funding and dependence on donors). It remains unclear whether there will be new deliveries after the current stock of ELISA tests is depleted.** • **Accessibility of test kits is limited due to poor information about locations where one can get tested for HIV.** • **Improper cooperation with schools in terms of information work - it remains highly ineffective.** • **Testing is not free if an adolescent has no local registration (e.g. in the city of Kyiv).**	• To introduce a projected scheme of uninterrupted supply of test kits, considering inputs from international donors. • Communication with peers may be a serious incentive for testing, therefore it is expedient to use a 'peer education' approach, and to disseminate useful information via social networks and in places where teens spend their leisure time. • HIV testing must be free of charge. Support from international donors is unable to fix the issue of provision of test kits. To ensure systematic work, local budgets should be responsible for funding HCT services. • To cancel the requirement concerning local registration for free HIV testing.
Competence of staff	
• **There are no systemic inspections of the professional competence of workers providing HCT, and no supervision of their work, especially against HCT standards. According to regulations, the duration of HCT procedure is 40 minutes per client, however, with the increasing inflow of patients, the timing may reduce to 30 minutes (Kyiv).**	• To introduce systematic quality control for HCT services and testing the level of training staff have received.

Barriers and bottlenecks	Further steps
HCT legislation and standards	
• **Violations of HCT standards:** • **Contradictions between provisions regulating the HCT procedure. According to the law, adolescents who have reached 14 years of age, may undergo HIV testing independently, without their parents' (or guardians') consent. However, the MoH order 'On the improvement of voluntary counselling and testing for HIV infection' (of 19 August 2005, N 415)** [105] **establishes that parents or legal representatives of underage persons have the right to be present at the HCT procedure and in case HIV infection is found in an underage person aged under 18 years, a health worker at a facility where this medical examination was conducted shall inform a parent or other legal representatives about it.** • **An ambiguous interpretation of the following clause of the joint order of six ministries (ORDER of 23.11.2007 No. 740/1030/4154/321/614a)** [106] **on the rights of parents: 'Parents (adoptive parents), guardians or trustees have the right to information about the health status of a child or fosterling in accordance with Article 285 of the Civil Code of Ukraine'.**	• To bring the MoH order regulating the HCT procedure into line with current Ukrainian legislation, which will allow adolescents aged 14-18 years to undergo HIV testing independently and anonymously. • To disseminate information among adolescents and their parents about the legal provision allowing adolescents over 14 years old to independently seek HIV testing services. • To ensure the implementation of the legal norm allowing adolescents to independently undergo HCT, and to raise the awareness of health workers, there is a need to develop standardised protocols on the provision of HCT services to adolescents (including MARA), or sections in the universal protocols with the focus on adolescents.
Knowledge level	
• **Insufficient awareness and refusal of adolescents to undergo HIV testing:** ◦ **The lack of knowledge about the right to independently seek testing among persons aged 14–17 years;** ◦ **stigmatisation of HIV testing in society; stereotypes among parents, teachers and peers;** ◦ **the lack of collaboration between YFC and schools, youth organisations, school and student governments.**	• To carry out public information campaigns for adolescents and parents on HIV testing in cooperation with secondary and vocational schools, school and student governments; • To use social media and networks more intensively to disseminate information about counselling and testing for HIV.

[105] [Online document]. – Available at : http://zakon5.rada.gov.ua/laws/show/z1404-05?nreg=z1404-05&find=1&text=%F7%EE%F2%E8%F0&x=0&y=0.

[106] Ministry of Health of Ukraine, Ministry of Education and Science of Ukraine, Ministry of Ukraine for Family, Youth and Sport, State Penitentiary Department of Ukraine, Ministry of Labour and Social Policy of Ukraine. Order of 23.11.2007, No. 740/1030/4154/321/614a, 'On activities to organize prevention of mother-to-child transmission of HIV, to provide health care and social support to HIV-infected children and their families' [Online document]. – Available at : http://zakon2.rada.gov.ua/laws/show/z1405-07/page.

3.4. Syringe exchange programmes for adolescents who are injecting drug users IDUs

Situation assessment:

- Accessibility of syringe exchange programmes for adolescents is limited since adolescent IDUs are not a target population for non-governmental organisations.
- In 2016, there was only one organisation (All-Ukrainian Charitable Organization 'Convictus Ukraine' in Kyiv) which implemented a project for MARA.
- According to the results of the assessment, the issue of involving adolescents in the prevention programmes was not specifically discussed by NGOs (except for NGO coordination in Odesa).
- The programme monitoring data show that in all selected cities the share of adolescent IDUs aged 14-17 years receiving syringe exchange services is insignificant and notably lower than the proportion of this age group within the general IDU population.

So, the situation regarding syringe exchange among most-at-risk adolescents aged 14-17 years is unsatisfactory.

The goal of intervention:

- To achieve 60 per cent coverage of adolescent IDUs aged 14-17 years with syringe exchange programmes (Table 16).

Table 16. Barriers and bottlenecks of interventions and further steps to tackle them

Barriers and bottlenecks	Further steps
Access to resources	
• **Organisations do not work with adolescents under 18 years as a specific category of clients; services are designed for adults, whereas service providers are not ready to work with adolescents due to:** ◦ **The lack of funding for programmes for adolescent IDUs, FSW and MSM;** ◦ **Donors do not view adolescents as a key population in the context of the spread of HIV;** ◦ **Donors try to avoid legal issues related to legal uncertainty of work with underage risk groups;** ◦ **The ineffectiveness of NGO cooperation between each other, and with social services and law enforcement agencies.**	• To include the issue of inaccessibility of syringe exchange for adolescents under 18 in the political agenda, and to lobby for recognition of this problem by the government. • To seek donors' recognition of the fact that adolescents play key role in early prevention of HIV epidemic in Ukraine, and to gain donor support for harm reduction programmes for adolescents under 18. • To set up a legal framework for regulating NGO work with underage MARA. To review and update regulations from the Ministry of Social Policy of Ukraine relating to working with adolescents. • To adapt services for adolescents to their specific needs. • To strengthen cooperation between NGOs offering harm reduction services, as well as cooperation with social services and law enforcement agencies. • To encourage NGOs to submit project proposals for syringe exchange services for adolescents.
Competence of staff	
• **The level of staff training to work with adolescent FSW and MSM is generally insufficient. Since syringe distribution services for adolescents are 'informal', NGOs lack specialists, trained specifically to work with this category of clients.**	• As in the case of adolescent IDUs, the work with adolescent FSW and MSM requires methods tailored to their age-specific peculiarities that are currently unknown to NGO workers.

