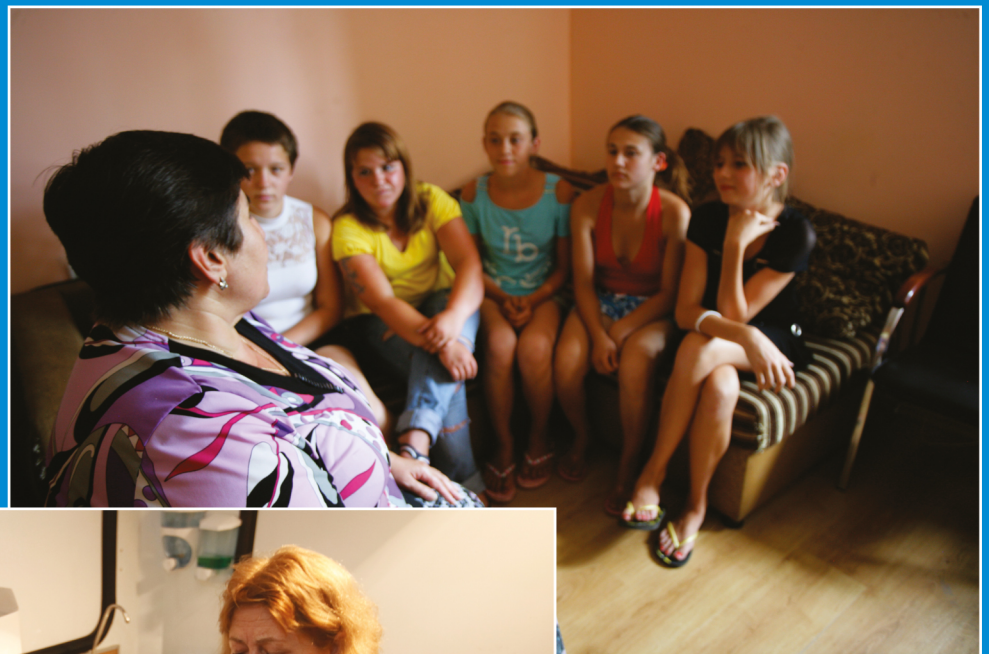




Comprehensive Study on Motivation and Accessibility of VCT on HIV for Children and Youth





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This publication presents the results of the online survey among adolescents, youth and VCT service providers conducted in 2012–2013 by UISR after O. Yaremenko within the project “HIV Prevention among Most-at-Risk Adolescents” with technical support of UNICEF Country Office in Ukraine. This work is based on methodological recommendations of the World Health Organization.

This analysis provides evidence based on current experience and describes issues faced by adolescents – including most-at-risk adolescents – in receiving VCT services; suggests practical recommendations for improving access to comprehensive VCT services of high quality for children and youth, and offers algorithms of actions and recommendations for service providers.

This publication may be useful for all specialists working with children and youth, specialists working in the area of VCT service provision and support of most-at-risk adolescents vulnerable to HIV infection, youth activists, parents and teachers.

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² <http://www.032.ua/>



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ABBREVIATIONS

AUCF	All-Ukrainian Charitable Foundation
HIV	Human Immunodeficiency Virus
WHO	World Health Organization
STI	Sexually transmitted infections
IFA	Indirect Fluorescent Antibody test for HIV
VCT	Voluntary counselling and testing for HIV infection
SGE	School of general education
YFC	Youth Friendly Clinic
CF	Communal (municipal) facility
ICF	International Charitable Foundation
MoFYS	Ministry of Family, Youth and Sports of Ukraine
MoSP	Ministry of Social Policy of Ukraine
MoH	Ministry of Health of Ukraine
NGOs	Non-governmental organizations
MARA	Most-at-risk adolescents
IDUs	Injecting drug users
AIDS	Acquired Immune Deficiency Syndrome, IV stage of HIV
MSM	Men who have sex with men
UISR after O. Yaremenko	NGO “Ukrainian Institute for Social Research after Olexander Yaremenko”
DH	(Oblast) department of health
CRP	Central rayon (city district) polyclinic
CSSFCY	Centre of social services for family, children and youth
CSPR	Centre for social and psychological rehabilitation
UNICEF	United Nations Children’s Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
PATH	International organization “Program for Appropriate Technology in Health”

INTRODUCTION

Ukraine has been a long-time leader in the rates of spread of HIV/AIDS epidemic among all countries of Eastern Europe and CIS. Particularly vulnerable to HIV infection are children and youth, as the prevalence of high-risk practices among them is higher than that among adults, as confirmed by several studies³. As of January 1, 2012 the estimated number of people living with HIV aged 15+ in Ukraine was 223,530; estimated HIV prevalence among adults aged 15–49 years reaches 0.76%⁴.

In addition to the growth of absolute numbers of people living with HIV/AIDS, the area of major concern is the fact that the epidemic went far beyond the communities of injecting drug users. Beginning from 2008 sexual transmission of HIV outpaces artificial, parenteral transmission that occurs during the use of injecting drugs.

According to the data of the Ukrainian Centre for the Control over Socially Dangerous Diseases at the MoH Ukraine, on January 1, 2013 there were 10,065 individuals under 18 years registered under medical follow-up of specialized HIV facilities, including 9,262 children born to HIV-positive mothers. During 2012 AIDS centres reached 4,113 children aged 0–18 years with follow-up care, including 4,048 children born to HIV-positive mothers⁵. The number of children affected by the epidemic also grows. By the end of 2012, 2,929 HIV-positive children were registered in Ukraine, and 12.6% of them are children under 3. 30.7% of HIV-positive children are those aged 4–10 years; 37.2% are children of 11–14 years, and 19.5% are adolescents of 15–17 years. Each of these categories requires special care and attention as these children face a variety of problems day in and day out, and many of these issues cannot be addressed single-handedly. It is obvious that social, psychological and material wellbeing of these children and young people significantly depends on timely external support, attention and assistance in addressing corresponding issues. Apart from underdevelopment of the networks of health and social service facilities, such support is hindered by limited capacities of these facilities that lack funding.

³ Most-at-Risk Adolescents: the Evidence Base for Strengthening the HIV Response in Ukraine: Analytical report [online document] / UNICEF, UISR after O. Yaremenko – Kyiv: K.I.S., 2008. – 192pg. – Access mode: http://www.unicef.org/ukraine/MARA_Report_eng_web.pdf; Analysis of factors contributing to initiation of injecting drug use: Analytical report / UNICEF, UISR after O. Yaremenko – Kyiv: “OBNOVA”, 2010–52pg.; Adolescent female sex workers in Ukraine: evaluation of the process and results of implementation of targeted interventions model: Analytical report (in Ukrainian) / UNICEF, UISR after O. Yaremenko – Kyiv, 2010. – 100pg. http://www.unicef.org/ukraine/ukr/Book_JKS_PROM_Web.pdf; Adolescents Living or Working on the Streets: Relevant Focus for Effective HIV Prevention (results of repeated socio-behavioural study) [online document] / UNICEF, UISR after O. Yaremenko – Kyiv, 2011. – 116pg. – Access mode: http://www.unicef.org/ukraine/ukr/MARA_WEB.pdf

⁴ National HIV/AIDS estimates at the beginning of 2012 [online document] – Kyiv, 2012. – Access mode: <http://www.unaids.org.ua/uk/situation>.

⁵ HIV Infection in Ukraine: Information Bulletin / MoH Ukraine, Ukrainian AIDS Centre, Institute of Epidemiology and Infectious Diseases after L. Hromashevskiy of the AMS of Ukraine, CSES of MoH Ukraine – 2012. #39. – 35pg.

Exceptionally high levels of self-stigma among children and young people who practice risky behaviours, as well as fear of possible disclosure of their HIV status and further stigmatization and discrimination in their social environment are also very important factors.

At the same time, political commitment, ample international assistance and effective cooperation between governmental and non-governmental organizations contribute to positive development of HIV service organizations and services, and to establishment of specialized health and social facilities specifically designed to provide professional and friendly services to children and young people affected by the epidemic.

Analysis of recent studies shows that despite the fact that counselling and testing for HIV (VCT) is one of the primary measures of HIV prevention, which is extremely important for timely assistance and treatment, adolescents' access to VCT remains comparatively low. Untimely diagnostics leads to various problems with the provision of support and treatment at later stages. Better access to antiretroviral therapy (ART) and prevention measures, as well as early diagnostics can reduce transmission of HIV and improve population's health, thus leading to reduction of adolescent morbidity and mortality.

Therefore, in-depth study of adolescents' attitudes towards HIV testing and counselling is particularly relevant. Study was conducted as an online survey among adolescents and young people with 971 respondents aged 13–24. Its findings will make it possible to objectively evaluate the level of access of the target group to necessary VCT services; to determine achievements and gaps in the system of HIV services that specifically target children and youth (including those at risk); and to define the extent, to which current VCT services meet their needs and ensure protection of their rights. Data analysis will also help to clarify the main trends in the development of HIV services for the target group; to explore the impact of external (institutional, organizational, etc.) and internal factors on the effectiveness of social services; and to illustrate their sustainability and prospects for development.

The survey “The voices, values and preferences of adolescents on HIV testing and counselling” was conducted in five countries – Ukraine, Azerbaijan, Georgia, Moldova and Belarus. Common methodology and tools were used. This study presents the results of the survey among Ukrainian adolescents. Preliminary results of this study were presented and discussed during focus group interviews with adolescents – including most-at-risk adolescents (MARA) – and with experts that provide VCT services in health and social settings.

There are certain limitations to the use of the results of this study as online survey results do not provide representative quantitative data for all young people. Nevertheless, data on motivation and barriers to VCT access can be used for effective HIV prevention among children and youth, improvement of service delivery by certain service providers, engagement of civil society and coordination and cooperation of key stakeholders.

Findings of this study will be of interest for decision-makers working in the area of HIV service provision, namely the specialists of the Ministry of Health of Ukraine and the Ministry of Social Policy of Ukraine, specialists of government institutions and facilities within the jurisdiction of these ministries, as well as staff members of institutions, facilities and organizations offering health and social services and VCT to children and youth, including those at risk for HIV infection.

SUMMARY OF FINDINGS

The report presents the results of the survey “The Voices, Values and Preferences of Adolescents on HIV Testing and Counselling” (based on WHO methodology), conducted in 2012–2013 by UISR after O. Yaremenko with the goal to identify the needs in testing for HIV, to review accumulated experience, and to improve access of adolescents and youth to high quality and comprehensive VCT services. In the course of this work researchers collected evidence based on current experience, identified key issues in receiving VCT services by adolescents, and developed practical recommendations and algorithms of actions for service providers.

Organization of the study. UISR after O. Yaremenko, in cooperation with MoH Ukraine and UNICEF, brought in a number of VCT service providers working with adolescents – including MARA – and experts (49 persons overall) for conducting in-depth interviews to verify results of the survey among children and youth.

Preparation for the online survey included adjustment of tools, piloting of tools by means of focused group interviews with representatives of the target population (young people aged 13–24 years, including MARA); moderation of the field stage of the survey, and analysis of collected data. *Online survey of youth was carried out in two waves:* the first wave did not envisage additional explanations to respondents (overall 465 persons), while children and young people could freely answer the questions posted on the websites of VCT service providers and other partner organizations. During the second wave of the study (which took into account results of the first wave) social workers provided relevant explanations to respondents (506 persons) prior to the survey.

Trained interviewers of UISR after O. Yaremenko strictly observed all research guidelines and norms.

Characteristics of the participants of online survey. 971 respondents aged 13–24 were covered by the online survey, out of which 483 boys and 488 girls. Respondents were not only from the capital and oblast centres but also from small towns and villages.

38.8% of respondents have incomplete secondary education; 16.4% have lower secondary education, and 10.6% – complete secondary education. 8.4% received university diplomas, while the remainder of respondents have either incomplete higher or vocational and technical education. 65.4% of all respondents study – as a rule, these are adolescents of school age. The majority of surveyed adolescents are unmarried – 87.3%. 36.9% of surveyed adolescents live separately from their parents.

Limitations of the study result from the methodology. Online survey does not provide data which are representative for all young people. This should be taken into account while interpreting the results.

The survey identified different *risky behavioural practices* among youth. In the age group under 19 years two-thirds of respondents (65.3%, N = 622) have had sexual contacts. Almost half of them (43.7%) had unprotected sex with partners of opposite gender; 42.2% (N=261) of respondents had one sexual partner in the last 12 months. The proportion of young people with 6 and more sexual partners reaches 10.4%. Each tenth male respondent (9.9%) reported having unprotected sex with either boy or man. 4.3% of respondents provided sex services for money or reward (food, clothes, housing, alcohol, drugs, and the like). 2.1% of boys used to pay for sex, while 0.7% of respondents had unprotected sex with HIV-positive individuals. Cumulative proportion of IDUs is 15.2%.

The survey results demonstrate *variations in respondents' answers by gender*. Responses of adolescents under 19 years of age show that the girls are more likely to be exposed to HIV infection: 66.3% of girls and 64.2% of boys reported having an experience of sexual contacts, while 50.2% of girls and 37.1% of boys ever had unprotected sex with persons of opposite gender.

The girls are more likely to become victims of violence – domestic (13.6% of girls and 9.3% of boys), psychological (12.6% of girls and 7.6% of boys), and sexual (7.8% of girls and 3.6% of boys).

Almost a quarter (22.3%) of respondents at risk for HIV infection live either without or separately from parents. 60.5% of most-at-risk adolescents currently neither study nor work. In addition, 5.7% of adolescents identify themselves as victims of sexual violence, 9.6% – of physical violence, and 14.4% – of psychological violence. 8.3% of adolescents faced physical violence on the part of peers, while 7.7% suffered from sexual, and 6.9% – from domestic violence.

Inadequate knowledge of HIV issues. The majority of respondents who answered the question (N=449) have correctly identified sexual contacts without condom use (91.1%), sharing of syringes during injecting drug use (88.6%), and transmission from HIV positive mother to her child (72.4%) as the main ways of HIV transmission. Overall, only a quarter of surveyed adolescents (28.5%) demonstrate knowledge of different modes of HIV transmission and the ways to prevent sexual transmission. The proportion of girls who both correctly identify ways of preventing sexual transmission of HIV and know main modes of HIV transmission is larger than that among boys (32% and 24% correspondingly).

Significant gaps were found in the following areas: each third (33.9%) adolescent is not sure whether HIV positive person may look healthy; each fourth (23.8%) is not sure or disagrees with the statement that the only way to find out one's HIV status is to take HIV testing; almost half of respondents (43.6%) do not know that sexual partners' testing results may be different.

Data analysis revealed that *only 10.3% of children and young people have the experience of testing for HIV*. Predominantly these are young adults (almost every second young person aged 20–24 and 18–19 (45.5% and 45.9% respectively), 2.8% of 13-year-old adolescents, 8.9% of 14–15-year-olds and 10.5% of 16–17-year-olds. . According to the online survey data, the proportion of girls who received HIV testing is almost twice as high as that of boys (14.5% and 7.2% respectively). Each third MARA (29.8%) underwent testing for HIV.

The most widespread types of testing (N = 191) are blood sampling from veins with a syringe (48.2% of respondents were tested this way during their most recent test), and rapid test (44%).

The most popular *venues (sites) of HIV testing* among participants of the online survey are: polyclinics and hospitals (34.6%); mobile testing sites (18.3%); NGOs (13.6%), and AIDS centres (13.1%). Each fifth respondent (19.9%) mentioned inconvenient timing of HIV testing and the need to miss almost a full day of studies/work in order to complete this procedure; the majority of such respondents are adolescents of younger age groups.

Experts identify the following *issues concerning VCT sites*: their territorial remoteness; inability of adolescents to pay for travel to such sites; limited knowledge of adolescents about testing facilities; the lack of comprehensiveness (rudimentary “one-stop shop” system) in the provision of VCT; undeveloped network of mobile units and labs; inadequate referral and social follow-up systems.

Respondents noted a number of most common *violations of principles and conditions of HIV testing* of adolescents.

Among those who took testing for HIV, 6.3% adolescents (14 years and older) reported not receiving testing results, while 8.2% had to conceal their true age. Only about half of respondents (54.1%) were asked about their age, whereas 17.3% of adolescents were not asked such questions at all. 78.1% noted that no one requested parental permission, while 9.2% needed such consent (including adolescents above 14 years of age).

Almost each fifth respondent (17.3%) answered “yes” when asked about the need to pay for HIV testing, and the number of cases when one had to pay for tests tends to increase with age. According to respondents, this service was fee-based in a polyclinic/hospital (20 persons), antenatal clinic (5 persons), AIDS centre (3 persons), NGO (2 persons), STI clinic/dispensary (5 persons), and in military enlistment office (1 person). Of those who paid for HIV testing 23.5% completed their education and work; 21.1% study and work; 18.8% neither study nor work, and 9% study and do not work.

About one-third of surveyed adolescents (33.5%) noted that testing was not anonymous. These include students of boarding schools (36.8%, N=64), adolescents having separate housing (34%), and adolescents living in dormitories (29.4%). 36.1% of those reporting violation of anonymity live separately / have no parents.

Adolescents were not asked to provide their consent (16.8%), or were not informed about the right to refuse HIV testing (22.5%). The largest percentage of those who encounter such violations was found among inmates of shelters for minors (33.3%) and boarding schools (26.3% were not asked to give consent, and 31.6% were not informed about the right to refuse testing).

Almost every third surveyed respondent (30.4%) reported having received no pre-test counselling, particularly in a polyclinic/hospital (35 persons), YFC (1 person), antenatal clinic (6 persons), AIDS centre (4 persons), drop-in centre (2 persons), mobile testing unit (2 persons), addiction treatment clinic/dispensary (2 persons), STI clinic/dispensary (5 persons), military enlistment office (3 persons), and NGO (3 persons).

Despite the fact that the majority of respondents who received testing for HIV (66.7%) confirmed having consultations in case of positive result, some adolescents still did not have such

counselling. Not all adolescents were advised to notify parents about positive result, but only about quarter of those tested for HIV (27.3%). Not a single surveyed adolescent dared to disclose his/her HIV status to classmates, but informed relatives instead.

Among relevant issues pertaining to VCT service provision experts also identify weak referral between service providers and undeveloped established social follow-up.

The study determined a number of **subjective and objective barriers** to VCT service provision for adolescents and MARA boys and girls. Objective barriers include:

- 1) *inconsistencies between regulatory acts* and their non-compliance with the sectoral law; vagueness of key terms “adolescents” and “most-at-risk adolescents”; problems with permission for testing adolescents under 14 years, when it is impossible to determine their parents or legal representatives, or to involve them in VCT process for certain reasons;
- 2) the lack of professional training in many specialists on the specifics of work with adolescents, and particularly with MARA; shortage and turnover of staff; insufficient number of health workers with adequate skills and practical experience to carry out outreach work with children and youth at risk, and work in mobile outpatient units/clinics;
- 3) *the absence of separate budget/expenditure items* on work with MARA;
- 4) underdeveloped infrastructure of facilities offering VCT services as current service provision system fails to meet all needs;
- 5) *informational and methodological support* requires improvement and introduction of innovative technical resources (36.7% of surveyed adolescents noted that online resources should provide clear and adolescent-friendly information about opportunities and sites for HIV testing, while 23.6% of adolescents suggested development of similar apps for mobile phones).

Subjective barriers include:

- 1) *Inadequate knowledge*. More than half of respondents have never thought about the need of testing for HIV (59.1%), whereas 36% of surveyed adolescents believe that their risk of infection is insignificant. Almost each fifth respondent (17.2%) has no idea where one can get tested for HIV, while 3.7% of respondents were not aware of opportunities to undergo testing without parental consent. At the same time, only about half of surveyed children and young people (48%) think that it is important for MARA to know their HIV-positive status and its consequences;
- 2) *Psychological barriers*. 8.1% of adolescents refused to get tested for HIV because of fear of its results; 6.7% were afraid of possible infection during testing; 6.1% were wary of negative attitudes of others; 3.6% were frightened by possible registration, and 2.8% assumed that health workers would notify their parents. Other respondents' fears and concerns included the following: 3.9% of adolescents thought that testing for HIV was paid service; 2% had no identification documents, while 5.1% just did not want to know their HIV status altogether.

Motives for testing. Children and young people believe that one of more convincing forms of motivation can be *encouragement during personal contacts*: a lesson or lecture (15.3%), friend's advice (11.7%), and the like. *The best place to get tested for HIV* can be non-governmental organization (14.1%), AIDS centre (41.7%), drop-in centre "Dovira" (25.3%), or Youth Friendly Clinic (21.9%). Each fourth adolescent (26.9%) was simply unaware of the best places for HIV testing. Similarly, respondents were not unanimous regarding location of HIV testing sites: 8.0% of surveyed adolescents believed that such sites should be as far away as possible, while 24.5% suggested that these should be located within easy reach of their places of residence.

To improve *conditions of testing* it is necessary to guarantee that no friends or family know about it (43.6%); that testing results are communicated to parents only upon adolescent's consent (26.4%); that no identification documents are requested (39.4%); that testing for HIV is offered to all adolescents (37.4%); that testing is carried out at time suitable for adolescents (33.9%).

Characteristics of HIV test that can encourage future testing for HIV include: free-of-charge service provision (42.6%); notification about testing results no later than in two hours after testing (33.6%); HIV testing based on saliva (29.%) or fingertip blood (20.6%) instead of venous blood samples.

About one-third of respondents believe that *proposals to all adolescents to undergo testing for HIV* made by health workers (35.8%) and social workers (29.1%) can serve as important motivator.

According to the results of the study the existing system of VCT services does not address all needs of adolescents and young people. New technologies such as online counselling, Internet and cell phones should be better utilized for spreading information on HIV and VCT among boys and girls. Right of older adolescents to receive HIV test without parental consent, voluntary nature of HIV testing and right to refuse from HIV testing should be further explained. Main remaining issues are accessibility of VCT to young people from small towns and rural territories, right to free-of-charge testing, effective referral system (social support based on VCT results etc.). Staffing is also crucial as lack of specialists, their unpreparedness to work with adolescents, in particular most-at-risk adolescents, staff turnover effect provision of VCT services. Increased cooperation between social, including NGOs, and medical service providers is needed for the development of model of integrated VCT services for adolescents.