Barriers and bottlenecks	Further steps
Legislation and government policy	
• **The lack of legislative regulation of syringe exchange for individuals under 18 years of age creates the risk of legal consequences for service providers and prevents donors from supporting such initiatives.** • **Non-recognition by the government of the existing problem of syringe exchange for adolescents under 18 years of age: the lack of cooperation with law enforcement agencies that are perceived as a threat by adolescents and some service providers (Dnipro).** • **Ineffective collaboration between NGOs and the state social services.**	• To strengthen the legal framework to regulate NGO work with underage most-at-risk adolescents. • To review and update the MoSP standards on the work with children from families in difficult life circumstances.
Knowledge level	
• **Age-specific psychological peculiarities, indifference towards one's own health and reduced sense of danger.**	• To introduce outreach methods; to involve adolescents in the prevention programmes through the Internet, mobile apps and social networks.

3.5. Programmes for MARA (most-at-risk adolescents) to increase safer behaviour regarding HIV/STI (adolescent men having sex with men (MSM) and adolescent female sex workers (FSW)

Situation assessment:

- Accessibility of condom distribution programmes for adolescent MSM and FSW is extremely low (significantly lower than access of adolescent IDUs to syringe exchange).
- As a rule, condom distribution programmes for MARA are implemented in parallel with syringe exchange programmes.
- Adolescent MSM and FSW aged 14-17 years in Odesa, Mykolayiv and Dnipro basically do not receive condom distribution services.
- Problematic access for adolescent FSW and MSM to these types of services is linked to their underage status.
- The researchers found no adolescent-oriented organisations working with MSM.
- According to the assessment results, coordination of work with adolescent FSW and/or MSM is not specifically discussed by NGOs.

So, the situation with condom distribution among most-at-risk adolescents aged 14-17 is unsatisfactory.

The goal of intervention:

To achieve 60 per cent coverage of adolescent FSW and MSM aged 14-17 years with condom distribution programmes (Table 17).

Table 17. Barriers and bottlenecks of interventions and further steps to tackle them

Barriers and bottlenecks	Further steps
Access to resources	
• **Low coverage of adolescent FSW and MSM with condom distribution services.** • **Organisations offering condom distribution services do not work with adolescents; their services are designed for adult clients.** • **Inaccessibility of condom distribution services for adolescent FSW and MSM.** • **Adolescents do not make the target group; service providers are not trained to work with this category of clients.** • **Donors do not view adolescents as a key population in the context of HIV spread.** • **Donors try to avoid legal issues related to legal uncertainty of work with underage persons.**	• To include the issue of inaccessibility of condom distribution for adolescents under 18 years into the political agenda, and to lobby for recognition of this problem by the government. • To seek donors' recognition of the fact that adolescents play a key role in early prevention of an HIV epidemic in Ukraine, and to gain donor support for harm reduction programmes for adolescents under 18 years. • To adapt condom distribution services to the needs of adolescents. • To strengthen the cooperation between NGOs offering harm reduction services and the state social services and law enforcement agencies. • To encourage NGOs to submit project proposals for harm reduction services for adolescents.
Competence of staff	
• **The level of staff training to work with adolescent FSW and MSM is generally insufficient. Since condom distribution services for adolescents are 'informal', NGOs lack specialists, trained specifically to work with this category of clients.**	• To train specialists providing condom distribution services to work with adolescents, taking into account their age-specific peculiarities.
Legislation and government policy	
• **The lack of legislative regulation of condom distribution for individuals under 18 creates the risk of legal consequences for service providers and prevents donors from supporting such initiatives due to legal uncertainty linked to condom distribution among underage individuals.** • **Non-recognition by the government of the existing problem of condom distribution among adolescents under 18 years.** • **Ineffective collaboration between NGOs and the state social services**	• To set up legal framework to regulate NGO work with underage most-at-risk adolescents. • To review and update the MoSP standards on the work with families in difficult life circumstances (DLC) and adolescents.
Knowledge level	
• **Age-specific psychological peculiarities, indifference towards one's own health and reduced sense of danger.**	• To introduce outreach methods; to involve adolescents in the prevention programmes through the Internet, mobile apps and social networks.

3.6. School educational curriculum on reproductive and sexual health and development of HIV prevention skills

Situation assessment:

- Schools of general education offer a course in 'The fundamentals of health' to students between the ages of 10-15 years, which includes topics such as HIV/STI prevention.
- Modern textbooks and accessible methodological materials are used in education.
- Most teachers are trained to teach the course and topics on HIV prevention.
- Teachers use additional video materials that they find themselves.

The current educational system does not monitor the level of students' knowledge about HIV transmission and prevention. By requesting the data directly from the departments of education, the researchers were able to collect information on the proportion of secondary and vocational schools which offer the course on HIV prevention, and which have teachers with relevant special training. For an overall situation analysis, the researchers used findings from the survey 'Health behaviour in school-aged children' (HBSC). Insufficient knowledge about the ways HIV can be transmitted remains the main problem in this regard (according to data from school surveys, only one in every four adolescents possesses the necessary knowledge [107]).

Since the proportion of young people aged 20–24 years with sufficient knowledge of HIV transmission modes is notably higher than that in the younger cohort [108], the school curriculum aimed at the development of HIV prevention skills is not effective enough, giving way to other channels of obtaining HIV-related information.

The goal of intervention:

To achieve 70 per cent of adolescents aged 14–17 years who possess sufficient knowledge of the ways in which HIV can be transmitted. (Table 18).

[107] Indicators and social context of adolescents' health development: monograph / O.M. Balakireva, T.V. Bondar, D.M. Pavlova, et al., science editor O.M. Balakireva; UNICEF, Ukrainian Institute for Social Research after O. Yaremenko, Kyiv, 2014, p. 113.

[108] The Ukraine Multiple Indicator Cluster Survey 2012 / The State Statistics Service of Ukraine et al., Kyiv: K.I.S., 2013, pp. 198-199.