Analysis of methodological and organizational gaps of the integrated study will be helpful for further research. Identified problematic areas contribute to understanding of the limitations of data interpretation and usage.

METHODOLOGICAL FRAMEWORK

Methodological approach is based on the study “The Voices, Values and Preferences of Adolescents on HIV Testing and Counselling” within Consultations for the development of the WHO HTC guidelines for adolescents⁶, and on the WHO materials “Adolescent job aid: a handy desk reference tool for primary level health workers”⁷.

The survey was carried out with **the goal** to improve adolescents’ access to quality and comprehensive VCT services. The study resulted in the development of practical recommendations and algorithm of actions for service providers.

Study objectives:

1. To explore current perspectives on the need of HIV testing and experience of VCT, and to identify VCT-related aspects that are important for adolescents, including most-at-risk adolescents.
2. To identify key barriers to VCT (regulatory, organizational, psychological and the like) for adolescents, including most-at-risk adolescents.
3. To determine technical needs and conditions for improving access to VCT services for adolescents, including most-at-risk adolescents, and refining efficiency of counselling as an important component of HIV prevention.

Overall methodology is characterized by **comprehensive approach** and is based on several data sources:

- 1) Quantitative (anonymous online survey) and qualitative (focus groups, in-depth interviews) methods of collection and analysis of data on different target groups:
 - a) students of schools of general education, universities and VTS;
 - b) most-at-risk adolescents;
 - c) adolescents with/without experience of seeking health and social services (including VCT);
 - d) providers of services, including VCT;
 - e) decision-makers.
- 2) Expert evaluation of voices, values and preferences, as well as practical experience of service providers.

⁶ Presentation ‘The Voices, Values and Preferences of Adolescents on HIV Testing and Counseling’ Consultation for the development of the WHO HTC guidelines for adolescents/ Alice Armstrong, Anke van der Kwaak and Liezel Wolmarans. Royal Tropical Institute (KIT) Amsterdam – presented in WHO (Geneva) in February 2012.

⁷ Adolescent job aid: a handy desk reference tool for primary level health workers. – WHO, 2010. – 180 p. (P. 9, 10) [electronic resource]. – Access mode: http://whqlibdoc.who.int/publications/2010/9789241599962_eng.pdf

Online survey covered adolescents and young people from different regions of Ukraine living in different types of areas/settlements (oblast centres, other cities and towns, rural areas).

Target populations:

- Adolescents, including MARA, with a history of seeking social and health services (particularly VCT), and those with no experience of this kind.
- Adolescents and young people aged 13–24 years from different regions of Ukraine (online survey).
- Service providers with experience of providing VCT services to adolescents, including MARA.
- Decision-makers (representatives of MoH Ukraine, the State Service on HIV/AIDS and other Socially Dangerous Diseases, the Central Department of Health of the city of Kyiv).
- Experts working with adolescents, but who do not directly provide VCT services (specialists in adolescent paediatrics of oblast / city polyclinics, social pedagogues, deputy headmasters of vocational and technical schools on extracurricular work).

Geography of the study: regions of Ukraine, especially Kyiv, Odessa, Mykolaiv and Donetsk oblasts, which is preconditioned by the experience of implementation of prevention models targeting most-at-risk adolescents within the framework of the UNICEF project during 2009–2013.

Preparation and organization of the survey

Development and piloting of adapted survey tools (two focus groups **with adolescents and most-at-risk adolescents**), as well as methodological support of the entire cycle of research work was ensured by NGO “Ukrainian Institute for Social Research after Olexander Yaremenko”. In addition, specialists of UISR after O. Yaremenko coordinated collection and processing of data, developed an analytical report and organized a number of working meetings (focus groups) within this study. Relevant recommendations were developed as a result of this analytical work.

Within the framework of focus group discussions efforts were made to coordinate activities with the local youth organizations and centres of social services for family, children and youth (Table 1).

To this end, objectives for local youth organizations to recruit adolescents were developed; second, moderators for focus group discussions were selected and trained; and third, observance of all focus group principles and guidelines of were ensured (see “*Study Guidelines*” below).

Characteristics of focus group participants

Focus groups to pilot research tools for online survey of adolescents, including MARA				
Target group – most-at-risk adolescents (8 persons):		Target group – students of schools of general education, first and second-year university students (10 persons):		
– Aged 13 to 19 years		– Aged 13 to 19 years		
– 4 boys and 4 girls		– 5 boys and 5 girls		
– 4 have experience of VCT, and 4 have no such experience		– 5 have experience of VCT, and 5 have no such experience		
Focus groups with adolescents (including MARA) on their views, values and experience of HIV testing				
City	Kyiv	Bila Tserkva (Kyiv oblast)	Odessa	Yuzhnoukrayinsk (Mykolayiv oblast)
Number of participants	11	8	9	10
Gender	6 boys 5 girls	5 boys 3 girls	5 boys 4 girls	3 boys 7 girls
Age	15–19 years	15–19 years	15–19 years	16–18 years
Experience of HIV testing				
Present	8	6	9	5
Absent	3	2	-	5
HIV status (among those with experience of testing)				
HIV+	1	-	1	-
HIV-	6	8	8	3
Refused to answer	1	-	-	2

UISR after O. Yaremenko, in cooperation with MoH Ukraine and UNICEF, also invited service providers and **experts** (49 persons overall) to participate in in-depth interviews to verify results of the survey among children and youth and to obtain more detailed information on the following:

- specifics of cooperation between service providers and representatives of target population;
- conditions and nature of VCT service provision to adolescents, with special focus on MARA boys and girls regardless of their HIV status;
- key issues and barriers to provision of VCT services that would meet the needs of adolescents;
- quality of VCT service provision to adolescents, including MARA.

VCT service providers who specifically work with adolescents, including MARA, were given preference in selecting interviewees (Table 2).

Characteristics of experts who participated in interviews

		EXPERT INTERVIEWS							
Categories of experts		Kyiv	Odessa	Donetsk	Mykolayiv	Mariupol	Zhytomyr	Sumy	TOTAL
VCT service providers	Health workers ⁸	3	2	1	2	2	1	1	12
	Social workers ⁹	1	1	2	1	2	-	2	9
	Heads of health and social work facilities/institutions ¹⁰	1	2	3	2	1	2	-	12
Are not direct service providers but work with adolescents (referral)	Health workers ¹¹	-	1	1	1	-	-	-	3
	Social pedagogues of VTS	-	-	-	1	-	-	-	1
Representatives of health departments at oblast state administrations (regional level)		-	1	1	1	-	-	-	3
Representatives of the Ministry of Health of Ukraine and the State Service on HIV/AIDS and other Socially dangerous Diseases (national level)		2	-	-	-	-	-	-	2
Representatives of Ukrainian and international NGOs (national level)		8	-	-	-	-	-	-	8
TOTAL		15	7	8	8	5	3	3	49

Experts have respectable experience of work in institutions and organizations providing VCT services to adolescents (with the exception of NGOs that in majority of cases of VCT service provision work with clients who are older than 18 years of age).

All interviewees demonstrated a great deal of interest and involvement in the topic under study and provided highly professional answers to all questions.

Local partners involved in the study (youth and non-governmental organizations, centres of social services for family, children and youth) provided adequate assistance in selecting potential respondents and focus group participants, recruited adolescents for online survey, and expanded technical capacity of online survey of MARA by using tablets.

⁸ VCT counsellors at AIDS centres; specialists of YFC (infectious diseases specialist, VCT expert); specialists of drop-in centres (health workers).

⁹ Social workers of non-governmental and youth organizations; specialists of city and rayon centres of social services for family, children and youth.

¹⁰ Heads (coordinators) of non-governmental organizations and departments for health and social assistance to adolescents and youth at Youth Friendly Clinics.

¹¹ Specialists in adolescent paediatrics at oblast/city polyclinics; health workers at health centres and vocational and technical schools.

Research tools

Specialists of UISR after O. Yaremenko adapted and developed the following research tools on the basis of recommended WHO tools:

- Seven guides for conducting focus groups among service providers and each category of experts. Guides included the following thematic blocks:
 - Regulatory and legal framework and information resources for VCT.
 - Training and supervision of VCT specialists; their involvement and experience in service provision.
 - Quality and existing resources of service provision.
 - Potential for scaling up access of adolescents to VCT and advocacy.
 - Recommendations on changes in the service provision system.
- Guide for conducting focus groups with adolescents, including MARA, includes the following questions:
 - Views and opinions about counselling and testing for HIV.
 - Experience of seeking VCT services.
 - Reasons for taking (or not taking) VCT.
 - Views on the improvement of procedure and content of VCT: how to make it more accessible, friendly and effective for adolescents.
 - Questions of VCT technology: categories of adolescents that require VCT, confidentiality, voluntary consent.

In accordance with WHO methodology focus group participants made their presentations and rationalized their viewpoints regarding this or that issue by using pictures and illustrations. “Brainstorm” methodology, suggested by the moderator, encouraged adolescents to participate in discussions and to make recommendations.

- A tool for online survey (Annex 1) that was previously piloted in the course of two focus group discussions, included:
 - Social and demographic characteristics.
 - Behavioural practices of respondents.
 - Knowledge about ways of HIV transmission.
 - Experience of testing for HIV and reasons that motivate or prevent adolescents from getting tested for HIV.
 - Conditions and quality of pre-test counselling, testing and post-test counselling as assessed by respondents with the experience of HIV testing.
 - Factors that can make VCT services more accessible, friendly and effective for adolescents, including most-at-risk adolescents.

In addition, all adolescents who participated in focus group meetings, as well as service providers and experts have signed *forms of informed consent* (Annexes 3 and 4).

Guidelines and principles that guided interviewers in their research work:

- ✓ Ethical considerations. While conducting surveys among children the research team was guided by “Ethical Principles for Social Research among Children in Ukraine”, approved by the Board of Sociological Association of Ukraine (Protocol #7 as of December 10, 2008)¹².

NGO “Ukrainian Institute for Social Research after Olexander Yaremenko” received formal approval from the Professional Ethics Commission of Sociological Association of Ukraine regarding ethical norms of conducting research among adolescents.

- ✓ Focus on the future. Suggested changes to the process of VCT service provision for adolescents requires time, thus it is very unlikely that focus group participants will directly benefit from them. From information sheets and guidelines these adolescents already know that changes in service provision are beyond the scope of work of project coordinators. Nonetheless, participation in this activity presents an excellent opportunity to voice their opinions and ideas.
- ✓ Consent to participate in the survey. Informed consent was obtained from all survey participants.

Taking into account part 1 of Article 11 (Grounds for the Accrual of Civil Rights and Obligations) of the Civil Code of Ukraine¹³, it can be assumed that even children under 14 years have the right to information without consent of their parents or other legal representatives.

Therefore, children from 14 to 18 years of age shall have the right to information without consent of their parents or other legal representatives.

Participation in focus groups and interviews is voluntary, and participants could discontinue their participation at any time.

- ✓ Confidentiality. The importance of confidentiality was highlighted in the texts of letters of informed consent that respondents read and signed prior to the focus group or interview.

Public nature of focus groups meant that confidentiality could not be fully guaranteed. Adolescents were warned about it and assured that all information will be generalized with no disclosure of private information. They were also warned about specific extraordinary cases, where upon receiving information about health- or life-threatening situations (e.g. facts of physical abuse), a moderator or coordinator could disclose it to undertake measures to protect a child. Nonetheless, such disclosure was not possible without prior discussion with an adolescent and his or her consent.

To further ensure principles of confidentiality, all participants of focus groups could use pseudonyms.

¹² Ethical principles were developed with the support of UNICEF Country Office in Ukraine. They are based on the need to observe human rights, provisions of the UN Convention on the Rights of the Child, and Guiding Principles of Ethics applied by the UNICEF Regional Office for CEE/CIS (2008). [Online document] – Access mode: http://www.unicef.org/ukraine/ukr/ethnic_principles.pdf.

¹³ Civil rights and obligations shall appear from persons’ actions provided by the acts of civil legislation, as well as from those that are not provided hereby but generate civil rights and obligations by analogy.

All information was stored in the password-protected computer, accessible only to the research team members. No identification information about staff members or adolescents was used in the reports.

- ✓ Sensitivity, reduction of possible harm. Prior to focus group meetings all participants were informed about possible emergence of sensitive issues related to adolescents' experience of VCT, which could affect the course of group discussions. Therefore, participants could discontinue their participation at any moment, talk to consultant, or be referred to relevant social service for assistance and support.
- ✓ Reward. The design of this survey did not envisage any specific reward for its participants, but sweets and drinks were made available at the focus groups to all participants of group discussions.
- ✓ Quality assurance. In order to prevent any bias on the part of the research team or moderator, and to ensure high quality of the research, local social workers and staff members of youth centres that were responsible for recruiting of participants were asked to look through the content of focus groups and interviews. Following each event relevant improvements were made to questions/agendas to be used in the next focus group meeting.

Focus group moderators represented local partners; they were selected on the basis of previous experience of holding group discussions with adolescents.

Data processing and analysis

➤ Focus groups with adolescents and expert interviews:

- Transcription of audio recordings was completed;
- Quality methods were used to analyse the primary data in order to summarize barriers to adolescents' access to quality VCT services.

➤ Online survey:

- Monkey Survey website was used for data collection;
- Data analysis employed qualitative methods using SPSS.PC software and taking into consideration variations of target groups, their gender and age.

Preparation for the online survey included adaptation of research tools, piloting of tools by means of focused group interviews with the representatives of the target population (young people), moderation of the field stage of the survey, and analysis of collected data.

Online survey of adolescents and youth was carried out in two waves¹⁴:

¹⁴ Information about the survey was posted on the partners' websites (ICF "International Alliance for HIV/AIDS in Ukraine", All-Ukrainian NGO "All-Ukrainian Network of PLWH", AUCF "The Coalition of HIV Service Organizations", CF "Way Home", CF "Unitus", and other). Relevant objectives were developed for NGOs regarding the number of MARA respondents (tentative number – 40 MARA boys and girls for the first and the second waves of the survey), as well as recommendations for even recruitment of respondents by gender and age.

- the first wave did not envisage additional explanations to respondents, while children and young people could freely answer the questions posted on the websites of VCT service providers and other partner organizations;
- during the second wave of the study (which took into account the results of the first wave) social workers provided relevant explanations to respondents regarding ways of HIV transmission, peculiarities and conditions of testing for HIV (Annex 1). During the second wave researchers used tablets which significantly broadened adolescent’s access to the survey;

Following the discussion of collected data, relevant conclusions and recommendations were developed and approved in the course of three focus group meetings (with adolescents, with most-at-risk adolescents and with experts).

Finally, the researchers prepared a summary report and recommendations for improving access of adolescents and young people to comprehensive and quality VCT services, and suggested algorithm of actions for service providers.

Limitations of the study. Limitations of the results are linked to the methodology of online survey and inadequate knowledge about HIV testing among adolescents and youth.

Method of online questionnaire does not provide representative data for the whole youth cohort (Table 3). Information about the survey was spread through web-sites of civil society organizations and through social workers who work with the target group. Adolescents were also recruited through NGOs, boarding schools, peers who are clients of NGOs.

Some respondents did not have a clear understanding of the notions “testing on HIV”, “positive result” and “negative result”.

Identified methodological and organizational gaps were treated as limitations in data interpretation by the research team. Detailed information on study limitations can be found in Chapter IX. *Lessons learnt (Methodological gaps).*

CHARACTERISTICS OF THE PARTICIPANTS OF ONLINE SURVEY

The sample of the online survey was based on responses of 971 respondents, including MARA. 465 respondents (187 boys and 278 girls) participated in the first wave of the study, and 506 respondents (296 boys and 210 girls) were surveyed during the second wave. The sample included adolescents and young people aged 13–24 with experience of seeking health and social services (including VCT), and those with no experience of this kind. During the second wave special attention was given to involvement of younger respondents. Therefore, the proportion of those aged 13 in the entire sample was 9.4% (4.1% in the first wave, and 14.2% – in the second). The distribution of other age groups in both waves of the survey was as follows: 14–15 years – 24.9% (15.1% and 34%); 16–17 years – 32% (21.3% and 41.9%); 18–19 years – 12.7% (18.1% and 7.7%), and 20–24 years – 21% (41.5% and 2.2% correspondingly). The sampling structure by age groups is somewhat different from the overall structure of target age cohort (see Table 3).

Table 3

The structure of respondents of online survey by age, number and %

Age	Waves				TOTAL		Statistics for the population of Ukraine, number of persons	%
	1 st wave		2 nd wave					
	N	%	N	%	N	%		
13 years	19	4.1	72	14.2	91	9.4	427.3	6.0
14–15 years	70	15.1	172	34.0	242	24.9	941.4	13.2
16–17 years	99	21.3	212	41.9	311	32.0	1,027.6	14.4
18–19 years	84	18.1	39	7.7	123	12.7	1,180.8	16.5
20–24 years	193	41.5	11	2.2	204	21.0	3,564.4	49.9
Total	465	100	506	100	971	100	7,141.5	100.0

The credibility of survey data was ensured by inclusion of individuals from the capital city and oblast centres and from other locations in each of selected regions, since respondents (adolescents and MARA boys and girls) were recruited at the places of their residence by using different channels of recruitment. The majority of respondents (43.8%) live in big cities; 41% of respondents are residents of oblast centres; 6.9% live in small towns; 4.6% are rural residents, and 3.7% live in townships (Table 4).

Sampling structure of respondents of online survey by the area of residence, number and %

Area of residence	Waves				TOTAL	
	1 st wave		2 nd wave		N	%
	N	%	N	%		
Big city (>100 thousand residents)	188	40.4	237	46.8	425	43.8
Oblast centre	160	34.4	238	47.0	398	41.0
Small town (<100 thousand residents)	60	12.9	7	1.4	67	6.9
Township	26	5.6	10	2.0	36	3.7
Village	31	6.7	14	2.8	45	4.6
Total	465	100	506	100	971	100

The sample included adolescents and young people who live separately from their parents – 36.9% (33.3% of boys and 40.4% of girls) (Diagram 1). Among those aged 13–17 years these are predominantly children living in residential institutions, and street teenagers (53.8% among those aged 13 years; 36% in the age group of 14–15 years; and 21.2% of those who are 16–17 years of age). As for the young people of 18 to 24 years, this concerns persons living in dormitories and young adults who changed residence after attainment of full legal age (including those who moved to other cities for the purpose of education): 42.3% of young people aged 18–19 years, and 51% of those aged 20–24 live outside their families.

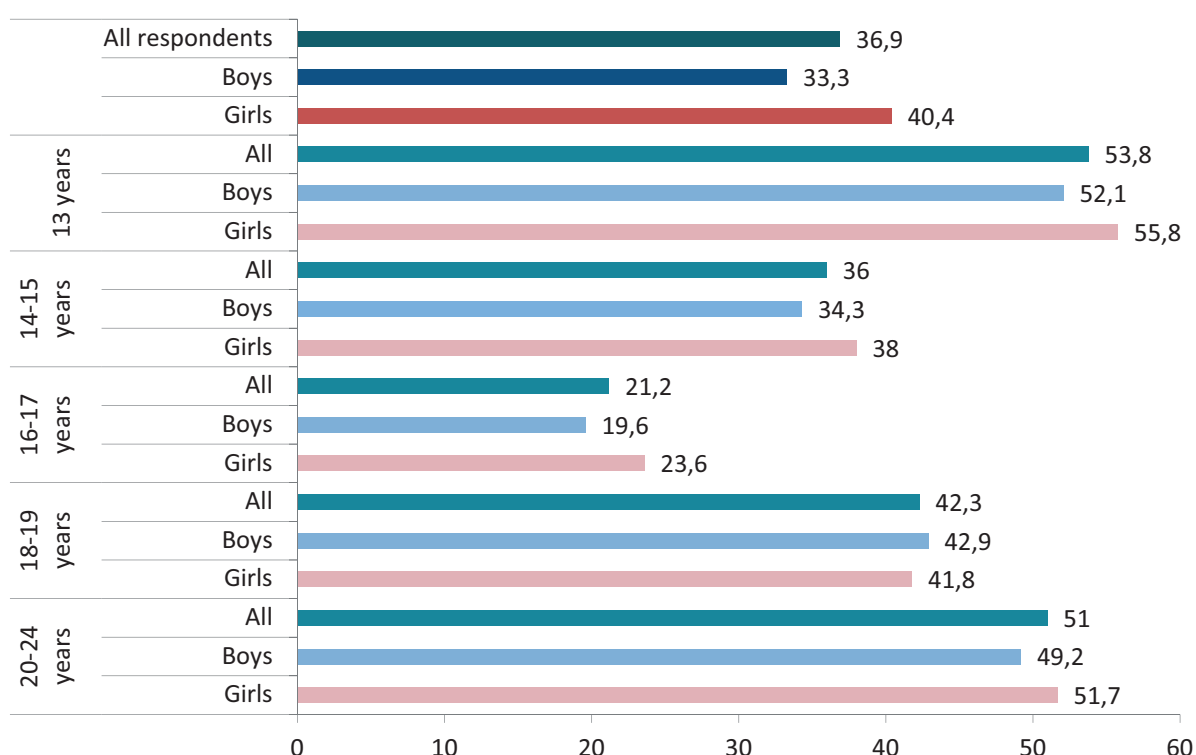


Diagram 1. Percentage of surveyed children and young people who reported living separately from their parents, by gender and age, %

The majority of respondents (68.7%) live in own or rented housing (predominantly these are older adolescents – 81.0% of boys and 80.3% of girls aged 16–17 years; 58.9% of boys and 74.6%

of girls of 18–19 years; and 90.2% of boys and 89.5% of girls aged 20–24). 20.5% of adolescents live in boarding schools (62.5% of surveyed boys and 72.1% of girls under 13 years; 44.8% of boys and 38.0% of girls aged 14–15 years; 8.7% of boys and 10.2% of girls of 16–17 years, and 7.1% of boys and 6.0% of girls aged 18–19). 8.9% of those surveyed live in dormitories (especially adolescents of older age); 1.1% live in shelters for minors (primarily children aged 13–16 years); 0.5% spend most of their time on the streets, while 0.3% do not have definite place of residence (Table 5).