Table 18. Barriers and bottlenecks of interventions and further steps to tackle them

Barriers and bottlenecks	Further steps
Competence of staff	
• **Teachers rarely use modern teaching methods and techniques that are considered more effective. Teachers believe that trainings instead of traditional lessons are better for mastering HIV/STI prevention skills.** • **Barriers to the introduction of effective teaching methods include the traditional school schedule (45 minute lessons), the large number of students per class, and the lack of proper premises.** • **Teachers usually receive the 1.5 of the wage rate-based payroll. Therefore, application of more effective teaching methods requires greater effort, while the use of new approaches in teaching is not materially encouraged.**	• Several focused trainings using multimedia and interactive methods, inviting practitioners, and applying 'peer education' approaches is the better alternative to traditional school lessons. It is possible to organise such trainings only in schools with properly equipped classrooms. • To introduce additional payments (bonuses) for teachers who use interactive training methods in teaching.
Knowledge level	
• **Only 24 per cent of adolescents aged 13–17 have a sufficient level of knowledge about the ways HIV can be transmitted (HBSC 2014):** ◦ **The lack of interest from parents and school administrations.** ◦ **The lack of cooperation of schools with YFC, NGOs, youth networks and young activists.** ◦ **Specialists and PLWH are not invited to classes.**	• Teachers and school administrations need to strengthen cooperation with parents to overcome barriers (e.g. stereotypes and cultural limitations in adolescents' families) to the development of proper HIV/STI prevention skills. • To strengthen the cooperation between general secondary and vocational schools with YFC, NGOs, youth networks and young activists, inviting specialists from these organisations to classes and involving them in the work with parents. • To introduce trainings on HIV prevention as a mandatory element of the school curriculum for senior students of general and vocational schools. • To introduce interactive methods of teaching (trainings), and to invite specialists (YFC, NGOs) and PLWH to classes.

Participants in the consultations stressed the importance of keeping the school course 'Fundamentals of Health' in the national educational standard, as well as in basic and standard curricula of primary and secondary schools during the reform process. At the same time, it is considered necessary to improve the quality of teaching, especially the topics of sexual and reproductive health and HIV prevention; to perform routine monitoring of students' knowledge; to introduce the optional course 'Get yourself protected from HIV' in the form of trainings within the complex educational work with senior students of secondary and vocational schools; and to involve specialists such as doctors, sexologists, psychologists, drug treatment specialists, law enforcement officers and the like, in the prevention education in educational settings.

3.7. Recommendations for strengthening key HIV prevention interventions among adolescents

The results of an in depth analysis of five interventions identified barriers and recommended actions which were discussed at an advisory meeting of the stakeholder working group on 12 April 2016. The discussion helped the participants to validate the results of in depth analysis of the existing barriers to interventions and their causes; elaborate suggested recommendations to remove gaps and barriers; agree on priority actions to overcome the existing barriers to selected interventions; and identify necessary resources and key players to implement the plan of action.

To improve adolescents' access to services, one of the priority actions in the legislative domain is to bring the MoH document regulating the HCT procedure in line with the relevant law, thus allowing adolescents between the ages of 14-17 to exercise their right to undergo HIV testing independently and anonymously [109].

The development of regulations for the delivery of harm reduction services to underage most-at-risk adolescents is another priority in this area, as it will increase coverage of the age group of 14-17 years with prevention services. Currently, the coverage among this age group is significantly lower compared to older cohorts, even though MARA are less knowledgeable about HIV than their adult counterparts, and are more prone to risky practices.

In addition to the legislative action described above, responsible government agencies should strengthen control and demand proper enforcement of the existing legal provisions to ensure that adolescents have access to services. Participants at the working meeting mentioned that these provisions are often violated by frontline workers or organisations (e.g. health facilities offering HCT, social services and schools). Reasons for this include inadequate training of specialists, which needs to be improved by using modern learning and communication methods (for example, webinars and educational online platforms).

Key actions to reinforce the work with adolescents, approved by stakeholders, should include public information campaigns to promote HIV testing (including through mobile apps and social networks); adaptation and introduction of comprehensive services for MARA; utilisation of outreach and peer education approaches; and establishment and support for multidisciplinary teams and the centres for HIV positive children and youth offering comprehensive services to meet their complex needs and address crisis situations.

[109] According to participants in the working group meeting, MoH specialists are continuing to develop such a document.

Other important management actions needed to increase the efficiency of the adolescent component of the National Targeted Social Programme on HIV/AIDS for 2014–2018 include strengthening the intersectoral collaboration and the use of proven practices by health facilities, social services and NGOs in their work with adolescents. It is essential to maintain adequate provision of resources for interventions to counter HIV among adolescents by international donors, and through effective use of funds of the State Budget and local authorities. The role of the latter should be increased further.

During the assessment, the researchers provided recommendations for a number of approaches, including: the development of a strategy for attracting private sector funds; allocation of funds from local authorities to ensure steady supply of test kits (including donor inputs); mobilisation of resources of the city and regional social programmes to provide psychosocial follow-up to adolescents living with HIV; attraction of donor funds, e.g. for public information campaigns to promote HIV testing among adolescents and young people as a component of a healthy lifestyle. Donors of harm reduction programmes should draw attention of service providers towards most-at-risk adolescents under 18 years of age, and support NGO projects that view MARA as their specific target group.

Following the assessment, it is safe to say that representatives of key ministries are aware of the need to set up and ensure a proper functioning the coordination body based on the national multisectoral working group on MARA; there is a perceived urgency for better cooperation between the different levels of government during the decentralization reform. The Ministry of Health of Ukraine recognized the need to strengthen control over the observance of HCT standards and to monitor the level of training of specialists who work with adolescents.

The results of key actions, recommended by stakeholders, are expected to include: reduced risk of HIV infection among adolescents aged 14-19 years; prevention of violations of the rights of adolescents; improved HIV knowledge in adolescents between 10-17 years; increasing the proportion of adolescents aged 14-17 years who have been tested for HIV and have received appropriate counselling; improved social protection of MARA, and increased coverage of this population with prevention services; improved care and psychosocial support for HIV positive adolescents aged 10-17 years.

Such an impact interventions can become a component of the current National Targeted Social Programme on HIV/AIDS for the period until 2018. In addition, the participants in the stakeholder meeting pointed at the importance of ongoing advocacy efforts and the inclusion of adolescents in the upcoming national programmes.

The key recommendations below cover the aspects of *supply*, *demand*, *structural determinants and the quality* of work with adolescents within the framework of the National Targeted Social Programme on HIV/AIDS.

Key recommendations	
Supply:	1. Ministry of Health (MoH): to monitor modern methods of treatment, and to introduce combination ARV drugs that are suitable for children and adolescents. 2. Local social services, AIDS centres, NGOs: to set up multidisciplinary teams, to improve workers' skills in the provision of comprehensive services, and to ensure ongoing psychosocial follow-up (support) of children and adolescents on ART. 3. Local authorities, social services, AIDS centres, NGOs in the regions with concentrated HIV epidemic among children and adolescents: to establish centres for HIV positive children and youth to provide ongoing psychosocial follow-up (such centres currently exist in Kyiv, Odesa, Kharkiv and Dnipro). 4. Local social services, AIDS centres, NGOs: to introduce 'peer education' approaches into the work with adolescents in cases of their refusal to receive ART, and to use online platforms and network resources to assist adolescents and young people living with HIV and in crisis. 5. NGOs, social services: to introduce outreach methods; to involve adolescents in prevention programmes through the Internet, mobile apps and social networks. 6. NGOs, social services: to adapt services offered to most-at-risk populations to the needs of adolescents, taking into account their age and gender-specific peculiarities and needs; to use games and 'peer education' approaches and the youth club models in the work with adolescents. 7. NGOs, social services: to train and upgrade skills of specialists providing harm reduction services for the work with adolescents, taking into account their age-specific peculiarities and needs. 8. Local authorities: to ensure a steady supply of test kits for HCT. 9. General secondary and vocational schools: to introduce trainings and interactive methods of education, inviting specialists with practical experience (YFC, NGOs) and PLWH to HIV prevention classes. 10. Local departments of education, schools: to increase the professional competence of teachers and to improve the quality of teaching in topics such as sexual and reproductive health and HIV prevention.