Table 5

The structure of respondents by living arrangements, according to gender, age and survey wave, %

Living arrangements	All respondents	Waves		Gender		Age, years									
		1st	2nd	Boys (M)	Girls (F)	13		14–15		16–17		18–19		20–24	
						M	F	M	F	M	F	M	F	M	F
Apartment, house (rented, own, parents' or partner's, including unofficial)	68.7	81.7	56.7	65.8	71.5	35.4	16.3	47.8	57.4	81.0	80.	58.9	74.6	90.2	89.5
Boarding school	20.5	4.5	35.3	22.8	18.2	62.5	72.1	44.8	38.0	8.7	10.2	7.1	6.0	0	0
Dormitory	8.9	10.1	7.7	9.3	8.4	0	4.7	3.7	1.9	9.2	9.4	33.9	19.4	6.6	8.4
Shelter	1.1	2.2	0.2	0.8	1.4	2.1	7.0	1.5	2.8	0.5	0	0	0	0	0
Spends most of the time on the streets (lofts, basements, etc.)	0.5	1.1	0	0.8	0.2	0	0	2.2	0	0	0	0	0	1.6	0.7
No definite place of residence	0.3	0.4	0.2	0.4	0.2	0	0	0	0	0	0	0	0	1.6	0.7

While speaking about the respondents' educational level, it should be noted that almost all of them have or had access to education, and currently they either completed or continue their studying, depending on the age (Table 6). The largest proportion of respondents has incomplete secondary education: 38.8% (11% of adolescents aged 13 years; 65.7% among those aged 14–15 years; 55.0% of adolescents of 16–17 years; 23.6% of respondents aged 18–19, and 3.9% – among young adults of 20–24 years of age). 16.4% of surveyed adolescents have lower secondary, 10.6% – complete secondary, 8.4% – complete higher, 7.8% have incomplete higher education, and 6.1% of respondents study in VTS on the basis of incomplete secondary education.

The range of responses regarding education and employment shows that the majority of respondents are motivated to continue their learning and work: 65.4% of adolescents study as the majority of respondents are adolescents of school age (9.2% of those aged 13 years, 88.0% – among adolescents of 14–15 years, and 78.5% among those aged 16–17). 19.7% of respondents both study and work (these are primarily older adolescents – 39% among young people aged 18–19 years, and 28.9% of those of 20–24 years). 11% of adolescents work, with majority of such respondents being 20–24 years of age (44.1%). 3.9% of surveyed adolescents neither study nor work (Table 7).

Table 6

The structure of respondents by education, according to age, %

Education	All respondents	By age, years				
		13	14–15	16–17	18–19	20–24
Incomplete secondary (8–9 classes)	38.8	11.0	65.7	55.0	23.6	3.9
Primary (4–7 classes)	16.4	86.8	27.7	1.6	2.4	2.5
Complete secondary education (10–11 classes)	10.6	0	1.2	21.2	22.8	2.9
Complete higher (specialist, master)	8.4	0	0	0.6	0.8	38.7
Incomplete higher	7.8	0	0	2.3	18.7	22.5
VTS on the basis of incomplete secondary education	6.1	0	3.7	10.6	8.9	2.9
Basic higher (bachelor)	4.5	0	0	1.0	2.4	18.6
Secondary professional (technical, VTS diploma)	3.4	0	0	2.6	8.9	6.9
VTS on the basis of complete secondary education	3.2	0	0.4	4.5	11.4	1.0
Incomplete primary (less than 4 classes)	0.7	2.2	1.2	0.6	0	0

Table 7

The structure of respondents by employment, according to age, %

	All respondents	By age				
		13 years	14–15 years	16–17 years	18–19 years	20–24 years
Study, don't work	65.4	9.2	88.0	78.5	44.7	19.6
Study and work	19.7	6.6	8.7	18.3	39.0	28.9
Don't study, work	11.0	0	0.8	1.9	7.3	44.1
Neither study not work	3.9	2.2	2.5	1.3	8.9	7.4

An absolute majority of surveyed adolescents (87.3%) are unmarried; 7.5% of respondents live in union with no registration (among older adolescents of 16–24 years, the proportion of girls living in union is almost twice as high as that of boys); and 5.1% of respondents are officially married (Table 8).

Table 8

The structure of respondents by marital status, according to gender and age, %

Marital status	All respondents	By gender		By age														
		Boys	Girls	13 years			14–15 years			16–17 years			18–19 years			20–24 years		
				Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Unmarried	87.3	93.4	81.4	98.9	97.9	100	97.5	97.0	98.1	95.5	97.3	92.9	86.2	91.1	82.1	58.3	72.1	52.4
In union, no official registration	7.5	4.1	10.9	1.1	2.1	0	1.2	1.5	0.9	4.2	2.2	7.1	12.2	7.1	16.4	20.1	14.8	22.4
Married	5.1	2.5	7.8	-	-	-	1.2	1.5	0.9	0.3	0.5	0	1.6	1.8	1.5	21.6	13.1	25.2

In order to verify collected data, examine hypotheses and clarify a number of inconsistent responses during the online survey, the researchers organized three additional focus group meetings: with adolescents, with most-at-risk adolescents and with service providers.

Table 9

Focus groups as a result of the survey¹⁵

Focus group meetings with adolescents to discuss results of online survey		
Target group – most-at-risk adolescents (10 persons):		Target group – adolescents (10 persons):
– Aged 16 to 20 years		– Aged 16 to 20 years
– 4 boys and 6 girls		– 5 boys and 5 girls
Experience of testing for HIV		
Present	6	6
Absent	4	4
HIV status (among those with experience of testing)		
HIV+	-	-
HIV-	5	6
Refused to answer	1	-
Focus group meeting with experts and service providers to discuss results of online survey		
Number of participants – 6 specialists involved in service provision to adolescents, including MATA:		
– specialists of social sphere (NGO manager, NGO social worker, YFC psychologist) (3 persons),		
– health workers (AIDS centre counsellor, YFC specialist, specialist in adolescent paediatrics) (3 persons)		

¹⁵ All participants of focus groups meetings summoned to discuss survey results did not participate in previous focus groups and in the survey.

I. REGULATORY AND LEGAL BASIS FOR VCT PROVISION TO MOST-AT-RISK ADOLESCENTS

“Legal aspects are the most difficult issues that we face in our work”. (Service provider, social worker, NGO, Mykolayiv)

1.1. National Legislation that Regulates VCT Service Provision to Adolescents

Nowadays specialists in the area of health and social services, including VCT, actively raise and discuss questions regarding the need of legal regulation of specific issues concerning provision of these services to adolescents in general, and to most-at-risk adolescents in particular.

This chapter includes information from the “Legal and regulatory review on HIV prevention and access of adolescents, including most-at-risk adolescents, to medical and social services” that was prepared within UNICEF project (currently being printed).

Ukraine’s national legislation on VCT is based on several fundamental documents. These are the Law of Ukraine “On Fundamental Principles of Health Care Legislation of Ukraine”¹⁶, the Law of Ukraine “On Prevention of Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Security of People Living with HIV”¹⁷, and the Law of Ukraine “On Approval of the National Programme to Ensure Prevention of HIV Infection, Treatment, Care and Support to HIV Positive People and Patients with AIDS for 2009–2013”¹⁸.

The Law of Ukraine “On the Protection of Childhood” guarantees every child the right to health care, to free and competent medical assistance in the state and municipal health facilities, and to safe environment for life and healthy development¹⁹.

Provision of health services to individuals under 18 years requires special attention to peculiarities of their legal status and division of this category into two age groups – under 14 and from 14 to 18 years of age. These peculiarities are regulated by in the Civil²⁰ and Family²¹ Codes.

¹⁶ The Law of Ukraine No 2801-XII as of November 19, 1992 “Fundamental Principles of Health Care Legislation of Ukraine”.

¹⁷ The Law of Ukraine No. 2861-VI as of December 23, 2010 “On Prevention of Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Security of People Living with HIV”.

¹⁸ The Law of Ukraine 1026-VI as of February 19, 2009 “On Approval of the National Programme to Ensure Prevention of HIV Infection, Treatment, Care and Support to HIV Positive People and Patients with AIDS for 2009–2013”.

¹⁹ The Law of Ukraine No 2801-XII as of November 19, 1992 “Fundamental Principles of Health Care Legislation of Ukraine”.

²⁰ The Civil Code of Ukraine, No 435-IV as of January 16, 2003.

²¹ The Family Code of Ukraine, No 2947-III as of January 10, 2001.

According to part 3 of Article 284 of the Civil Code of Ukraine, and part 1 of Article 43 of the Law of Ukraine “Fundamental Principles of Health Care Legislation of Ukraine”, medical assistance to an individual who attained 14 years of age shall be provided upon his/her consent, while assistance to a patient under 14 years is provided upon consent of his/her legal representatives.

The new version of the Law of Ukraine “On Prevention of Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Security of People Living with HIV” establishes *the voluntary right of individuals aged 14 and older to undergo testing for HIV infection conditional to the availability of a well-informed consent of an individual received after pre-test counselling, which informs about peculiarities of HIV testing, its results and possible consequences. Testing is provided in a confidential manner, which guarantees non-disclosure of any personal information, including the information on personal health status.* At the client’s request, medical examination in a health facility may be performed anonymously.

Information about the results of HIV testing, the presence or absence of HIV in an individual is confidential and constitutes medical secrecy (Article 8 of the Law). If HIV infection is discovered in a minor under 18 years of age, a staff member of the health facility performing the medical examination shall notify the minor’s parents or other legal representatives (Article 9).

The Procedure of voluntary counselling and testing for HIV (hereinafter – VCT Guidelines)²² defines *goal and objectives of VCT and its basic principles* (voluntariness, confidentiality, anonymity, accessibility and non-discrimination, reliability and sufficiency of information, professional and technical excellence, mobilization of resources), *its procedure, forms and content of pre-test counselling, general requirements to counselling and testing* (confidentiality, stages of counselling and requirements to counsellors, general provisions on counsellor’s skills and abilities in pre- and post-test counselling), *and list of organizations and facilities that may provide VCT services.*

VCT Guidelines also provide the *details on counselling aimed at specific groups of clients, such as adolescents and representatives of most-at-risk populations* (including injecting drug users, commercial sex workers and men who have sex with men).

In addition, “Methodological Recommendations for Health Workers on the Provision of HIV Counselling and Testing Services”, developed by the State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases²³ stipulate *testing for HIV infection only upon patient’s conscious and voluntary consent.*

Joint Order of MoH and MoFYS on medical services for children in shelters and centres for social and psychological rehabilitation approved the Scheme of examination of children in social protection institutions and in treatment facilities²⁴. Blood test for HIV infection was included in the list of mandatory examinations for children upon their placement in these institutions. Children are routinely placed in shelters for the period necessary to identify their le-

²² Order of MoH Ukraine No 415 as of August 19, 2005 “On Improvement of Voluntary Counselling and Testing for HIV Infection”.

²³ Methodological Recommendations for Health Workers on the Provision of HIV Counselling and Testing Services / The State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases – Kyiv, 2011.

²⁴ Joint Order of MoFYS and MoH Ukraine No 3297/645 as of September 28, 2006 “On Approval of the Procedure of Health Service Provision to Children in the Shelters for Minors of the Service for Children and in the Centres for Social and Psychological Rehabilitation of Children, and Schemers of Medical Examination of Children in Treatment Facilities”.

gal representatives and to decide on children's future placement (e.g. residential institution, guardianship, foster family, children's home of family type, and so on); the director of the relevant facility represents interests of a child during the term of such placement.

When legal representatives of a child cannot be determined, and the child has not attained 14 years of age, VCT may be carried out upon authorization of child welfare authorities following the request of services for children (Article 65 of the Civil Code of Ukraine: "*Relevant welfare authority shall be responsible for an individual's guardianship and protection prior to establishment of care and guardianship and appointment of formal guardian or caregiver*").

National legislation does not provide practical guidance in cases when a child under 14 years does have legal representatives, but it is impossible to involve them in VCT for various reasons. Yet services for children at government authorities that undertake measures to protect rights, freedoms and legal interests of children and maintain records of children in difficult life circumstances²⁵, may initiate testing of a child for HIV upon reception of a statement from the health facility confirming that such testing is necessary, and that non-testing poses a real threat to a child's health and life.

According to the Guidelines on the provision of health and social services to HIV positive children and Standard Provisions on multidisciplinary team providing health and social assistance to HIV positive children and their families, health workers have the right to carry out additional examination and treatment (if necessary) of an adolescent of 14 years and older without mandatory involvement of his/her parents, and to initiate testing for HIV even when the child's legal representatives object²⁶. It is also envisaged that *in the event of positive result of HIV testing in a child of 14 years and older, the decision on disclosure of information about his/her HIV status to parents or legal representatives shall be made by the patient*. At the same time, *if parents or legal representatives of an adolescent officially request information from a health facility regarding the child's health status, they should be able to receive all necessary data. Such information may not be disclosed by health workers only when it concerns a child of 14 years and older* in cases when it may damage personal interests, health and further treatment of a child. An appropriate decision of the multidisciplinary team shall be duly substantiated and included in the patient's health record.

This regulatory document does not describe specifics of diagnostics.

As for testing for STI, treatment of addictions, application of substitution therapy and ART, current Ukrainian legislation does not provide child-specific norms regarding the age, at which individuals may independently seek such services and procedures. In this case one should be governed by the general regulation – medical interventions for an individual who attained 14 years shall be provided upon his/her consent (Article 284 of the Civil Code of Ukraine). If a child did not reach the age of 14, medical care shall be provided only upon request or consent of the child's guardian²⁷.

²⁵ The Law of Ukraine "On Bodies and Services for Children and Special Child Care Institutions".

²⁶ Joint Order of MoH, MoES, MoFYS, the State Department for Enforcement of Sentences and the MoLSP No 740/1030/4154/321/614a as of November 23, 2007 "On Measures for Organization of Prevention of Mother-to-Child Transmission of HIV, Health Care and Social Follow-up of HIV Positive Children and their Families".

²⁷ Legal and Regulatory Review on the Rights of Children and Young People Living and Working in the Streets; Prevention of Homelessness and Neglect in Ukraine / Tetiana Bordunis – Kyiv: USAID | HIV/AIDS Service Capacity Project in Ukraine. 2011. pg. 50–53.

“I should say, some changes occur in our country almost every day, so most-at-risk adolescents require more focused attention, while our national legislation lags behind. I wish we had some progress in this area” (Expert, health worker, Odessa).

Therefore, adolescents aged 14 years and older may seek medical examination (testing) for HIV infection independently, without request or consent of their legal representatives. At the same time, medical examinations of this kind can be performed upon request or consent of legal representatives of underage children of 14 to 18 years, who also have the right to be present at such procedure.

1.2. Institutions in the System of VCT Service Provision to Adolescents, Including MARA, and Comprehensiveness of Services

“I wish we had well-developed infrastructure for adolescents to enable changes” (Health worker, national consultant, international organization, Kyiv)

According to VCT Guidelines, *only government and municipal health facilities that have adequately equipped laboratories accredited in line with procedures set by the Cabinet of Ministers of Ukraine may carry out medical tests to identify HIV infection and issue official conclusions on HIV test results.* These health facilities can also perform testing in mobile units and outpatient clinics. *In addition to health facilities, VCT services (using rapid tests) can also be provided by non-governmental organizations, including on the basis of mobile units and clinics, and in the centres of social services for family, children and youth*²⁸.

VCT Guidelines define the list of organizations and facilities that may provide VCT services according to established requirements, but VCT remain one of key activity areas of drop-in centres “Dovira” (Trust)²⁹. Additionally these services are available for adolescents in Youth Friendly Clinics³⁰. Moreover, pre- and post-test counselling for HIV is one of basic functions of CSSFCYs within provision of social services covering various aspects of HIV/AIDS prevention³¹.

- **Centres for AIDS Prevention** (hereinafter – AIDS centres). The current network of AIDS centres operates in all oblasts of Ukraine and in the cities of Kyiv and Sevastopol. These health facilities undertake measures aimed at preventing the spread of HIV infection and AIDS in their respective regions or cities; provide a comprehensive set of VCT services; offer specialized medical care to HIV positive individuals and AIDS patients, and cooperate with executive authorities, enterprises, institutions, organizations and citizen associations involved in HIV/AIDS response.

²⁸ Order of MoH Ukraine No 1141 as of December 21, 2010 “On Approving the Procedure of Testing for HIV, Quality Assurance, Forms of Primary Reporting Documentation on HIV Testing and Guidelines for Completing Them”.

²⁹ Order of MoH Ukraine No 102 as of February 25, 2008 “On Functioning of ‘Dovira’ Centres”.

³⁰ Order of MoH Ukraine No 604 as of November 14, 2005 “On the Improvement of Organization of Provision of Medical and Social Assistance to Children and Youth”.

³¹ Joint Order of MoFYS and MoH Ukraine No 1320/13194 as of December 18, 2006 “On Approval of the Procedures of Cooperation of the Centres of Social Services for Family, Children and Youth with Health Facilities on Various Aspects of HIV/AIDS Prevention”.

- **Youth Friendly Clinics** (hereinafter – YFC). According to YFC’s statutory provisions, age limits of YCF clients range from 10 to 24 years. In addition to health services, YFCs offer informational, psychological, social and legal services. Counselling and testing for HIV is a mandatory activity area of the entire YFC network in Ukraine. Staff members of YFCs receive training sufficient for working with adolescents and for providing VCT services. Specialists who completed training courses receive certificates. Primary supervision of VCT process is internal; in some occasions supervision is carried out by the specialists of AIDS centres, representatives of NGOs and international organizations. Every YFC undergoes certification once in three years; provision of VCT services and prevention work with adolescents is also subject to certification. *“Youth friendly clinics, specifically designed for this age category, perform both treatment and prevention functions. Unfortunately, their network is underdeveloped, and not all clinics are accessible for the most vulnerable and socially unprotected categories, such as most-at-risk adolescents and street children”; “Again, currently I do not see any other facilities that would be as fit for providing VCT to adolescents as these clinics”* (Health worker, national expert, international organization, Kyiv). *“I am very happy with these friendly clinics. They have psychologists and they always guarantee anonymity, confidentiality and accessibility”* (Service provider, health worker, Kyiv).
- **Drop-in centres “Dovira”**. Specialists of drop-in centres, including those operating in AIDS centres, offer VCT services to all clients, which may also include adolescents. Counselling is available to all adolescents regardless of age, while testing is only offered to those who turned 14. VCT services in drop-in centres are provided in line with current Ukrainian legislation. *“We have such structure, and it works. We call it “Cabinets of Trust”... There are plenty of such centres throughout the country, but it is too early to praise their absolute availability and accessibility... It is necessary not to just maintain current level of services, but to further develop this activity area... Their function is aimed at health protection – tests for HIV or for hepatitis, even performed with rapid tests in the field, need to be confirmed. Confirmatory tests are made in certified governmental labs. Only a laboratory can confirm testing results in Ukraine. Therefore, it would not be right to simply delegate this function to social services. There should be some kind of intersectoral, interdisciplinary programme. Anyway, I favour Youth Friendly Clinics* (Health worker, national expert, international organization, Kyiv).
- **Children’s polyclinics**. Specialists in adolescent paediatrics work with clients who attained 14 years. Within scope of their work they provide counselling on HIV infection, both during educational visits to schools, and during reception of patients. In addition to information about VCT received in the course of paediatrician’s consultation, adolescents may also learn about VCT and service provision sites from the posters on polyclinic walls. *“We provide consultations to children from the entire regions. However, children routinely come here for consultations with their parents. In other words, this is like planned assistance”* (Health worker, service provider, Odessa).
- **Rayon polyclinics**. Currently these facilities are the most popular venues where people seek medical services. But due to the absence of trained specialists and necessary conditions for HIV testing, staff of the rayon polyclinics usually refers patients to AIDS centres or drop-in centres.

- **STI clinics / dispensaries.** Municipal clinical treatment and prevention facilities – STI dispensaries – may provide VCT services depending on the presence of relevant specialists and testing conditions; in all other cases specialists of STI clinics refer patients to AIDS centres or drop-in centres “Dovira”.
- **Centres of social services for family, children and youth** (hereinafter – CSSFCY). According to the general provisions on CSSFCYs, these are specialized facilities that ensure organization and implementation of social work within a specific community targeting socially disadvantaged and vulnerable categories of families, children and youth in difficult life circumstances and in need of external support³². All CSSFCYs work with adolescents, but their resources in the area of VCT service provision are usually limited despite the fact that VCT Guidelines formally identify CSSFCYs as facilities capable of providing such services.

In addition, the Procedures of cooperation of CSSFCYs with health facilities on various aspects of HIV/AIDS prevention³³ also determine functions of these facilities in ensuring joint implementation of measures in response to HIV/AIDS in Ukraine, while Paragraph 4 also defines pre- and post-test counselling for HIV as one of CSSFCY’s functions. *“The Ministry of Social Policy is also involved, as this is the leading government institution in the area of service provision to this category of children in the context of prevention and social support. If this function is improved with introduction of clearly defined responsibilities, social standards, and relevant procedures of social commissioning of organizations that directly work with these children, then we can expect a breakthrough”* (Health worker, national expert, international organization, Kyiv).

- **Non-governmental HIV service organizations** (hereinafter – NGOs). NGOs working in the area of comprehensive VCT service provision routinely invite health workers from drop-in centres “Dovira”, AIDS centres, YFCs, and from other specialized facilities. As a rule, NGO staff provides referrals and follow-up of clients to VCT sites; in addition, NGOs are actively involved in the functioning of mobile outpatient clinics and in outreach work.
- **Departments of health** (hereinafter – DH). According to Provisions on the departments of health, DH are local executive bodies that ensure implementation of the government’s health policy, and also responsible for the overall state and development of the public health sector. Professionals responsible for paediatrics, maternity and child welfare at the oblast or city level are quite distant from the processes of VCT provision. Oblasts do have a number of mobile outpatient clinics that offer broad range of services, including counselling and testing for HIV infection.