Key recommendations	
Demand:	1. The Ministry of Information Policy of Ukraine, state-owned and public media, local authorities: to conduct public information campaigns to reduce stigmatisation of PLWH in society. 2. The Ministry of Information Policy of Ukraine, state-owned and public media, local departments of health: to conduct nationwide and local public information campaigns in order to promote HIV testing among adolescents and youth as a component of a healthy lifestyle. 3. Local departments of education, secondary and vocational schools, and YFCs: in collaboration with school governments and youth organisations to conduct educational events in schools for adolescents and parents on the importance of HIV testing as a component of a healthy lifestyle, to share information with adolescents and parents about the legal norm regarding independent seeking of HCT services for adolescents who have turned 14 years; to set up information stands in general secondary and vocational schools. 4. NGOs: to disseminate information on the importance of HIV testing of adolescents and young people as a component of a healthy lifestyle, and on the legal norm on independent seeking of HCT services for adolescents who turned 14 years via social networks, blogs and other online platforms, also using the 'peer education' approach. 5. Local social services, AIDS centres, NGOs: to work with parents (guardians) in cases of improper fulfilment of parental duties and violation of treatment recommendations for children and adolescents on ART. 6. AIDS centres, YFC, health facilities offering HCT services: to share information about combination ARV drugs, ART effectiveness and HIV treatment prognoses. 7. Secondary and vocational training schools: to work with parents on sexual education of adolescents and HIV prevention to eliminate stereotypes and to facilitate open discussion of sensitive matters.
Legislation:	1. MoH: to bring into force the MoH Order No. 415 'On improving voluntary counselling and Testing for HIV' as of 19 August 2005 (Annex 5, para. 4:The peculiarities of counselling of adolescents) that regulates HCT procedure in compliance with the current Law of Ukraine 'On prevention of diseases caused by the human immunodeficiency virus (HIV), and legal and social security of people living with HIV' (as amended on 5 December 2012). 2. MoH: to introduce changes to the training programme for specialists providing HCT services according to HCT standards. 3. MoH: to simplify the registration procedure for ARV drugs, and to register modern combination ARVs that are suitable and convenient for children and adolescents. 4. The Ministry of Justice of Ukraine, the Ministry of Youth and Sports of Ukraine, and the Ministry of Social Policy of Ukraine: to develop an interagency order regulating the work of HIV service NGOs with most-at-risk adolescents under 18 years of age.

Key recommendations	
Legislation:	5. The Ministry of Social Policy of Ukraine: to elaborate standards of work with adolescents in difficult life circumstances. 6. Ministry of Education and Sport (MoES), departments of education, secondary and vocational schools: to include trainings on HIV prevention (5 hours) in the educational work plan for 10th-11th grades of secondary and vocational training schools. 7. MoES: to include HIV prevention issues in the monitoring plan of education quality
Management / Coordination:	1. MoH, local departments of health, YFC, health facilities providing HCT services: to strengthen control over observance of HCT standards (especially anonymity and free provision of HCT). 2. Local departments of health, YFC, health facilities providing HCT services: to strengthen control over professional training of specialists providing HCT. 3. NGOs, social services: to focus on the significance of HIV testing of most-at-risk adolescents, to persuade MARA of the importance of testing, and to refer them to HCT services. 4. NGOs, social services: to strengthen collaboration of NGOs serving most-at-risk adolescents between each other and with the state social services, to use best practices derived from previous projects implemented with the support of UNICEF and other donors. 5. NGOs: to review statutory objectives and include most-at-risk adolescents as a target population. 6. NGOs, social services, YFC, health facilities providing HCT services, secondary and vocational schools: to strengthen intersectoral collaboration aimed at the provision of comprehensive services to adolescents, and to establish cooperation with school governments, youth organisations, public activists and youth networks of PLWH. 7. NGOs: to advocate for preservation of the study course 'Fundamentals of Health' in the extracurricular programme of the secondary school. 8. MoES: to keep the course 'Fundamentals of Health' with the topics on HIV prevention in the invariant section of the secondary school curricula. 9. Local departments of education and schools: to strengthen control over implementation of the MoES order, according to which the course in 'Fundamentals of Health' is to be presented by a teacher who has had relevant training, and who uses interactive teaching methods and approaches. 10. Local departments of education, secondary and vocational schools: to motivate teachers to use interactive teaching methods and the training format in classes on HIV prevention, and to consider the use of interactive methods during teacher attestation. 11. Secondary and vocational schools: to develop cooperation between schools so they can conduct HIV prevention trainings in educational facilities with properly equipped classrooms/ premises.

Key recommendations	
Budget / Expenditure:	1. NGOs: to seek donors' recognition of the key role that adolescents play in early prevention of an HIV epidemic in Ukraine. 2. Donors: to allocate funds for harm reduction programmes designed for adolescents under 18, and to support NGO projects that view most-at-risk adolescents as their target population. 3. NGOs: to develop project proposals for providing harm reduction services to most-at-risk adolescents under 18 years of age. 4. Local authorities: to allocate funds in order to ensure a steady supply of test kits (considering donor inputs) and relevant training of the staff to provide HCT to adolescents. 5. Donors: to allocate funds for public information campaigns to promote HIV testing among adolescents and youth as a component of a healthy lifestyle. 6. Donors: to allocate funds for the provision of psychosocial follow-up (support) of children and adolescents. 7. Local authorities: to support the establishment and proper functioning of the centres for HIV positive children and youth, ensuring ongoing psychosocial support. 8. Local authorities: to equip classrooms/premises in secondary and vocational schools for trainings using multimedia. 9. Donors: to allocate funds for regional assessment studies to determine the size and characteristics of the MARA population.
Quality:	1. MoH, NGOs: to reach 100 per cent of adolescents aged 10-17 living with HIV, covered with care and psychosocial support services. 2. MoES: to reach 70 per cent of adolescents aged 14-17, who study in secondary or vocational schools and have sufficient knowledge about the modes of HIV transmission and how HIV is not transmitted. 3. NGOs: to reach 60 per cent of adolescent IDUs aged 14-17 covered with syringe exchange programmes. 4. NGOs: to reach 60 per cent of adolescent FSW and MSM aged 14-17 covered with condom distribution programmes. 5. MoH: to reach 20 per ccent of adolescents aged 14-19 who were tested for HIV in the past 12 months and are aware of the test results.