In summary, currently in Ukraine there exists a quite developed network of institutions, facilities and organizations that coordinate and ensure provision of VCT services to different categories of the population.

³² Resolution of the Cabinet of Ministers of Ukraine No 1126 as of August 27, 2004 “On Measures for Improving Social Work with Families, Children and Youth”.

³³ Joint Order of MoFYS and MoH Ukraine No 3925/760 as of November 17, 2006 “On Approval of the Procedures of Cooperation of the Centres of Social Services for Family, Children and Youth with Health Facilities on Various Aspects of HIV/AIDS Prevention”.

Therefore, Ukrainian legislation establishes legal norms that enable adolescents who attained 14 years of age to independently seek and receive VCT services. In order to ensure provision of full-fledged diagnostics and testing for HIV to adolescents, it is necessary to set up appropriate conditions, where VCT services may be provided in any settings, and where consultations on HIV infection and AIDS may and should occur both inside and outside health facilities of different forms of ownership. VCT Guidelines establish that only government and municipal health facilities that have adequately equipped laboratories may carry out medical tests to identify HIV infection, and issue official certificates on HIV test results.

Findings of this study confirm that the problem of accessibility of health and social services – and VCT in particular – for children and young people at risk for HIV remains urgent. The following sections analyse access of target group representatives to these services.

II. RISK BEHAVIOURS FOR HIV INFECTION

“Can you imagine adolescent IDUs, adolescent FSWs, adolescent MSM separately? There exists this age-specific peculiarity that requires a very delicate approach. Another peculiarity is “MARA” itself. Therefore, a specialist just combines these two notions, and that’s it”. (Service provider, health worker, Kyiv)

It is known that adolescent’s vulnerability to HIV infection is usually defined by specific life circumstances, whereas his/her belonging to the most-at-risk population is determined by the presence of particular risky behaviours, such as injecting drug use; unprotected sex, including cases of sexual exploitation and human trafficking where victims have unprotected (often forced) transactional sex; unprotected anal sex of boys with men, including for reward.

For example, two thirds of adolescents reached by the survey (65.3%) in the age group under 19 years **have ever had sexual contacts** (N = 622): 14.4% of those aged 13 years, 49.8% of adolescents aged 14–15 years, and 68.0% of those who are 16 to 17 years. These proportions continue to increase with age, reaching 85.1% among adolescents aged 18–19 years, and 90.8% – among those who are 20–24 years (Diagram 2).

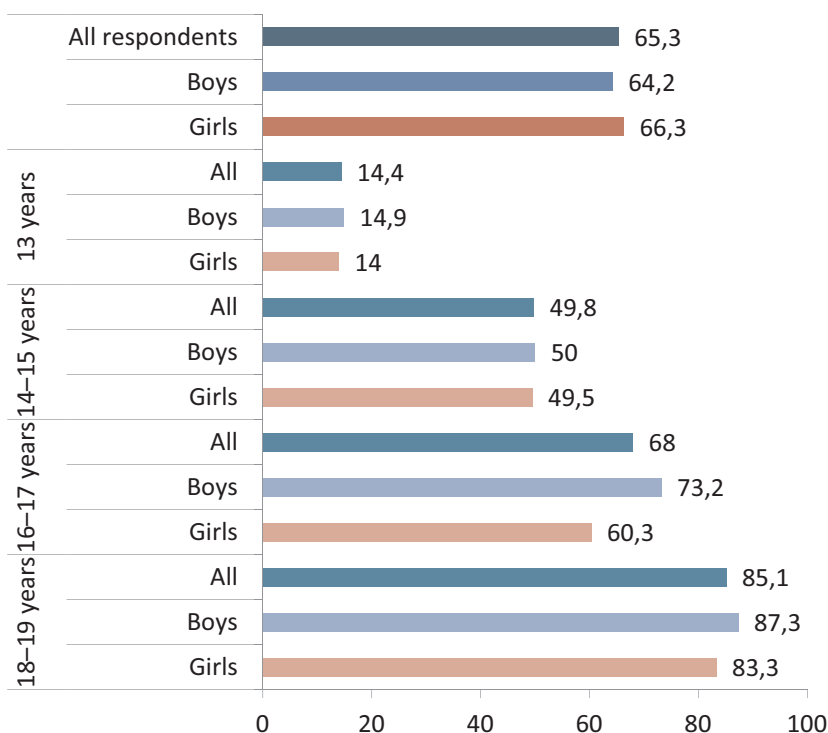


Diagram 2. Experience of sexual contacts among respondents under 19 years, by gender and age, %

One of the particularly risky behavioural practices is *unprotected sex*. Almost half of all surveyed adolescents and young people (43.7%) have ever had sex without condoms with persons of opposite gender, the proportion of such respondents among girls is significantly higher than among boys (50.2% and 37.1% correspondingly), including: 8.8% – among those aged 13 years; 28.5% – among adolescents of 14–15 years, and 40.8% in the age group of 16–17 years. With age these rates grow further to 61.8% among adolescents aged 18–19 years, and to 70.6% – among respondents of 20–24 years (Table 2.1).

Table 2.1

**High risk behaviours for HIV/AIDS among children and youth,
by gender, age and wave of the study, %**

Have experience of...	All respondents	Waves		By gender		By age, years				
		1 st	2 nd	M	F	13	14–15	16–17	18–19	20–24
Sexual contacts	65.3	76.6	55.0	64.2	66.3	14.4	49.8	68.0	85.1	90.8
Unprotected sex with a person of opposite gender	43.7	46.4	31.9	37.1	50.2	8.8	28.5	40.8	61.8	70.6
Injecting drug use ³⁴	15.2	14.9	15.4	17.6	12.8	31.6	20.9	10.4	22.0	10.2
Unprotected sex between men (for male respondents)	9.9	9.3	0.7	9.9	–	14.3	7.6	4.5	8.5	28.0
Providing sex services for reward	4.3	6.2	1.5	3.1	5.5	1.1	4.5	3.9	5.7	5.4
Paying for sex services	1.0	0.9	0.9	2.1	0	0	0.4	1.6	1.6	1.0
Unprotected sex with a person who is HIV positive	0.7	1.1	0.2	0.6	0.8	0	0	0.3	0	2.9

Almost half of respondents (42.2%, N=261) had one partner in the last 12 months prior to the survey. The proportion of those who had *six and more sexual partners* is 10.4% (14.2% of boys and 6.6% of girls).

According to the online survey data, each tenth boy (9.9%) practiced unprotected sex with other boy/man: 14.3% – among boys under 13 years; 7.6% of boys aged 14–15 years; 4.5% of boys of 16–17 years; 8.5% of boys aged 18–19 years, and 28.0% – among males of 20 to 24 years of age.

4.3% of all respondents – including 5.5% of girls and 3.1% of boys – provided sex services for money or reward (food, clothes, housing, alcohol, drugs, and the like). These rates for adolescent boys and girls are quite high: 1.1% among those aged 13 years; 4.5% of adolescents of 14–15 years, and 3.9% of adolescents aged 16–17. For older adolescents (age groups of 18–19 and 20–24 years) these rates make up 5.7% and 5.4% correspondingly.

³⁴ The sum of respondents' answers "yes, several times", "yes, many times", "I don't want to answer".

In some cases respondents reported paying for sex services (2.1% of boys), while 0.7% of surveyed adolescents had unprotected sex with HIV-positive individuals (1.1% of boys and 0.2% of girls).

Therefore, sizable proportions of surveyed children and young people identify the most common risk practices as unprotected sexual contacts (the highest rate among all categories of MARA – see Table 2.1), and **injecting drug use**: 7.2% of respondents (N=68) confirmed injection of drugs on several or multiple occasions (8.5% of boys and 5.9% of girls). 8% (N=76) refused to answer (9.1% of boys and 6.9% of girls), and this gives grounds for including them in the risk group. According to the survey findings, cumulative indicator of adolescents with the experience of injecting drug use reaches 15.2%.

The highest rates of attempt of injecting drug use is observed among the youngest age categories of adolescents: 31.6% among those aged 13 years, and 20.9% among adolescents of 14–15 years of age.

Integrated indicator for those at risk for HIV exposure (instances of unprotected sex and/or injecting drug use, sexual contacts with more than 6 partners, unprotected sex between males, and provision of sex services for money or reward)³⁵ is 15.9% (N=154). This rate is somewhat higher among the boys as compared to the girls (18% and 13.7% correspondingly). Risk indicator is above average in the cohort of those aged 14–15 years (Diagram 3). Speaking about adolescents in the risk group (N=154), 31.5% live in union (unofficial); 18% are officially married, and 14.3% are unmarried. 20% of at risk adolescents live in oblast centres, 12.9% – in big cities, 17.9% live in towns, and 11% are residents of townships.

Almost quarter of adolescents at risk for HIV infection (22.3%) have no parents or live separately from the family. The majority of these adolescents reside in settings that are ill-fitted for living: 40% spend most of their time on the streets and sleep in lofts or basements; 66% have no definite place of residence; others live in dormitories (23.2%), shelters (18.1%), or boarding schools (12.5%). 15.4% of MARA boys and girls live in a house or apartment (own, rented, parents' or partners' housing).

60.5% of most-at-risk adolescents currently neither work, nor study.

Violence. In addition, 5.7% of adolescents identify themselves as victims of sexual violence, 9.6% – of physical violence (Table 2.2). Each seventh respondent (14.4%) suffered from psychological violence; 8.3% of adolescents faced physical violence on the part of peers, while 7.7% suffered from sexual, and 6.9% – from domestic violence.

Boys were more likely to encounter physical violence on the part of peers – this is particularly true for respondents of older age, where the proportion of male victims of violence is two times larger than that among girls (16.7% and 7.2% correspondingly among those aged 18–19 years, and 10.3% and 5.8% among young people of 20 to 24 years of age). The number of victims of psychological violence increases with age, both among the boys and the girls.

³⁵ It is calculated on the basis of answers to the following questions: “How many sexual partners did you have in the past 12 months?” (answer “more than 6 partners”), or “Did you ever practice the following – unprotected sex between males” (answer “yes”), or “Did you ever practice the following – providing sex services in exchange for money or reward (food, clothes, housing, alcohol, drugs)?” (answer “yes”), or “Have you ever injected drugs (with syringe)?” (answers “yes, several times”, and “yes, many times”), or “Why did you decide to take test for HIV?” (answer “because I had unprotected sex and / or injected drugs”).

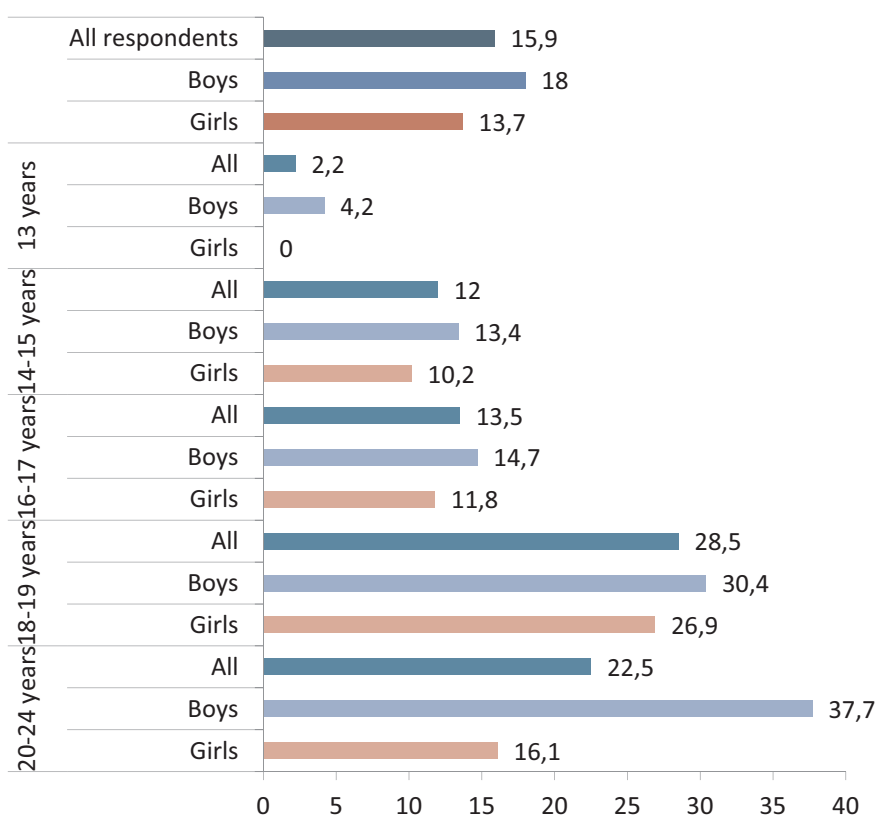


Diagram 3. Integrated indicator of risk for HIV infection (cases of unprotected sex and/or injecting drug use; sexual contacts with more than 6 partners; unprotected sex between males; provision of sex services for money or reward), by gender and age, %

Table 2.2

Adolescent and young victims of violence, by gender and age, %

Types of violence	All adolescents	By gender		By age									
		M	F	13 years		14-15 years		16-17 years		18-19 years		20-24 years	
				M	F	M	F	M	F	M	F	M	F
Domestic	11.5	9.3	13.6	27.7	23.3	10.6	19.0	3.3	12.7	14.8	13.8	5.2	7.2
Psychological	10.1	7.6	12.6	6.4	9.3	5.3	9.5	5.5	9.5	11.1	10.8	17.2	19.6
Peer physical	9.6	10.8	8.4	17.0	16.3	12.1	13.3	6.6	4.8	16.7	7.2	10.3	5.8
Sexual	5.7	3.6	7.8	4.3	2.3	3.0	8.6	3.3	7.1	1.9	7.7	6.9	9.4

The proportion of respondents who fell victim to domestic violence is relatively higher among adolescents aged 14-15 (10.6% of boys and 19.0% of girls), and adolescents of 18-19 years (14.8% of boys and 13.8% of girls). The number of female victims of domestic violence in the age group of 16-17 years (12.7%) exceeds that among boys (3.3%) by almost 4 times.

Practical experience of experts, who participated in interviews and focus groups, confirms that adolescents with risky behavioural practices are the most problematic category. In addition, almost all experts characterize these populations as hidden and hard-to-reach: "...if we speak about hidden groups, then these are boys who provide sex services to men. They are extremely hard to reach" (Service provider, manager of NGO projects, Odessa). Such hiddenness of

MARA leads to untimely and delayed provision of assistance, including medical care: *“As a rule, these are children with STIs. And they seek assistance only when they feel really bad. If they feel alright, they would never come. FSWs may visit us during raids. When they learn about their status, they come. MSM is the most “closed” group. Some of them do come for testing: they are reserved, but they are more disciplined. What I mean is that they come over whenever they have a problem and try to deal with it. Their attitude is more adequate”* (VCT service provider, Odessa).

Experts noted that in places, characterized by ongoing work with target groups, systemic involvement of outreach teams and regular communication with adolescents MARA boys and girls are much more open to contacts with the specialists: *“...it is much easier to contact them”*.

Experts also point to the increasing size of most-at-risk populations, especially MSM: *“The number of MSM has increased in the last 5 years. I work with them for as long as I am involved in VCT service provision, which is about 10 years. I would say that their number increased by 10”* (VCT counsellor, AIDS centre, Kyiv). But it was not possible to analyse trends of increasing numbers of boys-MSM during the specific period within the framework of this study. It may become an objective of one of the future surveys.

A child in any setting may enter the target group, and such occurrences are not uncommon. Above all, this concerns adolescents in different communities with different forms of communication or education, or adolescents in organized groups, where a child may start practicing risky behaviours (in particular, experts mentioned vocational and technical schools, boarding schools and shelters). *“You may also include kids that study in VTS, that is, organized groups ...”*; *“we should pay special attention to VTS students, as many of them are MARA – these are former inmates of boarding schools, orphans, children from single-parent families and children of alcohol and drug-using parents, children with disabilities, but they are still ready to perceive information and to respond to it. It would be good if VCT service network was available to them at their own territory”* (Health worker, national expert, Kyiv); *“Children from single-parent families, children in boarding schools... This is rather large group. Many of these adolescents can be counted as MARA”* (Service provider, psychologist, Kyiv).

Second, some children who run away from home may also easily enter the risk group, and this also concerns kids from successful, well-to-do families: *“Any child may enter this category, even a child from positive, non-needy family...”*; *“these may include children even from wealthy families. But eventually this wealth can lead to opposite results... even if an adolescent comes from a well-to-do family, but he uses drugs or has alcohol addiction or practices uncontrolled sexual behavior, it is obvious that he belongs to the risk group”* (National expert, consultant, international organization, Kyiv).

Analysis of survey data and experts’ practical experience shows that behavioural practices that increase the risk of HIV infection for children and young people include injecting drug use, unprotected sexual contacts and unprotected anal sex of boys with men.

This points to the need to intensify work with the target population, aimed at developing skills of healthy lifestyles and accepting greater responsibility for one’s own health among adolescents. The first step in this area may be strengthening of relevant activities and introducing new forms of work to increase awareness of children and youth regarding HIV/AIDS.

III. KNOWLEDGE OF ADOLESCENTS AND YOUTH ABOUT HIV ISSUES

“For one thing, every time an adolescent comes over to seek any medical assistance, I always ask probing questions to find out what he knows about HIV and ways of its transmission, while trying to address his immediate problem. This is how I start my “interrogation”. And if the kid is receptive, I can always suggest something. And I am always ready to answer any of his questions in this regard”
(Service provider, health worker, Kyiv)

The survey findings reveal relatively low awareness about HIV infection and AIDS and ways of its transmission among children and youth.

The respondents who answered the question about ways of HIV transmission (N=449) have correctly identified sexual contacts without condom use (91.1%), sharing of syringes during injecting drug use (88.6%), and transmission from HIV positive mother to her child (72.4%) as the main ways of HIV transmission.

At the same time, there exist significant gaps in adolescents’ knowledge about ways of HIV transmission, In particular, each third (33.9%) adolescent is not sure whether HIV positive person may look healthy; each fourth (23.8%) is not sure or disagrees with the statement that the only way to find out one’s HIV status is to take HIV testing; almost half of respondents (43.6%) do not know that sexual partners’ testing results may be the same or different.

Girls are generally better informed about HIV issues than boys. Moreover, respondents under 19 years of age – and particularly the youngest adolescents – have generally lower levels of knowledge regarding all statements.

Generally speaking, the majority of adolescents perceive HIV infection as a disease that can be transmitted in any possible way (Table 3.1).

Table 3.2 presents distribution of the same respondents’ statements depending on their residence (living conditions), education and employment. One can observe relatively high levels of knowledge about ways of HIV transmission among most-at-risk adolescents, but at the same time significant percentage of MARA are not certain whether the only way to learn about the person’s HIV status is to take HIV testing (21.1%), whether a healthy-looking person can have HIV (29.9%), and whether testing results of sexual partners may be the same or different (44.9%).

Table 3.1

**The level of knowledge about ways of HIV transmission,
by gender, age and wave of the study, %**

	All respondents	Waves		By gender		By age				
		1st	2nd	Boys	Girls	13 years	14–15 years	16–17 years	18–19 years	20–24 years
HIV can be transmitted through...³⁶										
Unprotected sexual contact	91.1	93.8	88.7	90.9	91.4	70.3	88.8	95.2	91.9	96.6
Shared use of syringes during the use of injecting drugs	88.6	89.0	88.1	85.9	91.2	79.1	86.8	90.2	96.9	88.6
From HIV positive mother to her baby	72.4	80.4	65.0	65.8	78.9	45.1	65.3	72.0	79.7	89.2
HIV CANNOT be transmitted through...³⁷										
Handshake	97.4	97.4	97.4	97.3	97.5	90.1	98.8	96.5	99.2	99.5
Sharing food with someone who is infected	93.4	94.4	92.5	93.2	93.6	79.1	92.1	94.9	95.9	97.5
Drinking from one glass in turns with someone who is infected	88.7	90.5	87.0	87.6	89.8	68.1	87.2	90.7	95.1	92.6
Sharing toilet, swimming pool and the like with someone who is infected	86.9	92.3	82.0	85.3	88.5	61.5	83.5	89.7	91.1	95.6
Mosquito bites	85.8	87.7	84.0	83.9	87.7	71.4	87.2	83.3	87.8	93.1
Unaware that testing results of sexual partners can be the same and different	43.6	31.4	54.8	48.6	38.7	61.1	53.2	46.3	37.2	24.1
Not sure that a healthy-looking person can have HIV	37.7	24.1	42.8	37.7	30.1	70.0	46.0	30.1	25.6	14.1
Not sure or reject the statement that the only way to find out one's HIV status is to take HIV testing	23.9	17.1	30.0	27.4	20.4	48.9	28.7	25.2	15.7	9.5

An indicator “Percentage of young people who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV”³⁸ is presented in Diagram 4.

³⁶ Correct answers.

³⁷ Correct answers.