Implementation of these recommendations will strengthen the adolescent component of the national HIV/AIDS programme.

Identification of bottlenecks and barriers to the five interventions made it possible to formulate priority actions to removing these obstacles. Such actions should be implemented nationally, as there are no substantive differences between the cities (regions) selected for the analysis. Suggested priority actions are summarized in the micro plan, based on the Phase 2 in depth analysis (Annex A, Table 2). The plan could be further adapted and used in subsequent assessments of programmes and interventions at the national level.

Section 4. Challenges to strengthening the adolescent component within the national HIV/AIDS response activities

To strengthen the HIV response within the adolescent environment and to share accumulated experience, it is important to consider the lessons learned as well as the challenges, in order to avoid repeating mistakes, and to remove barriers. The performance of UNICEF-supported projects, ongoing monitoring (both internal and external) and evaluation of implemented interventions, as well as discussions of the results within the framework of the study **'Strengthening the adolescent component of the national HIV/AIDS programme through country assessment'**, made it possible to summarise the lessons learned and identify challenges that are essential for implementing and scaling up the work with adolescents, including MARA.

Ukraine has made some progress in combating HIV among adolescents. All key interventions are in place, including educational programmes on reproductive and sexual health; services of HIV counselling and testing for adolescents; syringe exchange programmes for adolescent IDUs; programmes for MARA to promote safe behaviour for HIV/STI prevention, particularly for adolescent MSM and FSW; treatment and support programmes for adolescents living with HIV, including social and psychological follow-up (support) of adolescents on ART. However, limited access for adolescents to HCT leads to delayed diagnosis and treatment.

Results of the project 'Strengthening the adolescent component of the national HIV/AIDS programme through country assessment' enabled the **identification of barriers and bottlenecks** within the programme environment of the work with adolescents to counter HIV, as well as **challenges** in the work with adolescents within the national HIV/AIDS response.

Bottlenecks in the system of HCT services for adolescents include violations of standards and rights of adolescents; the conflict between the legal norm that allows young people of 14 years old to undergo testing without consent of their parents (guardians), and the current MoH order regulating the HCT procedure; and episodes of charging payment for testing. MARA should be given the highest priority. The estimated size of the MARA population (2015 updates) is 129,000 persons aged 10-19 (inclusive). However, there are no estimates at the city/regional level. HIV service organisations do not work with adolescents as a separate target group, and donors do not view them as key population in terms of HIV spread; donors and HIV service organisations often try to avoid legal problems related to legal uncertainty of work with underage risk groups; the effectiveness of

NGOs' collaboration between each other and with social services is low, with almost no cooperation with law enforcement agencies. According to 2015 bio-behavioural studies, HIV prevalence among adolescent IDUs aged 15-19 was 2.7 per cent, and among adolescents MSM between the ages of 14-19 years it is 3.1 per cent [110]. Estimated rates of HIV prevalence across all MARA groups are at least 1.9 per cent. Despite high levels of ART coverage, children and adolescents in most regions face problems of accessibility and quality of social and psychological follow-up.

Key challenges include:

1. The state policy should distinguish adolescents (10-19 years) as an age group requiring special attention;
2. Inclusion of adolescent population (including MARA) in the system of monitoring and evaluation of the national HIV response;
3. Ongoing and planned advocacy;
4. Targeted funding and provision of material and technical resources;
5. Access of adolescents, including MARA, to resources;
6. Work with specialists and teachers;
7. Accessibility and quality of HCT.

Challenge 1. The state policy should distinguish adolescents (10–19 years) as an age group requiring special attention

Recent activities of such international organisations as the UN Committee on the Rights of the Child, UNICEF and WHO specifically focus on adolescence as a period of life with rapid biological maturation, which 'outpaces' psychosocial maturation. The second decade of human life is characterised by profound changes in physiological, psychological and social spheres, as well as changes in the child's legal status. According to UN definitions, adolescence is the period of age between 10 and 19 years, which distinguishes 'older adolescents' (15-19 years) and 'younger adolescents' (10-14 years). Taking into account the General Comment No. 20 (2016) on the implementation of the right of the child during adolescence [111], approved by the UN Committee on the Rights of the Child (6 December 2016), related to children in their second decade of life, there is a need to pay special attention to this age group, to analyse the correspondence

[110] Calculations are based on the results of studies among IDUs and MSM within the framework of the project 'M&E-related technical assistance and improved data application in HIV' (METIDA), implemented by ICF 'Alliance for Public Health', and supported by the Centres for Disease Control and Prevention (CDC) under the United States President's Emergency Plan for AIDS Relief (PEPFAR).

[111] [Online document]. – Available at : http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=5&DocTypeID=11

of national legislation to the approaches suggested in this document, to organize the learning of key principles for ensuring adolescent rights by specialists from the appropriate authorities and institutions; to include relevant provisions and respective activities into the Draft National Programme 'National Action Plan to implement the UN Convention on Children's Rights for 2017–2021'.

Adolescent health and the formation of healthy lifestyles is one of the key spheres. Therefore, based on the assessment of bottlenecks and barriers to HIV prevention interventions, key government ministries should focus on the following:

The Ministry of Health of Ukraine:

- To take all measures towards implementing the Law of Ukraine 'On prevention of acquired immune deficiency syndrome (AIDS) and social protection of the population', with a special focus on respecting human rights of children and youth affected by HIV/AIDS or at risk of HIV/AIDS, including children living and working on the street and children suffering from substance abuse, and ensure access to confidential and youth-friendly services [112].
- To strengthen and introduce effective system of referrals of adolescents to the relevant health and social services.
- To develop standardized protocols on the delivery of prevention services for children and youth at-risk of and vulnerable to HIV.
- To settle the issue of bringing unattended (neglected) children to health faculties in case of positive HIV test results.
- To ensure appropriate health and social support to children and adolescents for strengthening their adherence to ART.

The Ministry of Health of Ukraine and the Ministry of Social Policy of Ukraine, with involvement of international and non-governmental organisations and mass media:

- To engage children, adolescents and youth in modern innovative projects, in order to monitor their views and needs regarding important and relevant issues, and to create a comfortable and enabling information space for the representatives of risk groups.
- To promote 'peer education' in the formation of healthy lifestyles in children and youth.
- To ensure continuity of the prevention work with MARA, particularly with adolescents in 'street situations'.

[112] The UN Committee on the Rights of the Child [Online document]. – Available at : http://www.unicef.org/ukraine/ukr/UN_CRC_ConcludingObservations_Ukr.pdf.

- To develop strategies for eliminating stigmatisation, discrimination and criminalisation of children and youth at risk of and vulnerable to HIV, and to ensure the provision of HIV services free from stigma and discrimination.
- To ensure the delivery of focused prevention services that meet the needs of adolescents, depending on their affiliation with a specific risk group, and consider their age, gender, and socio-economic peculiarities.
- To build the organisational, technical and workforce capacities of organisations working with children and adolescents to deliver comprehensive range of services 'under one roof' with minimum need for referrals.
- To improve the professional competence of specialists providing services to most-at-risk adolescents. To involve volunteers from among children and adolescents, and to build regional networks of MARA volunteers.
- To review the size and procedures of material assistance, provided by the government to children living with HIV in order to ensure sufficient minimum nutrition and meet their priority needs.
- To undertake regular monitoring of MARA, including estimation of their numbers.

The development and implementation of strategic plans of action for HIV prevention among children and youth at risk and vulnerable to HIV at the regional and local levels is another mandatory component of the government's policy. Work with MARA must be included in the regional and local HIV/AIDS programmes within the implementation of the National Targeted Social Programme on HIV/AIDS for 2014–2018 and other programmes to be adopted in the future.

Region state administrations:

- To include measures of HIV prevention, treatment, care and support of MARA in the regional HIV/AIDS programmes.
- To develop and implement strategic plans on HIV prevention among children and youth at risk of, and vulnerable to, HIV at the regional and local level.

There is significant demand for the development and introduction of new activity areas and mechanisms **for the cooperation between governmental and non-governmental sectors** to ensure effective work with adolescents. Therefore, it is necessary to bring the most pressing issues and needs of adolescents to the decision-making level in order to develop **enabling legislation** and social policy for adolescents, and to take all necessary

measures to implement the Law of Ukraine 'On prevention of acquired immune deficiency syndrome (AIDS) and social protection of the population', focusing especially on respecting human rights of children and youth affected by HIV/AIDS or at risk of HIV/AIDS, including children in street situations and children suffering from substance abuse, and to ensure their access to confidential and youth-friendly services [113].

Challenge 2. Inclusion of adolescent population (including MARA) in the system of monitoring and evaluation of the national HIV response

It is essential to perform **regular monitoring** of most-at-risk adolescents, as well as adolescents in street situations, including updates on the size of these populations. Considering high levels of mobility and the impact of the current political and military situation, it is important to make regular and timely estimates of the size of the MARA population at the regional level.

The national and regional M&E indicators of the national response to the HIV epidemic should be able to establish the amount of progress in different groups and categories of adolescents, including MARA.

Challenge 3. Ongoing and planned advocacy

To ensure sustainable service provision, we need to elaborate an advocacy strategy with the involvement of all stakeholders. Advocacy within the national conferences (e.g. the 3rd National Scientific and Practical Conference on HIV/AIDS), stakeholder meetings to discuss results of specific stages of the project implementation, a public information campaign for adolescents and youth (e.g. 'Get tested for HIV') and other efforts may not be sufficient to advance interests of the target population. It is important for the advocacy efforts to be consistent and focused.

Considering the specifics of the target population, and the goal and objectives of the project activities, advocacy plans should focus on the structures and organizations that either work with specific target groups, or are able to facilitate the implementation and development of programmes that are essential for adolescents. These may include individual decision-makers and MARA representatives, if it does not violate ethical principles of working with them.

Combating discrimination, stigmatisation and criminalisation of most-at-risk adolescents, as well as establishing MARA-friendly approaches during contacts and service delivery should become important components of advocacy efforts.

[113] The UN Committee on the Rights of the Child [Online document]. – Available at : http://www.unicef.org/ukraine/ukr/UN_CRC_ConcludingObservations_Ukr.pdf.

In addition, sometimes advocacy should include the elements of fundraising to strengthen funding of the programmes (e.g. additional finances for condom and syringe distribution among MARA, production of information materials about MARA for the general public, and the like).

Challenge 4. Targeted funding and provision of material and technical resources

The process of generating additional resources to improve and scale up the organisation's efforts in combating HIV is of paramount importance. Assessment of the existing interventions pointed at the need to secure resources for dedicated programmes and the centres for children based on systematic and targeted funding (as most of them depend on occasional funding from international donors). Organizations should get regularly involved in fundraising activities; write and submit grant proposals to raise funds from donors and the private sector; pursue the interests of target populations within regional programmes; and seek funding from the city and regional social programmes to deliver services of social and psychological support to adolescents living with HIV.

Challenge 5. Access of adolescents, including MARA, to resources

Combination ARV drugs. Assessment of interventions shows that introducing newer ARVs of better quality (as systematic, daily administration of several pills wears a person down psychologically) requires the expansion of the nomenclature of ARV drugs and lobbying for registration of new combination ARV drugs.

Testing for HIV should be free of charge. Considering the shortage of test kits, it is necessary to introduce a system of projected supply of such tests, also considering inputs and contributions of international donors. Systemic functioning of HCT services is only possible if funded from local budgets.

Syringe exchange and condom distribution. An assessment has pointed at the need to include inaccessibility of syringe exchange and condom distribution for adolescents under 18 into the political agenda, and lobbying for recognition of this problem by the government. Moreover, it is necessary to seek donors' recognition of the key role that adolescents play in early prevention of HIV epidemic in Ukraine, and to gain their support for harm reduction programmes for adolescents under 18.

As NGOs tend to work with adult clients, it is important to adapt relevant services to the needs of adolescents, and to encourage NGOs to submit project proposals for syringe exchange and condom distribution services, specifically aimed at adolescents aged 14-18. To do this, it is necessary to strengthen the legal framework regulating NGO work with underage most-at-risk adolescents, e.g. by reviewing and updating the

standards of the Ministry of Social Policy on working with children. In this regard, strengthening cooperation between NGOs offering harm reduction services, as well as their collaboration with social services and law enforcement agencies requires special attention.

Further development of the **effective referral system** of adolescents depending on their health and social needs and psychological peculiarities is also essential; the same is true of **focused prevention services** that would meet the needs of adolescents depending on their affiliation with a specific risk group, and considering their age, gender, and socio-economic peculiarities.

Challenge 6. Work with specialists and teachers

Training of specialists. The following key points need to be considered in the planning of specialist training: initial education and qualification of the staff; training should precede any work that focuses on peculiarities of adolescent psychology (motivation, counselling) and ethical principles of work with most-at-risk adolescents and children; training should bring together different stakeholders to ensure future interaction; it would be beneficial to combine training sessions with sharing of experiences regarding similar prevention intervention.