³⁸ Percentage of respondents who provided correct answers to the following questions: the main way of preventing HIV infection is to remain faithful to one sexual partner (*Can the risk of getting HIV be reduced by having sex with only one uninfected partner who has no other partners?*); the main way of preventing HIV infection is to consistently use condoms (*Can the risk of getting HIV be re-*

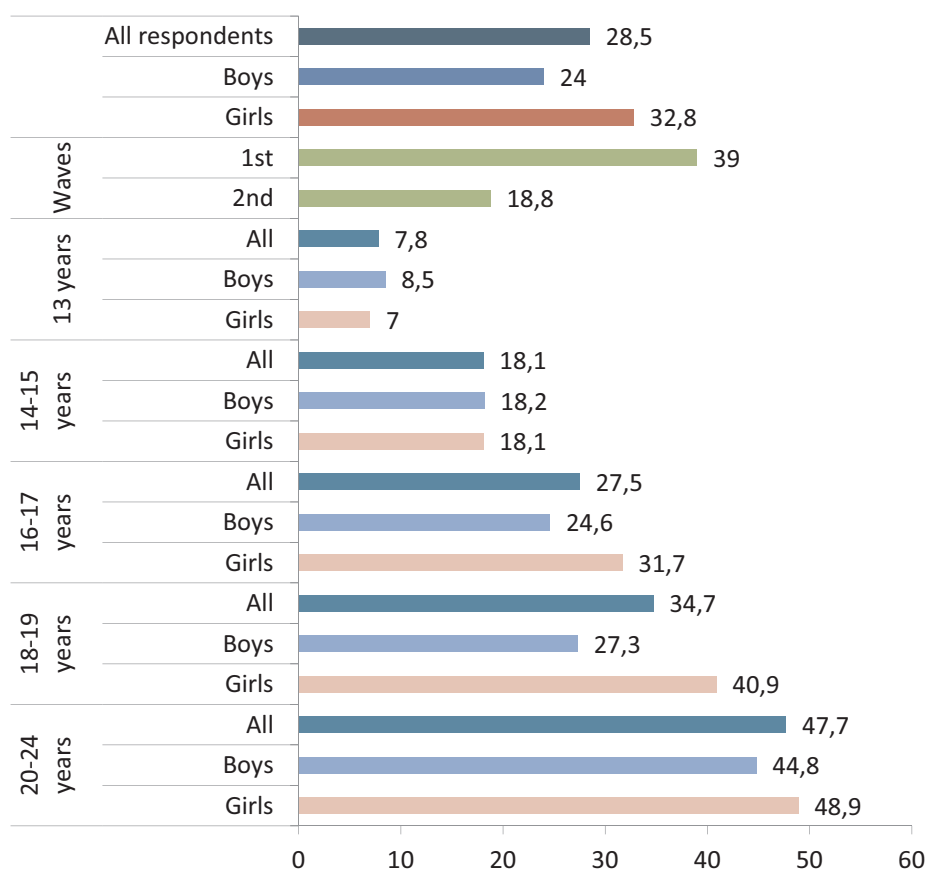


Diagram 4. Percentage of young people who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV, by gender, age, and wave of the study, %

The best knowledge of the modes of HIV transmission and the ways of preventing sexual transmission of HIV is shown by older respondents: almost one-third of those aged 16–17 years (27.5%) and 18–19 years (34.7%), and almost half of young adults of 20 to 24 years of age (47.7%). Overall, girls demonstrate better awareness in these issues than boys – 32.8% and 24.0% correspondingly.

Experts also point at the limited knowledge and awareness of adolescents (especially MARA and teenagers living in rural areas) about HIV and ways of its transmission. As a result, they are unable to adequately assess risks, associated with their own behaviour. Second, experts are concerned by the fact that despite almost universal access to relevant information and the use of a variety of public information and education methods, the level of adolescents’ knowledge about HIV remains low: “Today we have no problems regarding access to information” (service provider, social worker, NGO, Kyiv); “The main (problem) is information as you have to communicate it. You start asking “Do you know what HIV is?” – “Yes”. But when you get into details, they either know nothing or have some absolutely wrong information” (service provider, psychologist, Odessa); “Of course, those who belong to risk groups, I think, find it rather difficult to access information. But in general, speaking about HIV, no other topic has such plentiful informational support” (service provider, specialist in adolescent paediatrics, Kyiv).

duced by using a condom every time they have sex?), Can a healthy-looking person be HIV infected?; Can a person get HIV by drinking from one glass in turns with someone who is infected?; Can a person get HIV by sharing a toilet, pool, sauna with someone who is infected?

Table 3.2

**The level of knowledge about ways of HIV transmission,
by belonging to at risk groups, experience of HIV testing,
residence (living conditions), education and employment, %**

	Risk group ³⁹ (15,9%, N=154,)	Experience of HIV testing in the past 12 months (13%, N=126)	Residence (living conditions)					Live separately from parents (36,9%, N=358)	Education and employment			
			Apartment	Dormitory	Boarding school	Shelter	On the streets		Study, do not work	Study and work	Do not study, work	Neither study nor work
HIV can be transmitted through...												
Unprotected sexual contact	16.1	100	94.8	93.0	79.4	100.0	40.0	88.5	90.2	96.3	92.5	76.3
Shared use of syringes during the use of injecting drugs	15.5	96.8	89.2	90.7	86.9	81.8	40.0	91.9	87.6	91.6	94.4	73.7
From HIV positive mother to her baby	15.2	91.3	79.2	69.8	52.8	63.6	40.0	67.0	68.8	82.7	86.0	42.1
HIV CANNOT be transmitted through⁴⁰ ...												
Handshake	13.7	100	98.5	97.7	95.0	81.8	80.0	96.4	97.8	96.3	98.1	94.7
Sharing food with someone who is infected	14.0	98.4	95.7	91.9	88.4	63.6	100.0	91.6	92.8	95.3	93.5	94.7
Drinking from one glass in turns with someone who is infected	14.7	93.7	91.8	88.4	80.9	54.5	80.0	86.3	87.4	88.5	95.3	92.1
Sharing toilet, swimming pool and the like with someone who is infected	14.5	98.4	92.8	81.4	69.8	81.8	100.0	77.7	85.0	92.1	89.7	84.2
Mosquito bites	14.6	88.1	88.9	81.4	78.4	63.6	100.0	81.8	83.8	89.5	91.6	84.2
Not sure or reject the statement that the only way to find out one's HIV status is to take HIV testing	12.7	6.3	17.8	37.6	35.0	54.5	50.0	28.0	26.7	18.0	15.2	29.7
Unaware or not sure that a healthy-looking person can have HIV	14.0	15.9	24.8	35.3	61.4	54.5	50.0	42.7	39.4	20.1	17.1	59.5
Unaware that testing results of sexual partners can be the same and different	16.7	38.9	41.2	29.4	58.9	27.3	75.0	41.2	48.0	34.9	26.7	62.2

³⁹ Integrated indicator calculated on the basis of answers to the following questions: "How many sexual partners did you have in the past 12 months?" (answer "more than 6 partners"), or "Did you ever practice the following – unprotected sex between males" (answer "yes"), or "Did you ever practice the following – providing sex services in exchange for money or reward (food, clothes, housing, alcohol, drugs)?" (answer "yes"), or "Have you ever injected drugs (with syringe)?" (answers "yes, several times", and "yes, many times"), or "Why did you decide to take test for HIV?" (answer "because I had unprotected sex and / or injected drugs").

⁴⁰ Correct answers.

Analysis of research data reveals inadequate knowledge of children and young people about HIV. This raises the question of the need to carry out additional analysis of the effectiveness of current public information and education activities on HIV/AIDS for children and youth, to introduce new approaches to prevention, and to develop relevant recommendations for improving performance in this activity area.

IV. EXPERIENCE OF HIV TESTING

“Unfortunately only a few facilities accept them as it should be; in other words, “accessibility” of health system is quite limited”. (Health worker, national expert, Kyiv)

Findings of the first wave of the study (N=465) showed that 32.3% of respondents have the experience of testing for HIV. Research team, medical and social workers challenged these findings and developed the separate database for the second wave of the online survey. Meetings with youth representatives were arranged for understanding the reasons behind the significant indicator of testing for HIV. Results of the meetings show that adolescents and young people often do not differentiate between testing on HIV and other blood testing; therefore they confuse this experience and give wrong answers. Based on the above the research team has developed a separate methodology comment on the pre-survey conversation with respondents on HIV testing and its results (positive and negative status) (see Chapter IX).

Finding of the second wave of the study (N=506) show that 10.3% of adolescents and young people have experience of testing for HIV. This indicator is recommended for further quotations.⁴¹

Adolescents of older age groups generally have more extensive experience of HIV testing, e.g. almost every second respondent aged 20–24 and 18–19 (45.5% and 45.9% correspondingly). The distribution among *younger age groups* is as follows: 2.8% among those aged 13 years; 2.9% among children of 14–15 years old, and 10.5% among those aged 16–17 years. (Diagram 5).

As adolescents put it, very insignificant proportion of their peers have experience of HIV testing (Diagram 5); survey findings reveal clear tendency where the number of adolescents undergoing HIV testing increases with age. According to the online survey data, the proportion of girls who received HIV testing is almost twice as high as that of boys. Experts confirm almost double dominance of girls above boys among their clients as the former are afraid of becoming pregnant and understand their greater risk of getting STI.

Findings of the second wave of the survey show that not even each third MARA (29.8%) – that is, adolescents who practice unprotected sex and/or inject drugs, or have sexual contacts with more than 6 partners, or have unprotected sex between men, or exchange sex for money or rewards – underwent testing for HIV. The majority of most-at-risk adolescents (53.3%) – *did not receive testing for HIV* (or do not remember or don't know about that).

⁴¹ Results of the third Multiple Indicators Cluster Survey (MICS) (2012–2013), conducted by UNICEF jointly with the State Statistics Service of Ukraine, supported by the United States Agency for International Development (USAID) and Swiss Agency for Development and Cooperation (SDC) show that 17.4% of girls and 18.4% of boys aged 15–19 underwent testing for HIV, 7.1% of girls and 10.7% of boys from the same age group underwent testing during the last 12 months, 6.9% of girls and 9.9% of boys underwent testing during the last 12 months and received the result (733 girls and 357 boys aged 15–19 were surveyed). – Preliminary data was presented at the Round Table on the 25th of July 2013. – <http://www.idss.org.ua/stil.html>.

The proportion of respondents who *do not belong to risk groups*, but who reported being tested for HIV is 8.2%.

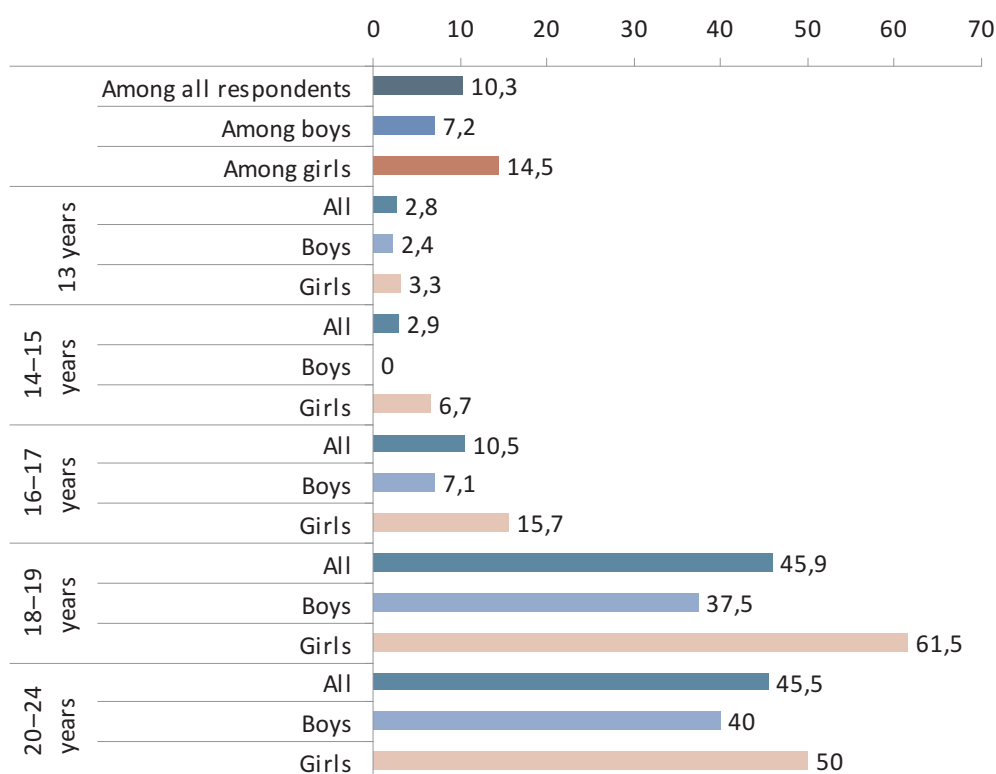


Diagram 5. Lifetime experience of HIV testing, by gender and age, % (second wave of the study)

The most widespread types of testing (N=191) are blood sampling from veins with a syringe (48.2% of respondents were tested this way during their most recent test), and rapid test (44%). The latter is more commonly used by non-governmental organizations that operate mobile outpatient units.

74.5% of adolescents with the lifetime experience of HIV testing (N=51) had their test less than one year ago; nearly each fifth respondent (19.6%) had his/her test for HIV 1 to 3 years ago, and 5.9% had themselves tested for HIV more than 3 years ago.

Diagram 6 presents the distribution of respondents' answers regarding HIV testing in the past 12 months (among respondents of the second wave of the study).

As for the age specifics, older adolescents are more likely to receive testing for HIV during the period under study: 35.9% of those aged 18–19 years (32.0% of boys and 42.8% of girls), and 36.3% of young adults of 20–24 years (40.0% of boys and 33.3% of girls) had themselves tested in the past year. Moreover, average proportion of girls who got tested is twice as high as that of boys –10.0% and 5.75% correspondingly, which may be evidence of girls being more attentive to their health and may result from the current tendency in testing. The lowest prevalence of HIV tests is observed among younger adolescents: 0% among those aged 13 years, and 2.3% – among adolescents of 14–15 years of age and 7.5% – among those aged 16–17 years. Focus group participants confirmed the fact of such weak seeking of VCT services: “Younger

generations still do not understand... they are yet to realize the importance of this issue” (Adolescents, focus group participants, Kyiv).

In general, 26.3% of most-at-risk adolescents got tested for HIV in the past 12 months.

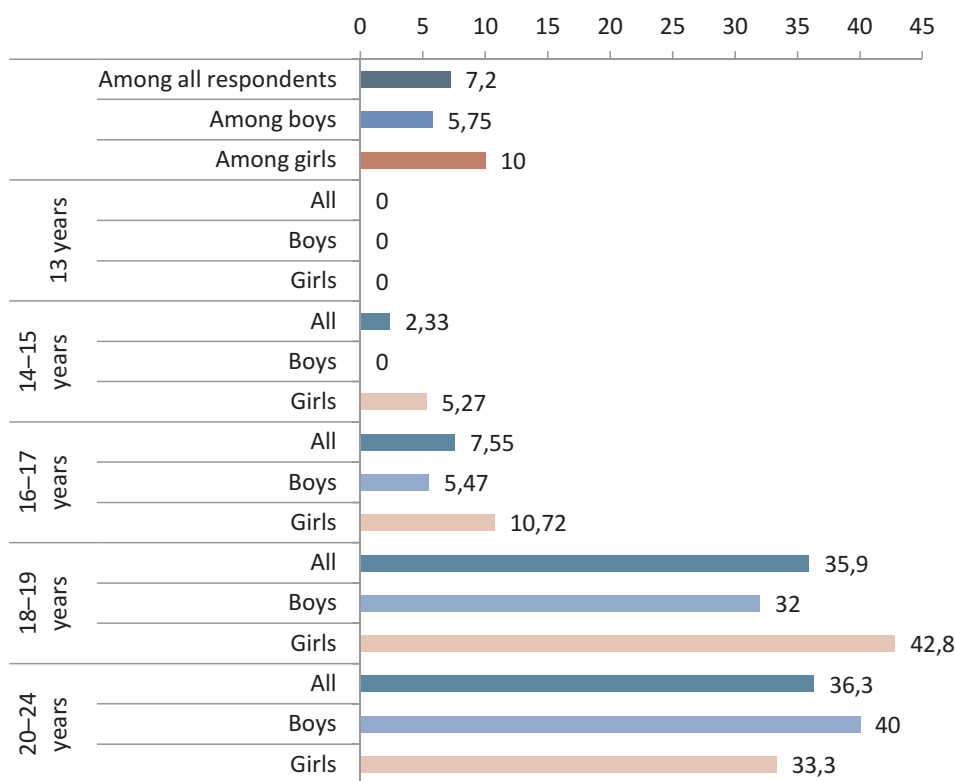


Diagram 6. Experience of HIV testing in the past 12 months (among all respondents), by gender, and age, % (second wave of the study)

For the majority of respondents, the most recent testing for HIV was the only VCT experience in their lives (while answering the question “How often did you take testing for HIV before the most recent test”, 66.7% of respondents answered “Never”); each fifth adolescent (21.6%) had only one test before this one, while 3.9% of respondents undergo HIV testing annually.

According to interviewed experts, despite declaring the existence of the broad network of facilities and organizations that offer VCT services in Ukraine, there are many issues pertaining provision of these services:

- Speaking about Youth Friendly Clinics, only half of YFCs have their own medical procedure rooms and relevant specialists which enables provision of VCT services in comprehensive manner; 10% of YFCs have neither procedure rooms nor specialists (representative of one of such YFCs participated in the study). About 40% of YFCs use procedure rooms of host facilities. In this case the majority of adolescents are personally accompanied to the procedure room to receive testing for HIV following the pre-test counselling. YFCs refer their clients to AIDS centres with which they maintain contractual relations. Therefore, VCT service provision is “interrupted”.
- Two respondents from drop-in centres admitted that if an adolescent under 14 years was the client of a CSSFCY or an NGO and came over in the company of a social work-

er, then such adolescent would receive full package of VCT services without going deep in the maze of legal formalities or determining whether accompanying social worker had a status of an adolescent's legal representative. It should be noted that all drop-in centres "Dovira" participating in the study provide comprehensive VCT services (offer both counselling and testing). Testing is performed with rapid tests, or a client has his/her blood sample taken to confirm the results of rapid test or to issue a certificate about the client's HIV status. This saves a significant amount of time as a client can receive the full package of VCT services during one visit.

- Quite widespread is the practice of VCT provision to adolescents in residential facilities, shelters and reception centres on the basis of agreements with these institutions. In this case adolescents come for VCT services accompanied by the representative of such facility.
- Specialists in adolescent paediatrics (2 of 3 paediatricians) refer their clients to YFC or to the drop-in centre to receive VCT services. In two polyclinics (1 among surveyed experts and 1 – among focus group participants) paediatricians offer such services themselves, and testing for HIV occurs in the same facility. One paediatrician reported that their polyclinic previously provided VCT services, but after recent funding cuts they stopped procuring test kits. In cases of referral paediatricians always try to find out whether an adolescent eventually came to receive the service. One of specialists noted that upon referral only about 20% of adolescents show up to receive VCT.
- 2 of 3 surveyed experts confirmed the existence of inadequate coordination with other structures, particularly with the social service: *they do not know anyone who to contact if adolescent's social problems, revealed during consultation, cannot be addressed by a doctor.*
- VCT of adolescents in residential facilities (e.g. in boarding schools) or in institutions of temporary placement (shelters, centres for social and psychological rehabilitation, reception centres) is initiated by the director of such institution, usually with a counsellor's visit on site.

Therefore, only about ten per cent of surveyed adolescents and young people have the experience of HIV testing. Experts explain this fact by a number of issues, including the lack of "one-stop shop" approach (incoherence) in VCT service provision; inability to provide services in a comprehensive manner in a single facility; and underdevelopment of the system of referrals. This creates a number of additional barriers to VCT services for children and youth (see Section VI for more detail), and further fails to motivate adolescents to get tested for HIV and restricts conditions for making these services more accessible.

V. OBSERVANCE OF PRINCIPLES AND CONDITIONS OF VCT

“Absolute accessibility means an opportunity for anyone in any location of the country regardless of administrative unit – be it big city or small village – to have his or her blood tested and to receive high quality consultation on free-of-charge and anonymous basis. Unfortunately, this is not the case in our country yet. It is possible in large municipalities with functioning AIDS centres. But the farther we move away from the centre, the poorer is the quality of such services”. (Health worker, national expert, international organization, Kyiv).

Analysis of adolescent and young people survey findings reveals quite important problems. According to information, collected among adolescents, a relatively large proportion of specialists fail to observe established principles and conditions of VCT service provision (see Table 5.1).

“Our principles of work are friendliness, trust and accessibility. Well, also anonymity and non-judgmental attitude as well” (VCT service provider, Kyiv).

Table 5.1

Observance of principles and conditions of VCT, by age, %

	All respondents	By age				
		13 years	14–15 years	16–17 years	18–19 years	20–24 years
Testing WAS NOT anonymous	33.5	33.3	31.3	15.4	4.5	36.8
NO pre-test counselling provided	30.4	20.0	33.3	23.5	30.8	32.6
NO post-test counselling provided	27.3	0	0	0	0	30.0
DID NOT inform about the right to refuse from testing	22.5	33.3	25.0	7.7	9.1	27.6
DID NOT ask about adolescent’s age	17.3	0	9.5	8.1	25.0	20.4
Testing WAS NOT free of charge	17.3	0	12.5	7.7	18.2	21.8
DID NOT ask permission to perform testing	16.8	33.3	18.8	7.7	9.1	19.5
Adolescents had to conceal their real age	8.2	0	18.8	6.7	13.0	1.1
Adolescents were ordered to present parental permission to undergo testing	9.2	0	18.8	0	17.4	1.1
DID NOT receive testing results	6.3	0	18.8	7.7	4.5	5.7

Responses demonstrate that the most widespread examples of violations of VCT principles and conditions are: failure to provide pre-test (30.4%) and post-test (27.3%) counselling; vi-

olation of the right to anonymity (33.5%); non-provision of information on the right to refuse testing (22.5%); failure to specify the age of the service recipient (17.3%); fee-based service provision (17.3%); adolescents were not asked for permission to perform testing (16.8%).

At the same time, 6.3% of respondents (usually adolescents aged 14 years and older) noted that they did not receive testing results and 8.2% had to conceal their real age. 9.2% of adolescents of 14 years and older were ordered to present parental permission to undergo testing.

These and other issues of observing principles and conditions of VCT provision to adolescents are described below.