While assessing interventions and key barriers to their implementation, the researchers identified the need to constantly improve the skills and competence of specialists responsible for the provision of comprehensive services to adolescents on ART. It would be expedient to introduce online courses and conduct webinars for the staff, as well as to consider possibility of delegatiing the responsibilities of prescribing ART to adolescent doctors and paediatricians of health facilities other than AIDS centres.

Since there is no systemic assessment of the professional competence of workers providing HCT, and no supervision of their work, especially against HCT standards, it is essential to introduce systematic quality control for HCT services and staff attestation procedures depending on the level of training.

The work with adolescent IDUs, FSW and MSM requires methods tailored to their age-specific peculiarities – these are currently unknown to NGO workers.

Motivating teachers to use innovative teaching practices. Conducting a series of focused trainings using multimedia and interactive methods, inviting practitioners, and applying peer education approaches is a better alternative to traditional school lessons. It is possible to organise such trainings only in schools with properly equipped classrooms.

Staff loyalty. Another major task is to maintain staff stability and composition. In the event of staff changes and involvement of new specialists, the organisations need to develop and apply plans for short-term and additional training for the newest members of the staff. To ensure effective realisation of the model and to maintain staff loyalty, it is important to motivate people and develop a system and mechanisms of alleviating the workload at the primary place of employment following the person's involvement in the intervention.

Challenge 7. Accessibility and quality of HCT

Bottlenecks in the system of HCT services for adolescents include violations of standards and rights of adolescents; the conflict between the legal norm that allows young people who have reached 14 years of age to undergo testing without consent of their parents (guardians), and the current MoH order regulating the HCT procedure; and the reported cases when client had to pay for testing. Most-at-risk adolescents should be given the highest priority in this regard.

To improve adolescents' access to services, one of the priority actions in the legislative domain is to bring the MoH document regulating the HCT procedure in line with the relevant law, thus allowing adolescents aged 14-18 to exercise their right to undergo HIV testing independently and anonymously. It is also necessary to upgrade the protocol for treatment and follow-up of HIV positive adolescents. The development of regulations on the delivery services to most-at-risk adolescents is another priority, as it will increase coverage of the age group of 14-17 years with prevention services.

Another important aspect is providing information about adolescents' rights and giving advice as to when one needs to undergo HIV testing. To do this, it is necessary to conduct public information campaigns for adolescents and their parents promoting HIV testing, including information about **HIV testing opportunities** for those who have **reached 14 years**. These should be done in close cooperation with secondary and vocational schools, school and student governments. It would also be beneficial to use social media and networks more intensively to disseminate information about HCT.

Having summarised the challenges, identified in the course of implementation of the UNICEF project, and having taken on board the lessons of previous studies and assessments of adolescents, including MARA, we can emphasise the importance of managerial decisions to **improve the effectiveness of the adolescent component of the National Targeted Social Programme on HIV/AIDS**, further development of intersectoral collaboration, and the use of the best practices from the work with adolescents that have proved their effectiveness.

It is essential to maintain adequate provision of resources for interventions to counter HIV among adolescents both from international donors, and through effective use of funds of the State and local budgets.

Of particular relevance is the **involvement** of adolescents in **modern innovative projects** to monitor their views and needs concerning various important issues, as well as establishing a friendly and accessible information environment for most-at-risk adolescents.

Annex

Table 1. Domains and determinants for in depth analysis of interventions (Phase 2) [114]

Domains	Determinants	Description
Enabling environment	Social norms	Widely followed social rules of behaviour, formed under 'social pressure'
	Legislation / Policy	Adequacy of laws and policies (at the national and subnational levels)
	Budget / Expenditure	Allocation and disbursement of required resources (at the national and subnational levels)
	Management / Coordination	Roles and accountability / Coordination / Partnership
Supply	Availability of essential commodities / inputs	Essential commodities / inputs required to deliver a service or adopt a practice
	Access to adequately staffed services, facilities and information	Physical access (services, facilities, information)
Demand	Financial access	Affordability of a service / practice; direct and indirect costs
	Social and cultural practices and beliefs	Individual beliefs and practices that can be shared by others, but not formed under 'social pressure' or expectations
	Continuity of use	Completion / continuity in services, practice
Quality	Quality	Adherence to required quality standards (national or international norms)

[114] Strengthening the adolescent component of the national HIV programmes through country assessments / Guidance Document. UNICEF, July 2015, p. 13.

Table 2. Micro plan based on in-depth analysis of interventions in the city/region

Subnational locations for implementation *(to identify the region/city)*		Responsible agency	Term of implementation *(months)*												Indicators *(if necessary)*
			1	2	3	4	5	6	7	8	9	10	11	12	
Target: 100% of adolescents aged 14–17 have sufficient knowledge of the ways of HIV transmission and know how HIV is not transmitted															
Outcome 1: Percentage of schools with trained teachers, who teach disciplines linked to sexual education and HIV prevention, and use interactive methods of education, increased from _____ to ___															
Action	To develop (or use the existing) online resource to improve qualification of teachers.	MoES, the Institute for Modernisation of Educational Content													Availability of the online resource
	To develop an order requiring the use of interactive methods of education, and to develop a methodology for considering this parameter during teacher attestation.	MoES													An order, teacher attestation methodology
	To conduct webinars for teachers (selection of topics depending on needs).	the Institute for Modernisation of Educational Content													The number of webinars
	To ensure participation of teachers in webinars.	School headmasters													The number of participating teachers
	To control implementation of the order on teaching disciplines by teachers who completed the training and use interactive methods of education.	Departments of education													The number of inspected educational establishments
Review of results	Performance monitoring. The discussion of the state of implementation and progress at the meeting of representatives from MoES, the Institute for Modernisation of Educational Content, departments of education, secondary and vocational schools														
	Recommendations: based on the results of monitoring and discussion														

Subnational locations for implementation *(to identify the region/city)*		Responsible agency	Term of implementation *(months)* 1 2 3 4 5 6 7 8 9 10 11 12	Indicators *(if necessary)*
Outcome 2: Percentage of educational establishments that introduced the optional course on sexual education and HIV prevention in the complex educational work with senior students of secondary and vocational schools, increased from ___ to ___				
Action	To develop an order on the inclusion of the optional course on sexual education and HIV prevention (5 hours) in the educational work plan for grades 10-11 of secondary and vocational schools.	MoES		Order
	To introduce the optional course in the educational work plan of secondary and vocational schools.	School headmasters		The number of educational establishments that introduced the optional course
	To control introduction of the optional course.	Departments of education		The number of inspected educational establishments
	To include HIV prevention issues in the monitoring plan of education quality.	MoES		Order, monitoring methodology.
Review of results	Performance monitoring. Discussing the state of implementation and progress at the meeting of representatives from MoES, departments of education, secondary and vocational schools.			
	Recommendations: based on the results of monitoring and discussion.			