5.1. Adolescent's Age

“The main achievement during these years is an opportunity to register children over 14 years without guardians and parents. In other words, a child who turned 14 or an adolescent under 19 years of age has the right to come over to the drop-in centre, to receive counselling, to have his blood collected and tested, and to receive the result”.
(National expert, Kyiv)

As it was noted, current Ukrainian legislation grants adolescents aged 14 years and older the right to receive VCT services independently (without involvement of their parents or legal representatives) and even anonymously. However, inconsistencies between the basic Law and the current VCT Protocol on the provision of services to minors under 18 years in practice cause a number of contradictions.

Table 5.1 above shows that in the majority of cases specialists do not specify adolescent's age in the provision of VCT services: about half of surveyed adolescents (54.1%) were asked about their age, while 17.3% were not. In other words, no one was interested in adolescent's age in almost quarter of cases. Similar ratios are found among adolescents above 14 years, who, according to the survey data, are more likely to seek VCT services. We believe that there may be two reasons for clarifying the age of a service recipient: first of all, sometimes MARA boys and girls lag behind other peers in their physical development, therefore a specialist has to clarify the adolescent's age before services are provided. And second, despite the legal norm that allows testing of children of 14 years and older without consent of their parents or legal representatives, health facilities may have internal guidelines (directives or orders of chief physician that need to be followed by specialists in their work), which only allow independent HIV testing to individuals who attained 18 years of age (according to reports of the focus group participants, Kyiv).

8.2% of surveyed adolescents gave positive answer to the question “Did you have to conceal your age?” At the same time we should note that the highest rates of “age concealment” are observed among age categories of 14–15 (18.8%) and 18–19 (13.0%) years. This problematic age scale raises concerns both among children and specialists. The fact is that adolescents are aware – at least partially – of their right to testing for HIV without being accompanied by an adult. Unfortunately, within this survey we could not clarify the reasons why some adolescents still try to conceal their age.

Workers of social sphere – in CSSFCY network, considering official name of such facilities and their statutory provisions, *adolescent's age status is by no means a barrier to receiving services. Beginning from the age of 14 years CSSFCYs observe the principle of anonymity of their clients, and parents are notified only upon adolescent's consent. If a client is 14 years or younger, parents or other legal representatives are involved.*

Currently not many NGOs in the country are ready to work with adolescents, especially in the area of VCT provision. NGO experts explain it by *additional responsibilities, vagueness of normative and legal regulations of NGO activities, and the need in additional staff training to be able to work with this age category of clients.* Particularly challenging is the situation with organizations that are ready to work with MARA under 14 years, as typical issues associated with MARA-specific activities even double in this age.

During interviews representatives of two organizations noted that their projects targeted adult representatives of most-at-risk populations. One organization blankly *denied any work with individuals younger than 18 years*, while the other representative *stated that their NGO would provide VCT services to anyone who was 14 and older – as is permitted by the law – but not routinely, only upon request.* Accordingly, the organization did not maintain any records on the number of adolescents receiving services – all statistics was included in the general reporting disaggregated by most-at-risk groups (IDUs or FSWs). According to another specialist, their project works in the remand prison, including with adolescent detainees, but it does not specifically target this age category.

2 experts – focus group participants (Kyiv) noted that in the provision of VCT services there is no need to get too deep into the issue of MARA's age limits, as VCT Guidelines encourage greater attention to specifics of service provision to adolescents in general, which also includes representatives of most-at-risk groups. Therefore, MARA boys and girls have full right to services in line with VCT Guidelines.

“Starting from 14 years, but in rare cases we also had younger clients; those aged 11–12 years were accompanied by adults. But those who turned 14 have the right to come alone (VCT counsellor, Kyiv);

“There are some controversial issues, for example, capacity of an adolescent from 14 years on to come without parents and get oneself tested for HIV. This is controversial. Some people say that the law prohibits it when he comes without adult guardian. Our specialists insist that an adolescent can choose a specialist and make conscious decisions (Service provider, psychologist, Odessa).

According to health workers, regulatory inconsistencies regarding juveniles' age limits need to be settled anyway. In practice parents or other legal representatives get involved during counselling of children under 14 years of age. But the issue of age qualification emerges when it comes to testing and further prescription of treatment, as orders and instructions of health facilities' chief physicians are based on the MoH documents, which in turn are yet to be brought in line with the new version of the Law of Ukraine “On Prevention of Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Security of People Living with HIV”.

“There exist certain discrepancies between the regulatory base and practical work. Children from 10 to 18 cannot receive treatment and diagnostics procedures independently. This requires parental consent. But after attaining 14 years they can, but we still need consent of the child’s guardian, and the child himself. Therefore, we need to clarify what children actually can do, and where they can seek assistance. Specialists that provide services to children need special books, literature – for a doctor to be able to find necessary page in the book and to know exactly what to do. We had so many questions that we had to invite lawyers... Yes, many different regulatory documents regarding services to adolescents need to be harmonized” (National expert, health worker, Kyiv);

“10–14, 14–18 years implies counselling only. Probably, there exists a solution already. I mean, they can give their consent. No one can give anything before 14 years, except for counselling” (National expert, health worker, Kyiv);

“There are absolutely no problems for Youth Friendly Clinics to provide services to those aged 20 to 24 years. AIDS centres serve different clients, both adults and children. And children here are individuals from 0 to 18 years (Health workers, national experts, international organization, Kyiv);

“We have children – persons aged 0 to 18 years. This falls within limits. We also have health centres, both for children and adults. Those serving people under 18 years are children’s facilities, and centres for people above 18 are adult health facilities. Well, we also have adolescent therapists – no one eliminated this specialty yet. Officially these are not exactly children. On the other hand, they are special” (Health worker, service provider, Kyiv);

“The need for HIV testing among those aged 10–13 years is lower as at this age children are less exposed to HIV infection – not many of them can be found on the streets... The situation is totally different for adolescents aged 14–17 – at this age children like to experiment, they are more susceptible to adverse environments. This is the age category that we work the most” (Service provider, head of NGO, Odessa).

Therefore, the existing contradictions in the work with adolescents are associated with inconsistencies between regulatory and legal acts that can be addressed by their the review and harmonization at the governmental level; by developing relevant guidelines and methodological instructions for sectoral specialists; by introducing additional trainings for VCT service providers to adolescents taking into account peculiarities of all age groups (under 13 years, 14–15 years, 16–17 years, 18–19 years, and 20–24 years), and determining possibility (or impossibility) of providing VCT services in the presence of parents / legal representatives of underage person, and in case of positive result – further prescription of ART (“Health specialists prescribe treatment, ART. Of course, they cannot provide free treatment for no special reason. And these people told us that it is virtually impossible to suggest it to individuals of 14 and older years without guardian. In this case it would be simply impossible for such person to make any decisions in favour of his or her health” (Psychologist, VCT service provider, Odessa .

5.2. Parental Consent

“As a rule, they come with parents, usually with mothers... When we begin VCT procedure, we ask an adolescent if he or she can answer all questions in the presence of mother or grandmother. If not, mothers leave the room, and we continue our conversation with an adolescent. More delicate questions are normally discussed during the examination itself, while general issues, like formalization of documents, are addressed in the presence of parents. Again, all parents and relatives leave the room, and all sensitive issues are discussed individually with a patient” (VCT service provider, Odessa).

Practical experience of the provision of health services to minors has a number of peculiarities. Having analysed current Ukrainian legislation, one can decide that in order to receive medical assistance a child needs to know his/her exact age⁴². Since health interventions for individuals under 14 years can be provided only upon consent of their legal representatives, the law prohibits provision of VCT services to most-at-risk adolescents of this age without permission of their representatives. While removing MARA boys and girls from the streets, the members of outreach teams cannot determine the children’s age as they do not usually carry the documents that confirm their age. The only situation when medics in the outreach team can provide medical assistance without children’s own or their representative’s consent is the presence of real threat to the child’s life. No consent of a sick child or his/her legal representatives is necessary under these circumstances (the decision is made by a doctor at his/her own discretion).

As for adolescents under 14 years, involvement of their parents or other legal representatives in VCT process is mandatory. All surveyed specialists observe these norms:

“10–14 years implies counselling only. Those aged 14–18 years can give own consent. But if the kid did not reach 14 years, you cannot do anything except for counselling – and it does not matter, MARA or not” (Health worker, national expert, Kyiv);

“Until the age of 12 – only counselling, upon permission of the child’s guardians, parents, and the like. And no problems from 14 years on” (Health worker, service provider, Kyiv);

“I did not have precedents of this kind. Only upon the child’s consent”;

“A homeless child can come and undergo examination on his own. Social follow-up is mandatory” (VCT service provider, Kyiv).

At the same time, survey findings reveal a quite controversial picture: 78.1% of surveyed respondents noted that no one had ever asked them to present parental consent, and only 9.2% mentioned that service providers asked for such permission (see Table 5.2).

⁴² Legal and Regulatory Review on the Rights of Children and Young People Living and Working in the Streets; Prevention of Homelessness and Neglect in Ukraine / Tetiana Bordunis – Kyiv: USAID | HIV/AIDS Service Capacity Project in Ukraine. 2011. pg. 50–53.

Distribution of answers to the question “Did they request a parental consent from you to perform the test?”, by gender and age, %

	All respondents	By gender		By age				
		Boys	Girls	13 years	14–15 years	16–17 years	18–19 years	20–24 years
Yes	9.2	6.4	5.1	40.0	23.8	16.2	10.0	1.1
No	78.1	74.5	82.7	20.0	52.4	59.5	77.5	94.6
Don't remember	12.8	19.1	12.2	40.0	23.8	24.3	12.5	4.3

First, it is unclear why adolescents aged 14 years and older were asked to present parental consent. Second, speaking about children of 13 years of age (about 40 per cent of them recalled requests to provide parental consent, while another 40% of respondents of this age did not remember such requests altogether), 20% of adolescents who were suggested to undergo HIV testing without preliminary parental consent are inmates of shelters for minors; it is known that directors of such institutions serve as official representatives of minors for the period of their placement. However, questions regarding testing in the presence of other adult who represents a child were not included in this survey.

5.3. VCT site

“In practice, accessibility of information and geographical location of the site ‘discourages people from seeking these services’”. (Health worker, national expert, Kyiv)

In the course of the survey respondents voiced the overall opinion that VCT services are generally accessible for different categories of the population.

Speaking about adolescents and young people in general, and MARA in particular, the most popular places where one can get VCT services are polyclinics and hospitals (34.6%), mobile testing units (18.3%), NGOs (13.6%), and AIDS centres (13.1%).

However, age-specific data reveals somewhat different picture: if the majority of adolescents aged 13 received services in traditional health facilities (AIDS centres – 40%, polyclinics, hospitals and drop-in centres – 20% each) and in NGOs that work with target population (20%), then the diversity of testing sites increases with age – adolescents mentioned military enlistment offices (4.7% of adolescents aged 16–19 years), mobile testing units, antenatal clinics and maternities (6.3% of adolescents and young people aged 14–24 years), YFCs (4.7% among those aged 16–24 years), addiction treatment (2.6%) and STI clinics / dispensaries (5.8%) – see Table 5.3.

In addition, each fourth respondent (24.5%) expressed a request to have HIV testing site in the vicinity of his/her place of residence.

**Sites (venues) where respondents received testing for HIV the most recent time,
by age, %**

	All respondents	By age				
		13 years	14–15 years	16–17 years	18–19 years	20–24 years
Polyclinic / hospital	34.6	20.0	38.1	32.4	33.3	35.9
Mobile testing unit	18.3	0	19.0	23.5	23.1	15.2
NGO	13.6	20.0	23.8	11.8	10.3	13.0
AIDS centre	13.1	40.0	9.5	5.9	5.1	18.5
Drop-in centre "Dovira"	7.3	20.0	0	2.9	10.3	8.7
Antenatal clinic / maternity	6.3	0	4.8	2.9	7.7	7.6
STI clinic / dispensary	5.8	0	4.8	0	2.6	9.8
Military enlistment office	4.7	0	0	11.8	12.8	0
Youth Friendly Clinic	4.7	0	0	5.9	2.6	6.5
Addiction treatment clinic	2.6	0	4.8	5.9	0	2.2

Each fifth respondent (19.9%) mentioned inconvenient timing of HIV testing and the need to miss almost a full day of studies/work in order to complete this procedure; the majority of such respondents are adolescents of younger age groups (Diagram 7). Participants of concluding focus groups also confirmed the fact of territorial remoteness of testing sites and the need to miss the entire day of schooling, and also informed about cases of students' manipulations with testing procedures as an excuse to skip school.

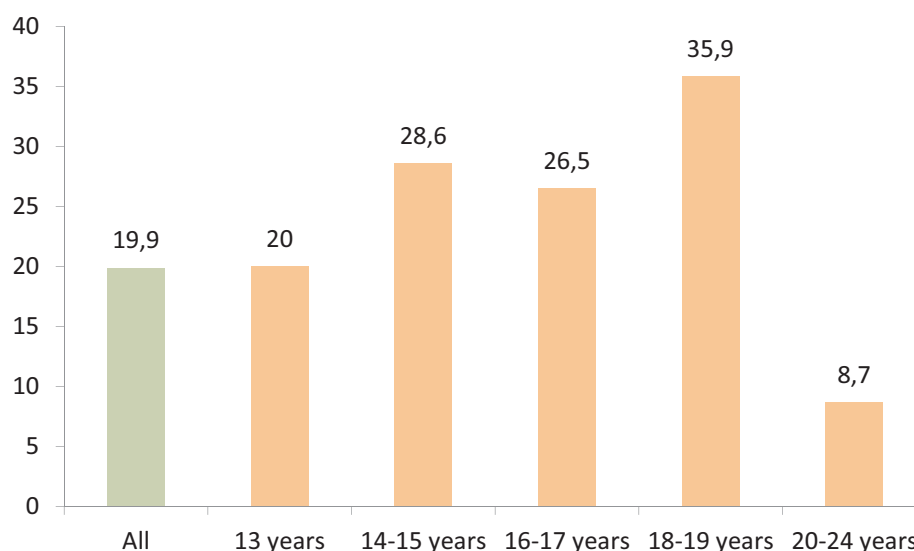


Diagram 7. Percentage of adolescents and young people who had to miss the entire day of schooling/work to undergo testing for HIV, by age, %

Therefore, service providers need to be more attentive to working hours of their respective facilities, and to make them more convenient for this target population.

At the same time, experts and services providers identified the following issues, associated with testing sites:

1. Territorial remoteness of VCT service provision sites (especially for rural residents). Also territorial remoteness of YFCs and drop-in centres in small towns and villages, and their remoteness from downtown areas of large cities, where it takes a lot of time and effort to travel from one end of the city to another. This creates additional pressure associated with the need to pay for transportation to a VCT site.

On the one hand, a children's polyclinic is one of the most easily accessible health facilities – at least from the territorial standpoint, but on the other, not all polyclinics are capable of providing VCT services in comprehensive manner. Some refer their adolescent clients to other services. Information about places where one can get such services is provided to an adolescent in full. Paediatricians work with adolescents of all age categories.

2. Inability of adolescents to pay for transportation of VCT service provision sites. Specialists of drop-in centres mentioned the need to compensate adolescents' travel expenses, as the lack of money for transportation to the service provision site is one of the serious obstacles.
3. Limited knowledge of MARA about the existence of facilities offering such services. Information about VCT sites is usually provided by staff members of these facilities during prevention work in educational establishments and outreach activities, as well as through distribution of IEC materials.
4. The lack of comprehensiveness (“interruption”) in VCT service provision.

4.1. The lack of procedure rooms in almost half of all Ukrainian YFCs and the deficit of trained specialists makes it almost impossible to provide comprehensive VCT services. As a result, they refer their clients to AIDS centres with which they maintain contractual relations.

4.2. Only 2 of 6 YFCs covered by the study have rapid tests readily available for their clients (judging from the respondents' answers, such testing is performed in YFC within the framework of NGO projects), while the other 4 provide comprehensive HCT services using IFA tests. The remaining two YFCs either collect blood samples to be shipped to the lab for testing, or refer clients to other health facilities.

Therefore, an adolescent will have to go elsewhere to have his blood sample collected, and then to return to YFC for test results and post-test counselling. Not all adolescents are sufficiently motivated to exert extra effort to learn their HIV status, so many clients are lost to the statistics due to described time and location “breaks”.

4.3. VCT of adolescents, institutionalized or temporarily placed in residential facilities (boarding schools, shelters for minors, centres for social and psychological rehabilitation of children, anti-crisis centres, reception centres and the like), is usually initiated by the director of such institution, usually with a counsellor's visit on site. The problem resides in unpreparedness of staff to perform such work, and in the weakness of measures aimed at preserving health-specific information about children.

5. Current network of VCT facilities fails to address all needs. For example, an expert noted that the entire city of Mykolayiv has only one YFC: “*This is one of the regions*

with relatively high rates of HIV infection. At the same time, Mykolayiv has only one clinic, which does not deal with MARA issues at all. Several times we offered this facility our support – including financial – and proposed to set up special clinic to work with most-at-risk groups, which are quite sizeable in the city. A project, self-organized charitable organization works there. But they refused... The problem is that this is truly significant, hard work, which is very specific. It requires separate premises, relevant management and staffing, organization of activities, and the like” (Health worker, national expert, Kyiv).

6. The need to scale up the network of mobile units and labs. Survey participants appreciated the effectiveness of mobile units in the provision of VCT services to MARA as such adolescents rarely seek services themselves. Therefore, it is expedient to approach places, frequented by MARA and to ensure their follow-up. “It is necessary to expand the number of mobile labs, their working hours and the number of units” (Service provider, health worker, Kyiv).
7. Underdeveloped system of referrals. Two of three interviewed paediatricians refer their clients to YFC or to the drop-in centre to receive VCT services. The third paediatrician offers such services himself, and testing for HIV occurs in the same facility. In cases of referral paediatricians always try to find out whether an adolescent eventually came to receive the service. One of specialists noted that upon referral only about 20% of adolescents show up to receive VCT.
8. Weak mechanism of social follow-up of MARA. The absence of follow-up leads to the loss of clients: an adolescent may come, have his or her blood sample collected, but then never returns to pick up the results. If VCT services were anonymous, especially for street children, then it would be virtually impossible to find these clients.

Two of three specialists mentioned the issue of insufficient coordination with other organizations, particularly with social services: they did not know anyone to contact if an adolescent’s social problems, revealed during consultations, could not be addressed by a doctor.

“Young people have to have its own place within the health system in the form of specialized clinics for youth, or some kind of departments with interagency focus, I would say, where social services or services for children could be involved as partners with clearly defined responsibilities and functions” (Health worker, national expert, international organization).

“We do not have adequate infrastructure in our country. I think we generally fail to understand that this category of the population requires special, very specific services, which need to be supported with incoming international funds” (Health worker, service provider, Kyiv).

Both providers and recipients of services underline the importance of conditions for bringing a system of VCT services closer to places (locations) frequented by the target group representatives, reviewing working hours of institutions that provide these services, and strengthening the system of referral and social follow-up of children and youth to receiving counselling and testing for HIV.

5.4. Cost of Service

“Well, the law says that everyone’s rights are equal. The other question is whether these services are paid or free. This is why if you’ve got money – you have paid services available, I mean, with minimal payment. If you have to pay for the service, it is obvious that no street child can afford it, and this creates a barrier. Everything’s based on money. The same is true for the quality of medical care. If we speak about street kids – yes, they can get emergency assistance, but there is no money for further examination and prevention” (Service provider, health worker, Kyiv).

VCT Guidelines enable testing for HIV, including with rapid tests, by all organizations/facilities (laboratories) on the territory of Ukraine regardless of their sectoral subordination and form of ownership that carry out free-of-charge testing for serological markers of human immunodeficiency virus⁴³.

Unfortunately, survey findings reveal cases where adolescents and MARA boys and girls are asked to pay for HIV testing.

Almost each fifth respondent (17.3%) answered “yes” when asked about the need to pay for HIV testing, and 7.9% of adolescents did not remember.

Judging from adolescents’ responses, the number of cases when one had to pay for tests tends to increase with age. HIV testing was not free for 12.5% of those aged 14–15 years, for 7.7% of adolescents in the age group of 16–17 years; for 18.2% of adolescents aged 18–19 years, and for 21.8% of respondents who are 20–24 years of age (Table 5.1); in other words, the older the age of a respondent, the more frequent are the situations when they are asked to pay for the service.

According to respondents, this service was fee-based in a polyclinic/hospital (20 persons), antenatal clinic (5 persons), AIDS centre (3 persons), NGO (2 persons), STI clinic/dispensary (5 persons), and in military enlistment office (1 person).

Among those who paid for the test (N= 33) 19.3% live in an apartment or house (own, rented, parents’ or partner’s); 15.8% live in boarding schools, and 5.9% – in dormitories.

Of those who paid for HIV testing 23.5% completed their education and work; 21.1% study and work; 18.8% neither study nor work, and 9% study and do not work.

Experts who participated in the study also expressed different views: if provision of VCT services is declared to be free, then appropriate information about opportunities to receive free service should be widely disseminated among target populations. Moreover, practitioners should ensure such absence of payment.

“...not much effort and money is necessary to do it” (Health worker, national expert, Kyiv);

“The service is affordable and free anyway. There are many facilities that offer it. We only need to disseminate information in the hotspots” (Service provider, psychologist, Kyiv);

⁴³ Order of MoH Ukraine No 1141 as of December 21, 2010 “On Approving the Procedure of Testing for HIV, Quality Assurance, Forms of Primary Reporting Documentation on HIV Testing and Guidelines for Completing Them”.

“...not until we have normal regulatory base, not until we are able to place our children in inpatient departments and provide medicinal treatment for free... instead of buying simple and cheap drugs. It’s a matter of great concern for me” (Service provider health worker, Donetsk).

Reported cases of requests of payment for HIV testing violate the principle of free provision of VCT. Therefore, all treatment and prevention facilities in Ukraine need to be duly informed about unacceptability of requesting payment for the provision of health services to underage individuals, and particularly to MARA, on counseling and testing for HIV infection.

5.5. Anonymity

“The issue of anonymity is very common: Will you tell anyone? What if someone finds out? – It is very important for them” (Health worker, service provider, Donetsk)

The legislation of Ukraine guarantees accessibility, quality and effectiveness of medical examination, including anonymous, to identify HIV infection with provision of preliminary and subsequent counselling assistance, as well as safety of such examination both for the client and for staff that performs it.

According to survey findings, the rights of the client for anonymity of testing for HIV were violated in each third case.

About one-third of respondents (33.5%, N=64) of those who answered the question noted that testing was not anonymous (30.8% of boys and 34.9% of girls, Table 5.1). Violations were reported by 33.3% of adolescents aged 13 years; by 31.3% of those aged 14–15 years; by 15.4% of respondents of 16–17 years; by 4.5% of adolescents aged 18–19 years. The highest proportion of such reports was observed among young adults of 20–24 years –36.8%.

Those who reported that HIV testing was not anonymous, include students of boarding schools (36.8%), adolescents having separate housing – own or rented house or apartment (34%), and adolescents living in dormitories (29.4%). 36.1% of those reporting about violation of anonymity live separately / have no parents.

Experts who participated in the study point to the need for mandatory observance of anonymity as the main requirement to testing.

“We did not have such situations because adolescents usually come alone. As if parents have nothing to do with it” (Service provider, psychologist, Kyiv);

“The main focus is on anonymity, accessibility and free provision of service”. “In the past there was fear and distrust. They were afraid that testing was not confidential. Now these fears disappeared as children understand they can come themselves and get everything done” (VCT service provider, Odessa).

We should note that since the research methodology envisaged interviewing of experts who primarily work with the target population, these specialists routinely ensure observance of anonymity in their work and in activities of their respective facilities and organizations. They cannot have information about adherence to anonymity principles in other institutions and organizations working in this area. This is why results of analysis of experts and adolescents' responses are different.

Therefore, all **institutions, facilities and organizations involved in VCT service provision should undertake adequate measures to prevent any violations of the principle of anonymity of HIV testing.**

5.6. Adolescent's Consent and the Right to Refusal

In order to perform full-fledged testing of a child for HIV infection, it is necessary to create adequate conditions. According to experts, however, in some cases the principle of voluntariness was violated.

1. The issue of medical examination of children who did not attain 14 years of age upon request of their parents / legal representatives who have the right to be present at such examination, is legally regulated. At the same time it does not take into consideration an adolescent's possible dissent to undergo such examination.
2. A situation when an adolescent has turned 14 and has a full legal right to receive VCT independently, but that he/she is forced to take HIV tests against own will is particularly unacceptable. In such cases it is very important to provide an adolescent with clear and sound information on the need of testing or any other examination, and to motivate him/her to agree to such testing.

"There was this young man with positive status. We encouraged him to visit us and to have his blood collected for the initial IFA test. We also offered him follow-up, meetings, and a care plan. We explained to him all risks and consequences as he lived on the streets. Unfortunately, he never returned for consultation" (VCT counsellor, Kyiv).

"Such situations are common. We offer them testing. But the majority – about 80 per cent – just refuse to undergo testing" (service provider, psychologist, Kyiv).

"In most cases, this is their own decision. They decide whether to return or how to deal with the situation. And in many cases an adolescent's environment plays a decisive role. Even if we did help him and told him everything, he eventually returns to the same old community and environment where everything gets lost" (service provider, specialist in adolescent paediatrics, Kyiv).

Experts note that a large percentage of adolescents refuse to take an HIV test.

Respondents' answers demonstrate (Table 5.4) that despite the fact that most of them are asked to give consent (66.5%) and informed about the right to refuse HIV testing (59.2%), in some situations these norms are ignored. In particular, 16.8% of respondents were not asked their permission for HIV testing, while 22.5% were not informed about their right to refuse testing.

Table 5.4

Observance of principles of adolescent's consent and his/her right to refuse testing, *By gender, age and living conditions, %*

	All respondents	By gender		By age					Residence (living conditions)				
		Boys	Girls	13 years	14–15 years	16–17 years	18–19 years	20–24 years	Apartment	Dormitory	Boarding school	Shelter	Streets
Were NOT asked permission to perform testing	16.8	18.5	15.9	20.0	14.3	11.8	15.4	19.6	16.0	11.8	26.3	33.3	0
Were NOT informed about the right to refuse testing	22.5	20.0	23.8	20.0	19.0	20.6	12.8	28.3	22.0	11.8	31.6	33.3	0

The largest proportion of those who were not asked permission and were not informed about the right to refuse testing is found among the inmates of shelters for minors (33.3%), and boarding schools (26.3% were not asked permission, and 31.6% were not updated about the right to refusal).

Testing of an underage person for HIV infection can only be performed after receiving informed and voluntary consent of a patient. This means that an adolescent should receive sufficient information provided in clear and reasonable manner, understand all positive and negative consequences of determining his/her HIV status, give written consent to testing, refuse testing or delay his/her decision about testing without any coercion. Forced or coerced testing is unacceptable. Voluntariness also entails the absence of any coercion regarding decisions on changing risky behaviour of an individual seeking VCT services.

5.7. Pre-Test Counselling

“I believe that each subgroup of most-at-risk populations needs separate procedure of pre-test counselling, as each of them has its specifics” (Service provider, psychologist, Kyiv)

Pre-test counselling is an integral and mandatory component of VCT process.

Overall, each third surveyed adolescent (30.4%) complained about non-provision of pre-test counselling, as they received neither oral nor written information prior to HIV testing. Those deprived of such counselling include 20.0% of adolescents aged 13; 33.3% of adolescents of 14–15 years; 23.5% of adolescents in the age group of 16–17 years; 30.8% of adolescents aged 18–19 years, and 32.6% of young adults of 20–24 years (Diagram 8).

Pre-test counselling was not provided in a polyclinic/hospital (35 persons), YFC (1 person), antenatal clinic (6 persons), AIDS centre (4 persons), drop-in centre (2 persons), mobile testing unit (2 persons), addiction treatment clinic/dispensary (2 persons), STI clinic/dispensary (5 persons), military enlistment office (3 persons), and NGO (3 persons).

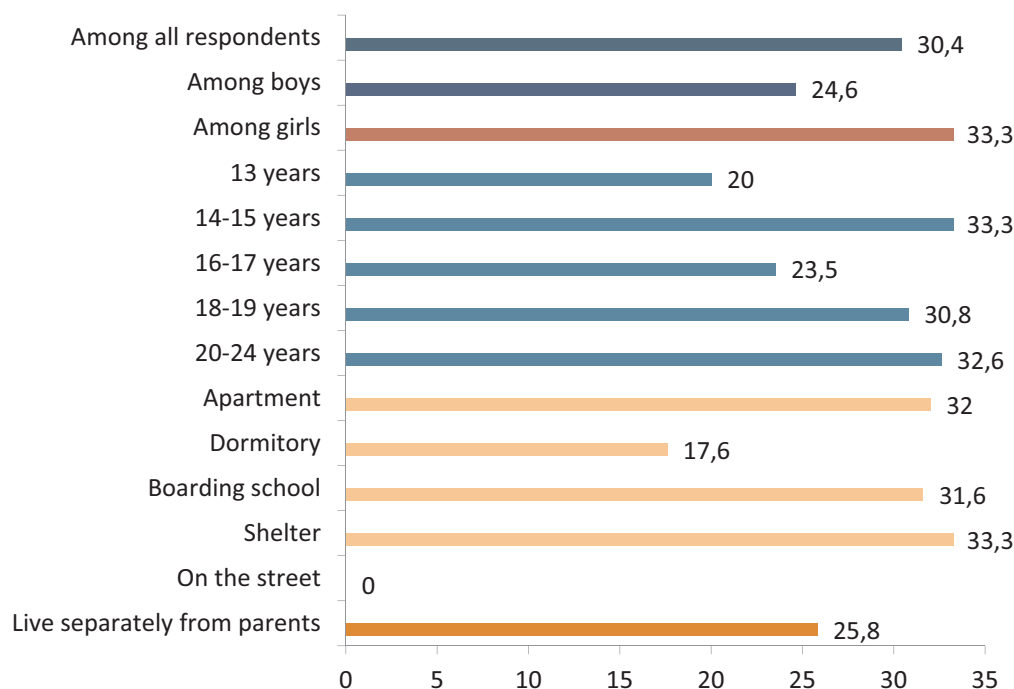


Diagram 8. Percentage of respondents who did not receive pre-test counselling (among those with the history of testing), by gender, age and living conditions, %

Unfortunately, the research tool did not envisage clarification questions about why pre-test counselling was not provided to almost one-third of surveyed adolescents. Also the list of possible answers did not envisage selection of several options about the content of pre-test counselling.

From the experts' statements it becomes clear that sufficient numbers of specialists of both the health and social sectors have been trained recently to provide pre-test counselling. At the same time interviewed experts note that it is most beneficial when one and the same specialist provides pre- and post-test counselling to his/her client.

In addition, experts identified a number of weaknesses in various aspects of pre-test counselling.

- According to experts, the most urgent issue is the need to review and strengthen the mechanism of VCT service provision by NGO staff (from pre-test counselling to blood test), because NGOs have neither technical nor human capacities to do so (as a rule, NGOs involve relevant professionals from health facilities): *“We are not responsible for them. They need to learn. What do you mean they want to perform VCT? VCT consists of three components. The first one is counselling for the client to agree to have his blood tested. Second is blood sampling. How NGOs will deal with this blood?”* (Health consultant, national expert, Kyiv).

Therefore, experts believe that the main objective of HIV service NGOs should include efforts aimed at ensuring access of the target population to VCT services and at strengthening cli-

ents' motivation to receive testing; and second, the question of licensing of NGOs involved in VCT service provision needs to be properly regulated.

- The absence of the list of adolescent and youth groups that are offered counselling and testing for HIV in VCT Guidelines further complicates service providers' activities: *"If this boy never had sexual contacts, then what's the point of offering him VCT service? Well, only if direct indications are present, including drug use"* (Service provider, psychologist, Kyiv); *"If this adolescent has sexual contacts or injects drugs, then such services will be definitely offered to him"* (Psychologist, service provider, Odessa).
 - Unpreparedness of specialists to perform pre-test counselling with MARA, taking into account specifics of this population⁴⁴.
 - Service providers mentioned possible emergence of unacceptable conditions for pre-test counselling of adolescents in general and MARA in particular (waiting lines, limited time for communication with an adolescent, and the like): *"In our facility everything is in order. The doctor provides as much information as possible. But again, it depends on the day of the week, on the waiting lines. For example, if there are many people, the doctor is hurried. But such situations are rare. An individual receiving VCT services requires maximum attention and explanations with no rush. In this case VCT is a rather slow process and takes a lot of time, because information needs to be communicated properly. How the client uses it is the other question, but our responsibility is to provide such information"*.
- "We provide VCT services to all as requested. That is, every person who asks for help and wants to undergo testing for HIV, receives counselling"* (VCT service provider, Odessa).
- Specialists of the telephone helplines "Dovira" should be more actively involved in pre-test counselling.

Therefore, children and young people report cases of non-provision of pre-test counselling, which is a mandatory component of VCT service provision.

Issues of pre-test counselling, described by the experts (regulatory vagueness regarding the list of adolescent and youth groups that are offered counselling and testing for HIV; unpreparedness of specialists to perform pre-test counselling for the representatives of the target population; the lack of licensing for NGOs that work in the area of VCT provision; unacceptability of settings / conditions for performing pre-test counselling for adolescents and MARA boys and girls), **create additional barriers for adolescents and MARA receiving a comprehensive package of VCT services.**

⁴⁴ In February 2012 a working group on counselling and testing for HIV infection was established pursuant to the Order of the State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases. Currently this working group is developing a new version of VCT Guidelines, which, as expected, will be fully in line with Ukraine's Law on HIV.

5.8. Receiving Results

“They threat themselves a little recklessly. Some are in depression, and you also try to take them out of it. And some scoff at it and treat it childishly. And when some learn about their status... well, you test him, register him, provide necessary assistance, do everything to support him – he learns his status, shrugs, turns around, leaves and never returns. I asked some social workers if they saw this boy – yes, he feels alright, but he doesn’t seek any assistance” (VCT service provider, Odessa)

Information about the results of HIV testing, the presence or absence of HIV in an individual is confidential and constitutes medical secrecy, therefore further communication of such information is only allowed to the person that this information concerns⁴⁵.

The experts were almost unanimous pointing at adolescents’ immature and irresponsible attitude to their own health and the lack of understanding of issues related to the spread of HIV in their environment. In addition, experts note that when alone, adolescents usually never return to receive testing results, which is evidence of their weak motivation. On the other hand, those who came to testing in the company of parents, social workers, staff members of child care facilities and outreach workers, are much more likely to pick up their test results.

An absolute majority of respondents (90.6%) reported receiving results of their HIV tests; 6.3% did not receive testing results, and 3.1% do not remember.

In general, 88.4% of respondents with the experience of HIV testing received negative results. 6.4% of surveyed adolescents had HIV positive result, and 5.2% refused to answer this question (Table 5.5).

As for the most at-risk adolescents who had themselves tested for HIV (64 respondents in this cohort), 63.6% have positive, and 34.6% – negative status. 44.4% of MARA respondents refused to answer.

Table 5.5

Results of testing for HIV (among adolescents with the experience of HIV testing), by gender, age and the wave of the study, %

	All respondents	Waves		By gender		By age									
		1 st wave	2 nd wave	Boys	Girls	13 years		14–15 years		16–17 years		18–19 years		20–24 years	
						Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
HIV positive	6.4	7.8	2.2	12.3	3.4	0	0	0	10.0	0	0	7.1	0	25.0	4.8
HIV negative	88.4	86.7	93.3	80.7	92.2	0	100	100	70.0	83.3	88.2	85.7	100	75.0	93.5
Refused to talk about it	5.2	5.5	4.4	7.0	4.3	100	0	0	20.0	16.7	11.8	7.1	0	0	1.6

⁴⁵ Order of MoH Ukraine No 1141 as of December 21, 2010 “On Approving the Procedure of Testing for HIV, Quality Assurance, Forms of Primary Reporting Documentation on HIV Testing and Guidelines for Completing Them”.

As for the term of waiting for the testing result, 45.1% of respondents received it in less than 2 hours; 32.1% – in less than one week; 15% – in two weeks; and 7.5% – in two and more weeks.

Speaking about the reasons for not returning to receive testing results, only relatively few adolescents (8.3%) mentioned their distrust towards the facility, while 16.7% said that they forgot or were busy. 25% had problems with transportation, and more than half of respondents (58.3%) mentioned other reasons. In particular, focus group participants described the following reasons for not receiving test results: *“they do not give results away as they need it for reporting”*; *“if you are sick, they will take you to the hospital and make you stay there”*; *“they told me if there is a problem, they will let me know”*; *“I received result of the first test, but the second time I underwent testing for HIV in the hospital together with other tests. They told me that results would be ready in 2 weeks, but by that time I was discharged from the hospital and left the city”*; *“they never told me”*.

6.3% of respondents (N=12) with the experience of HIV testing did not receive its results: 5 persons aged 14–15 years; 2 persons of 16–17 years; one adolescent in the age group of 18–19 years, and 5 respondents aged 20–24. Of them 7 persons live with parents; 5 respondents live separately from their families; 9 live in own or rented apartment / house; 2 live in the dormitory, and one respondent is an inmate of boarding school. 4 of such respondents live in small towns, 5 are residents of oblast centres, and 3 live in big cities.

15.5% of respondents who did not return to pick up their testing results did not receive preliminary oral or written information (had no pre-test counselling).

No significant links between employment and non-receiving of HIV testing results were found within the study.

Therefore, relatively rare cases of adolescents’ not receiving results of testing for HIV are predominantly associated with the lack of adolescents’ understanding of risks linked to HIV infection, as well as with problems of getting to the site. Very few adolescents (8.3%) explain their not returning for testing results by distrust of the facilities.

“Today he promises one thing, and tomorrow he does not come over to the meeting with a social worker – that’s fecklessness. This is often linked to overconfidence – they are not afraid of anything, they don’t care much about their health. Therefore, it is extremely difficult to motivate such kids” (service provider, psychologist, Kyiv).

5.9. Post-test Counselling

“Further actions are not elaborated as well. If an adolescent receives testing result that requires further interventions, treatment or examination, then we need his documents. This part is not envisaged by the Law – that is, his capacity to independently decide on more serious health interventions”. (Health worker, VCT service provider, Kyiv)

Post-test counselling is provided by health workers and psychologists, who usually receive adolescent’s testing results (including directly from the lab) before counselling.

Despite the fact that the majority of respondents who received testing for HIV (66.7%) confirmed having consultations in case of positive result, some adolescents (N=3) still did not have such counselling (two boys and one girl aged 20–24 years). Situations of non-provision of post-test counselling occurred in hospitals.

In the course of conversation that occurred immediately after receiving testing results 36.4% of adolescents received psychological support; 36.4% talked about the importance of healthy lifestyles; 54.5% discussed treatment and opportunities to receive psychological assistance; 45.5% talked about how to live with HIV; 36.4% discussed the topics of preventing transmission of HIV to other people; 27.3% learned about places where to get condoms, and 54.5% discussed, where one can get psychosocial support.

Analysis of legal field and practical experience of VCT service providers leads to the conclusion that post-test counselling, including information about positive testing results, also depends on respondent's age:

- 18–19 years – testing results are not disclosed to anyone except for an adolescent;
- 14–17 years – in case of confirmation of HIV positive status an adolescent should be encouraged to disclose his/her status to parents, legal representatives or significant adults, but these cannot be involved without adolescent's consent;
- 10–13 years – testing results are subject to mandatory disclosure to adolescent's parents or legal representatives.

5.10. Informing Parents and other Individuals on Positive Result

“Speaking about adolescents, there are too many nuances on who we should inform testing results. Do we have the right, or we don't? Are there any specifics or exceptions? What should we do, if the kid needs to be registered but he has no documents? Are there any bodies or services that can provide follow-up or issue at least temporary documents for a child to be properly registered and administered the most essential medications?” (VCT service provider, Kyiv)

Parents or other legal representatives of an adolescent under 14 years of age shall be notified about testing results. If adolescents have already reached they 14th birthday, counsellors in the course of post-testing counselling shall encourage them to inform parents or significant others about positive results.

Positive testing results in MARA (particularly boys and girls who live on the streets, flee from home, or live in asocial families) create a number of additional problems, as documents are needed in order to register these children. According to experts, if such adolescent has documents, there is no need to involve his/her parents and to provide information.

Survey findings show that not all adolescents were encouraged to inform their parents about positive testing results (63.6%). Only about quarter of those tested (27.3%) received such recommendation.

All respondents (N=7) who did not notify their parents about their HIV status, live in the apartment or house; 28.6% live with parents, and 71.4% live separately from their families.

Sites where adolescents were not encouraged to inform their parents include: NGOs, addiction treatment clinics, hospitals/polyclinics, and AIDS centres.

At the same time, many respondents shared information on the testing results with their sexual partners (66.7%), friends (66.7%), parents (44.4%), social workers (44.4%), health workers (different from those who performed testing) (22.2%), and siblings (22.2%) – see Diagram 9.

All respondents (100%) noted that they:

- did not share information about their HIV status with classmates, which means that fear of disclosure of one's positive status in educational settings is the highest;
- shared information with other relatives, but the study did not attempt to find out whether it did occur.

The survey data confirms that adolescents and young people are not ready to immediately disclose their positive status to family and friends: 77.8% shared information about their HIV positive status during one month, and almost quarter of respondents (22.2%) could disclose their status only in one year.

Reasons that prevent adolescents from informing their parents or other significant ones about their status include: fear that other people will learn about it (72.7%); they would like to start dealing with it independently (18.2%); there is no one to share with (18.2%); and other reasons (18.2%).

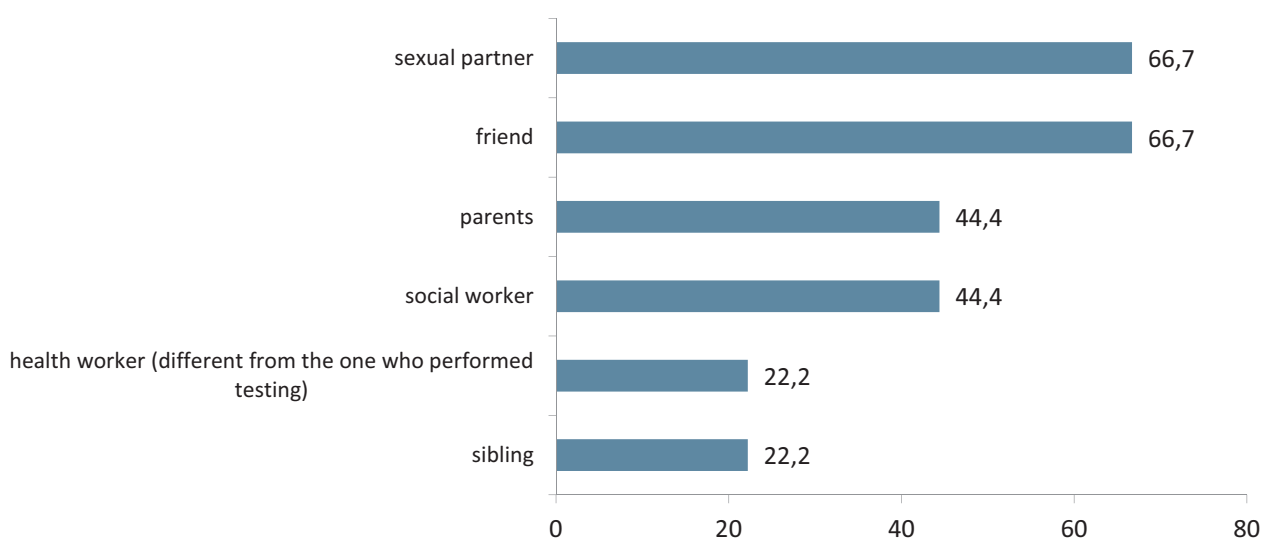


Diagram 9. Distribution of respondents' answers to the question "Who did you tell the results of your test?, among those who disclosed testing results, % (The sum may exceed 100% as respondents could select several options)

As we can see, not all adolescents and young people with HIV positive status inform their friends and family about their diagnosis. Therefore, specialists of the social sphere face the need to improve work with the social environment of HIV positive adolescents and MARA boys and girls.