Subnational locations for implementation *(to identify the region/city)*		Responsible agency	Term of implementation *(months)* 1 2 3 4 5 6 7 8 9 10 11 12	Indicators *(if necessary)*
Target: 20% of adolescents aged 14–19 tested for HIV in the past 12 months and are aware of testing				
Outcome 1: Ensuring access of adolescents aged 14+ to independent seeking and receiving of HCT services, as established by relevant regulatory documents				
Action	Draft the order in line with the current law, and to introduce relevant changes to the training programme for specialists providing HCT services.	MoH		Order
	Improve professional competence of specialists providing HCT services.	Departments of health, the heads of health facilities offering HCT		The number of specialists who improved their competence
	Control the execution of the ministerial order.	Department of health		The number of inspected establishments
Review of results	Performance monitoring. Discussing of the state of implementation and progress at the meeting of representatives from the MoH, departments of health, YFC,s drop-in centres and the AIDS Centre.			
	Recommendations: based on the results of monitoring and discussion.			
Outcome 2: Adolescents aged 14-19 are aware of the importance of HIV testing and know their rights				
Action	Conduct public awareness campaign in mass media and social networks.	City authorities, media, youth organisations		The number of campaigns.
	Conduct an information campaign in educational establishments.	Departments of education, school headmasters, heads of YFCs.		The number of educational establishments participating in campaigns.
Review of results	Performance monitoring. Discussing the state of implementation and progress at the meeting of representatives of the city administrations, mass media, departments of education, schools, YFC, youth organisations and school governments.			
	Recommendations: based on the results of monitoring and discussion.			

Subnational locations for implementation *(to identify the region/city)*		Responsible agency	Term of implementation *(months)* 1 2 3 4 5 6 7 8 9 10 11 12	Indicators *(if necessary)*
Target: 60% of adolescent IDUs aged 14–17 reached by syringe exchange programmes				
Outcome 1: Improved regulation of the provision of syringe exchange services for individuals under 18 years				
Action	Draft the order regulating the work of NGOs providing HIV services with most-at-risk adolescents under 18 years of age.	The Ministry of Justice, the Ministry of Youth and Sports, MoSP.		Order
	Develop the standards of work with adolescents in difficult life circumstances.	MoSP.		Service standards
	Review statutory objectives of NGOs concerning coverage of the target population of adolescent IDUs under 18.	HIV service NGOs.		The number of NGOs
	Conduct training for HIV service NGOs.	MoSP, HIV service NGOs.		Trainings for NGOs (number of participants).
Review of results	Performance monitoring. Discussing the state of implementation and progress at the stakeholder meeting.			
	Recommendations: based on the results of monitoring and discussion.			
Outcome 2: Syringe exchange services for adolescents under 18 adapted to their needs and age-specific peculiarities				
Action	Conduct a regional study on the needs of adolescent IDUs.	IFC 'Alliance for Public Health'		Publication of results.
	Develop methodological recommendations for the work with adolescent IDUs.	IFC 'Alliance for Public Health'		Methodological recommendations
	Conduct training for NGOs offering HIV services.	IFC 'Alliance for Public Health', HIV service NGOs		Trainings for NGOs (number of participants).
Review of results	Performance monitoring. Discussing the state of implementation and progress at the stakeholder meeting			
	Recommendations: based on the results of monitoring and discussion			

Subnational locations for implementation *(to identify the region/city)*		Responsible agency	Term of implementation *(months)* 1 2 3 4 5 6 7 8 9 10 11 12	Indicators *(if necessary)*
Target: 60% of adolescent FSW and MSM aged 14–17 reached by condom distribution programmes				
Outcome 1: Improved regulation of the provision of condom distribution services and counselling on safe behaviour for HIV/STI prevention for individuals under 18 years				
Action	Draft the order regulating the work of HIV service NGOs with most-at-risk adolescents under 18 years of age.	The Ministry of Justice, the Ministry of Youth and Sports, MoSP		Order
	Develop the standards of work with adolescents in difficult life circumstances.	MoSP		Service standards
	Review statutory objectives of NGOs concerning coverage of the target population of adolescent FSW and MSM under 18 .	HIV service NGOs		The number of NGOs
	Conduct the training for NGOs providing HIV services.	MoSP, HIV service NGOs		Training for NGOs (number of participants).
Review of results	Performance monitoring. Discussing the state of implementation and progress at the stakeholder meeting			
	Recommendations: based on the results of monitoring and discussion			
Outcome 2: Condom distribution services and counselling on safe behaviour for HIV/STI prevention for adolescents under 18 adapted to their needs and age-specific peculiarities				
Action	Conduct the regional study on the needs of adolescent FSW and MSM.	IFC 'Alliance for Public Health'.		Publication of results.
	Develop methodological recommendations on the work with adolescent FSW and MSM.	IFC 'Alliance for Public Health'.		Methodological recommendations
	Conduct the training for HIV service NGOs.	IFC 'Alliance for Public Health', HIV service NGOs.		Training for NGOs (number of participants).

Subnational locations for implementation *(to identify the region/city)*		Responsible agency	Term of implementation *(months)* 1 2 3 4 5 6 7 8 9 10 11 12	Indicators *(if necessary)*
Review of results	Performance monitoring. Discussing the state of implementation and progress at the stakeholder meeting			
	Recommendations: based on the results of monitoring and discussion			

Subnational locations for implementation *(to identify the region/city)*		Responsible agency	Term of implementation *(months)* 1 2 3 4 5 6 7 8 9 10 11 12	Indicators *(if necessary)*
Target: 100% of adolescents aged 10–17 living with HIV reached with care and socio-psychological follow-up (support) services				
Outcome 1: 100% of adolescents aged 10–17 on ART do not interrupt their treatment				
Action	Simplify the registration procedure for ARV drugs.	MoH		Order
	Supply combination ARV drugs to AIDS centres, NCSH 'OKHMATDYT'.	MoH, donors		The number (%) of adolescents receiving combination ARV drugs
	Set up multidisciplinary teams (MDT) to ensure ongoing psycho-social follow-up (support) of children and adolescents living with HIV.	Departments of health, AIDS centres, social services, NGOs		The number of MDT
	Establish a centre for HIV positive children and youth (if necessary).	City authorities, Departments of health		The centre for HIV positive children and youth
Review of results	Performance monitoring. Discussing the state of implementation and progress at the meeting of representatives of MoH, departments of health, AIDS centres, social services and NGOs.			
	Recommendations: based on the results of monitoring and discussion.			

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