On the other hand, interviewed experts claim that they always try to observe requirements on notifying parents and immediate environment of an adolescent about his/her HIV positive status.

For example, information about the presence of HIV in an adolescent of 14 years and older is communicated to this adolescent; such adolescent is further encouraged to pass this information to someone from his/her immediate environment. In some cases specialists recommend to come over in the company of adults or acquaintances.

Information about HIV status of a child under 14 years is provided in the presence of his/her parents or other adults who accompany the minor to receive testing results.

According to experts, a great deal of confusion and collisions may occur when adolescents are temporarily placed in child care institutions, when they live or work on the streets, when they run away from families, or inject drugs. In such cases it is quite problematic to inform an adolescent's (MARA) families about positive status. Under such circumstances the priority role should be given to social workers that need to ensure ongoing social follow-up of such children and families.

In addition, all experts who participated in the focus group (Kyiv) unanimously supported the statement, confirmed by their experience: by no means and under no circumstances should an adolescent's HIV status be communicated to pedagogical and health staff of the child's educational establishment, because stigma and discrimination of HIV positive children in schools is the highest.

“The problem is linked with existence of the entire system of disclosure of positive diagnosis. I mean this has reasons. For example, they conduct some organizational measures for kids to come with parents rather than alone” (Health worker, national consultant, Kyiv);

“In simple terms, if one is younger than 14 years, then we have the right to inform guardians. If older – we do not have this right” (Health worker, VCT service provider, Kyiv);

“We can involve a social worker as the child's guardian – no problem with that. The main thing is to ensure that these children – I mean, street children – received adequate attention from social workers” (Health worker, VCT service provider, Odessa).

While speaking about disclosure of HIV status, an absolute majority of surveyed adolescents and young people express concerns about such disclosure to family and friends, and are afraid that their environment will come to know their diagnosis. In other words, psychological barriers remains one of the most difficult obstacles in the system of VCT service provision to children and youth, particularly to most-at-risk adolescents, and in work with the social environment of the target population.

5.11. Referrals after Receiving Results

“If a clinic (YFC) works as it should – in line with standards and so on – then it has strong system of referrals. If this is a traditional facility – forget about referrals. They say: you may go there and do that. But in clinics everything is clear, as they work with many partners and know precisely who to contact. They can even bring a child by the hand and then call... in other words they keep track of the entire process. Generally speaking, these clinics were designed to provide assistance and support to adolescents who come to regular health facilities. Of course, many barriers exist” (Health worker, national consultant, Kyiv)

Thanks to information obtained from the experts, researchers clarified the entire situation with referrals in the area of VCT by service providers.

Currently close to 10% of YFCs have neither procedure rooms nor trained specialists (one of such YFCs participated in the study). As a rule, they refer their clients to AIDS centres with which they maintain contractual relations.

Not all polyclinics are capable of providing VCT services. In the majority of cases they refer adolescent clients to other services. Information about places where one can get such services is provided to an adolescent in full. Two of three interviewed specialists in adolescent paediatrics referred their clients to a YFC or to the drop-in centre to receive VCT services. In cases of referral paediatricians always try to find out whether an adolescent eventually came to receive the service. One of specialists noted that upon referral only about 20% of adolescents show up to receive VCT.

According to specialists of CSSFCY, accompanying of adolescents upon referral to receive VCT services is insufficient. Almost all interviewed experts raised the following questions:

- The problem of further examination of an adolescent (MARA in particular) to confirm diagnosis and to complete registration is due to a lack of consistency of service provision by health and social workers;
- The current mechanism of internal referrals within a health facility does not have links with social services, which results in non-provision of follow-up;
- Weak follow-up processes with adolescents: in case of referral of an adolescent from another (social, educational) facility he or she may be accompanied by the representative of this facility, but the presence of the latter during counselling and testing is unacceptable unless an adolescent expresses such preference;
- If testing for HIV is not provided, VCT service is usually limited to pre-test counselling, and adolescents are further referred to a health facility to receive testing and post-test counselling.

“In our case we refer girls to this charitable organization – The Right to Health”. Also to social centres – on Dovzhenko Street, 2, or to the AIDS centre” (Service provider, psychologist, Kyiv);

“Let’s say, you refer this kid – and he gets lost. If he’s referred here – he usually comes, if not “lost” at his own will. We lose children when they leave our facility, even though we have close contacts with the youth friendly clinic. We receive feedback from them”;

“...including law enforcement agencies for these children to be registered somehow, or to be followed. In principle, these provisions are included in legislation. But in practice this does not happen”;

“...I am fully satisfied with our cooperation with this friendly clinic – we maintain very close contacts. If I refer an adolescent, they will always call and ask what we did, when he left, and so on” (Service provider, specialist in adolescent paediatrics, Kyiv);

“I cannot put it this way. We have a strong referral system and ensure adequate provision of medical care. The only problem is that we do not have our own laboratory. Therefore, we use labs of city’s general polyclinics (VCT service provider, Odessa).

For their part some adolescents confirm that after receiving testing results they were referred elsewhere to receive other types of services. In particular, only 9.8% of all respondents were referred to other services after receiving the test results, while 23.7% did not remember.

Specifically, adolescents were referred to AIDS centres (29.4%), to YFCs (23.5%), to STI clinics / dispensaries (23.5%), and to self-help groups (17.6%). Also adolescents received a telephone number of counselling hotline (11.8%), or were referred to addiction treatment (5.9%) and antenatal (5.9%) clinics (Diagram 10).

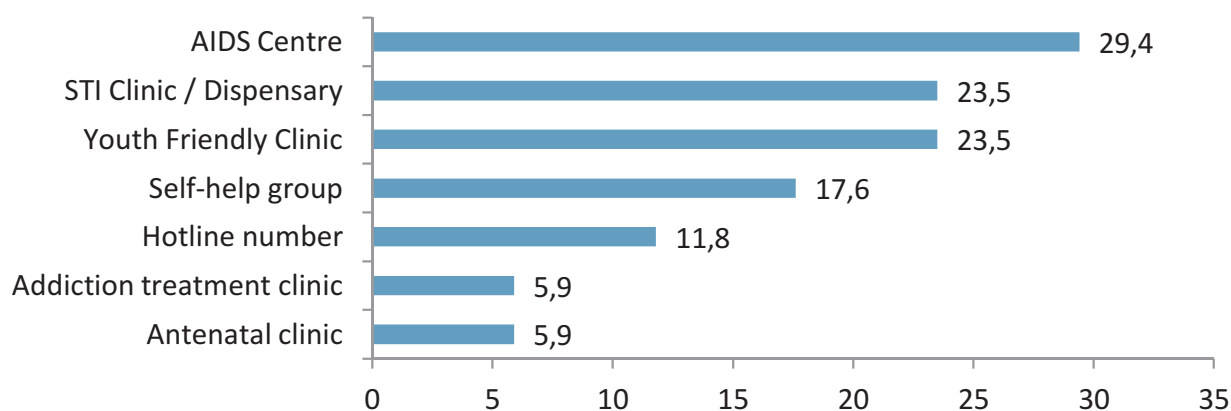


Diagram 10. Distribution of respondents’ answers to the question “Where were you referred to after receiving results of HIV testing? (you can choose several options)” (among those referred), % (on the basis of online survey data)

At the same time respondents note that they were given only addresses and telephone numbers of a facility where they should seek additional support (58.8%), while 41.2 adolescents and young people were accompanied by the social worker. Only 11.8% of surveyed adolescents and young people reported about appointments.

The current system of referrals between health and social services does not work well. Therefore, there is an urgent need to develop and to introduce an efficient mechanism of client (including minors) referrals at all levels, with functional social follow-up.

“I wish we had better cooperation with social services, because after you refer a child he simply disappears. All my colleagues face the same problem – what to do next? When a child comes with parents, this is one thing, but what if he runs away? The majority of our clients are children from problem families. So we talk, explain, provide pre-test counselling, but what will happen next? Nobody knows” (Psychologist, service provider, Odessa).

Therefore, inconsistencies between legal acts regarding age qualification of VCT service recipients, especially adolescents and MARA boys and girls, create confusion among service providers. In most cases such situations emerge when it is necessary to obtain parental permission to perform HIV testing for adolescents under 14 years of age, but the child’s parents or legal representatives cannot be identified, or when it is impossible to involve them in VCT process for various reasons.

The survey confirmed almost universal observance of such VCT principle as “friendliness”: not a single surveyed adolescent complained about disdainful or arrogant treatment, or the fact of disclosure of the client’s HIV status by service providers. Comparatively few respondents with the experience of HIV testing exhibited distrust toward facilities where HIV test was performed (8.3%). Attitudes toward educational establishments are opposite, as the issue of stigma and discrimination of children with HIV positive status in schools remains very acute (this was confirmed by the experts during the focus group discussions, and by adolescents who mentioned it as one of key reasons for their unwillingness to disclose HIV status).

At the same time, survey findings reveal quite controversial evidence on the observance of voluntariness, anonymity and free provision of VCT services.

Despite the fact that specialists that provide HIV counselling and testing to adolescents generally try to observe core principles of VCT, the respondents reported a number of violations. In particular, 16.8% of respondents with the experience of HIV testing were not asked permission for HIV testing, while 22.5% were not informed about the right to refuse testing; 17.3% of respondents were asked to pay for the test, while 33.5% stated that their testing was not anonymous. It was shocking to learn that each third respondent (30,4%) did not receive pre-test counselling, while 30.0% of young people aged 20–24 years who had been tested for HIV did not receive post-test counselling.

Additionally the survey found a number of weaknesses that need to be addressed: both experts and surveyed adolescents mentioned remoteness of testing sites, inconvenient working hours, the need to wait in lines, the lack of “one-stop shops”, weak systems of referral and social follow-up of the clients, and so on.

Therefore issues outlined in this report require urgent interventions on the part of VCT service providers in order to improve the situation.

VI. BARRIERS TO VCT SERVICE PROVISION

Analysis of current practices of accessing VCT services by adolescents and MARA boys and girls revealed a number of subjective and objective barriers.

Objective barriers

One of priority issues that needs to be addressed in order to strengthen the system of VCT service provision to the target population is the absence of a clearly formulated national policy on HIV/AIDS response in adolescent's social environment and the lack of focus on such specific target population as most-at-risk adolescents, which results in uncoordinated actions of local specialists.

The lack of professional training on peculiarities of work with adolescents in general and MARA in particular, significant staff turnover and the shortage of professionals with relevant skills and practical experience for outreach work with children and youth at risk, and for work in outreach outpatient units / clinics is another important barrier.

Another obstacle to receiving HIV counselling and testing is inconvenient working hours of health facilities offering HIV tests. The VCT system does not employ "one-stop shop" principles of service provision: it is virtually impossible to obtain full package of VCT services (including testing results) during a single visit in almost all social and in the majority of health facilities and institutions, identified by the VCT Guidelines as service providers.

Currently no funding is specifically designated for this activity area.

Only a limited number of NGOs that work in the area of VCT service provision offer adolescent-centred services. Moreover, the content of services offered by NGOs significantly depend on donor priorities, which rarely target adolescents.

Fragmentation and sporadic nature of informational and methodological work, as well as inadequate use of modern information technologies do not contribute to adolescent's knowledge and awareness in the area of counselling and testing for HIV.

Subjective barriers

Lack of awareness about HIV/AIDS issues on the one hand, and limited knowledge about opportunities and conditions of receiving services among adolescents (this primarily concerns rural teenagers and MARA, as the issue of service accessibility is the most urgent for these populations) prevents them from seeking services.

Many issues in the system of VCT service provision emerge as a result of psychological barriers linked with the service recipient's fear of learning his/her HIV status, and with fear of possible disclosure of the status in adolescent's environment.

Another barrier is financial inability of children and young people to pay for transportation to the testing site (this is particularly relevant for rural adolescents), and sometimes – for HIV testing (respondents reported about cases when providers demanded money for testing).

The absence of documents also prevents adolescents from seeking VCT services.

In many instances adolescents' views coincide with experts' statements on the existing barriers to comprehensive services (Table 6.1).

6.1. Objective Barriers

6.1.1. Regulatory and Legal Obstacles

“Good knowledge of legislation is not sufficient to ensure adequate level of quality. The legislative and regulatory base establishes a legal field within which every specialist can work without fear of possible sanctions. Quality, however, is based on the specialist's professional knowledge and attitude. And we still lack it” (National expert, health worker, Odessa)

Practical experience and analysis of survey results on the abovementioned issues points to the existence of various inconsistencies and discrepancies in regulatory acts, which require further elaboration at the level of ministries and other central executive bodies to make necessary amendments.

According to experts representing CSSFCYs and NGOs, normative and legal barriers to the provision of services to adolescents, particularly to MARA, are especially difficult to overcome when it comes down to the following:

- a) the absence of identification documents and legal representatives;
- b) impossibility to confirm diagnosis as these adolescents do not return to receive results;
- c) impossibility to enrol into care and to begin treatment without ID documents. Restoration of documents takes too much time, while an adolescent may require emergency medical intervention. Respondents even recalled several fatal consequences of such bureaucracy;
- d) inconsistencies between different normative and legal documents.

Therefore, a number of issues require adequate legal regulation.

- Absence of clearly formulated national policy on HIV/AIDS response in adolescent's social environment and among MARA, which results in:

Table 6.1.

**Distribution of respondents' answers to the question
"Why haven't you been tested for HIV?",
By gender, age, and adolescent's belonging to the risk group, %**

	All respondents	By gender		By age					Among most-at-risk adolescents ⁴⁶
		Boys	Girls	13 years	14–15 years	16–17 years	18–19 years	20–24 years	
Never thought about it	59.1	59.8	53.8	70.4	68.3	54.1	53.7	48.5	11.3
Was sure that the risk of infection is insignificant	36.0	35.0	36.9	35.2	30.6	36.8	38.8	43.3	9.9
Does not know where one can get tested	17.2	12.0	22.5	14.1	13.4	18.2	14.9	25.8	6.3
Was afraid of testing results	8.1	8.5	17.5	2.8	3.2	9.1	14.9	14.4	19.2
Was afraid of possible infection during testing	6.7	6.8	10.6	2.8	2.7	7.7	10.4	12.4	13.9
Was afraid of negative attitudes of the environment	6.1	3.4	9.4	0.0	5.9	7.3	6.0	8.2	25.6
Does not want to know own status, even if infected	5.1	5.1	5.0	4.2	4.3	6.8	6.0	3.1	36.6
Had to pay money for testing	3.9	4.3	8.8	2.8	1.1	1.8	9.0	11.3	20.0
Was afraid of registration in the health facility	3.6	2.6	6.3	1.4	2.7	4.1	7.5	3.1	39.1
Thought that testing was not possible without parental consent	3.7	1.7	3.1	5.6	7.0	2.7	1.5	0.0	8.3
Thought that no testing was offered to minors without parental consent	3.7	5.1	1.9	2.8	7.0	2.7	4.5	0.0	8.3
Was afraid that health workers would notify parents	2.8	2.6	4.4	1.4	0.5	4.5	4.5	3.1	38.8
Did not have identification documents	2.0	5.1	1.9	0.0	2.7	1.8	3.0	2.1	23.0

- *the lack of mechanisms of control over implementation of the state programmes and measures*, for example, objectives of the National Programme to Ensure Prevention of HIV Infection, Treatment, Care and Support to HIV Positive People and Patients with AIDS for 2009–2013, and the National Strategic Action Plan on HIV Prevention among Children and Youth from Most-at-Risk and Vulnerable Populations and

⁴⁶ Integrated indicator calculated on the basis of answers to the following questions: "How many sexual partners did you have in the past 12 months?" (answer "more than 6 partners"), or "Did you ever practice the following – unprotected sex between males" (answer "yes"), or "Did you ever practice the following – providing sex services in exchange for money or reward (food, clothes, housing, alcohol, drugs)?" (answer "yes"), or "Have you ever injected drugs (with syringe)?" (answers "yes, several times", and "yes, many times"), or "Why did you decide to take test for HIV?" (answer "because I had unprotected sex and / or injected drugs").

on Care and Support for Children and Youth Affected by HIV/AIDS⁴⁷. All measures and actions in this document, including those on VCT, focused on most-at-risk adolescents. But after reorganization of the Ministry of Family, Youth and Sports of Ukraine and its State Social Service for Family, Youth and Sports⁴⁸ the fate of this Strategic Plan remains vague, as there is no clarity regarding legal successor and executing agency of said measures;

- *the lack of coordination both at the level of central executive bodies, and at the local level*. There is no clearly designated central executive body and relevant subordinate local authorities that would be responsible for coordination of activities in this area. “...speaking about minors, there need to be clear guidelines at the governmental level. Drafting of some temporary documents for a specific region is not correct, because if there is no legal support at the national level, it is extremely difficult to work in the regions” (Service provider, social worker, Kyiv).
- The absence of legal definition of terms “adolescent”, “most-at-risk adolescent”;
 - “Ukrainian legislation does not contain such term as “an adolescent”. WHO Recommendations and some other international documents provide the definition of “an adolescent”, but in our legislation this term is absent” (National expert, Kyiv);
 - “There is no such term as “an adolescent” in the legislation” (Service provider, social worker, Mariupol);
 - “The definition “Most-at-risk adolescents” does not exist in the conceptual system of Ukrainian legislation. We have legal definition of children in difficult life circumstances, for example, neglected or homeless children. Therefore, there exist some inconsistencies between lexicon and definitions that we use in international organizations, and terms that are officially used in Ukraine” (Health worker, expert, international organization, Kyiv);
- VCT Guidelines are not brought into compliance with the new version of sectoral Law on HIV. Current VCT Guidelines establish that medical examination of minors under 18 years can be performed upon request or by consent of their parents/legal representatives who have the right to be present at such examination, and this violates the principles of voluntariness and confidentiality;
 - “The current protocol on VCT service provision is yet to be reviewed to bring it into compliance with new legislation – the one that was lobbied by many specialists who supported and promoted provision of independent VCT without parental consent from 14 years”;
 - “They analysed the Civil Code and many legal and medical issues, and finally introduced this Law on HIV that reduces the age of independent testing to 14 years. Unfortunately its provisions are not reflected in other documents. This legal collision creates loopholes for those who do not want to work and provide services” (Representative of All-Ukrainian organization, national trainer on VCT, Kyiv);

⁴⁷ The National Strategic Action Plan on HIV Prevention among Children and Youth from Most-at-Risk and Vulnerable Populations and on Care and Support for Children and Youth Affected by HIV/AIDS, approved by the National Council on HIV/AIDS and Tuberculosis on May 25, 2010.

⁴⁸ Decree of the President of Ukraine No 1085 as of December 9, 2010 “On the Optimization of the System of Central Executive Bodies”.

“Some contradictions do exist, for example, provisions of the Civil Code of Ukraine, articles 284, 286, 301, as well as Article 40 of the Law on Medical Secrecy. They create age-specific inconsistencies. If the law reads that a child aged 14 and older has the right to choose a doctor and to know what treatment is prescribed, then other provisions stipulate informing the child’s parents about diagnosis and disease. As we see, inconsistencies exist in these laws” (Service provider, social worker, Kyiv);

“There exist some nuances that need to be addressed, but in reality two laws prohibit something that one law permits. This is serious obstacle that creates many difficulties for us” (Service provider, health worker, Odessa).

- The lack of regulation regarding age categories of VCT service recipients (children, adolescents and young people) and their rights. Still unresolved is the issue of legal status of adolescents under 14 years, which prevents them from receiving health services independently. While testing most-at-risk adolescents from amongst those who live or work on the streets, service providers often disregard their views and opinions, and ignore legal provisions that require obtaining child’s or his/her legal representative’s consent to testing.

Analysis of current national legislation demonstrates that adolescents’ opportunities to receive VCT services significantly depend on their age. In particular, adolescents aged 14 years and older have the right to receive VCT services independently (without involvement of their parents or legal representatives) and even anonymously. At the same time, VCT services to a client under 14 years may be provided only upon consent of his/her parents or legal representatives.

“Legal mechanisms of how to officially work with minors are still unclear. This particularly concerns their age. Do we need permission? If yes then where to obtain it?” (National expert, All-Ukrainian NGO, Kyiv);

“This particularly concerns adolescents, because they are eligible for treatment and diagnostics only if parental consent is available. But if we talk about counselling, there is no need for any permissions” (Health worker, national expert, Kyiv);

“This primarily concerns “14 years reform” – it is not that simple and clear” (Health worker, national expert, NGO, Kyiv);

“There are some controversial issues, for example, capacity of an adolescent from 14 years on to come without parents and get tested for HIV. This is controversial. Some people say that the law prohibits it when he comes without adult guardian. Our specialists insist that an adolescent can choose a specialist and make conscious decisions. This is strange” (Service provider, psychologist, Odessa).

- VCT Guidelines do not define such category as “most-at-risk adolescents”; the documents does not describe peculiarities of counselling for adolescents who practice high risk behaviours similar to those prevalent among adult representatives of most-at-risk populations, even though the combination of age specifics, social status and behavioural practices of these adolescents requires rather specific approach to counselling.

“Today there exists an urgent need – and it was discussed at international conferences on numerous occasions – to develop some document that would regulate specifics of service provision to adolescents. This is a very special group, as adolescents are no longer children but not adults yet” (National expert, health worker, Kyiv);

“Risk groups, like other categories of adolescents, are affected by the lack of agreement between legislation and their specific needs, including treatment and diagnostics” (National expert, health worker, Kyiv).

The procedure of provision of medical care to children and youth at risk for HIV exposure, who live or work on the streets or temporary placed in institutions, is not regulated by any legal documents, and this violates the rights of these children. Staff members of institutions for temporary placement of children are usually unaware of:

- a) the right of the child to health care, including testing for HIV infection,
- b) the prohibition to disclose information about the child’s health status.

This is why cases of violation of children’s rights by the staff of such institutions are quite common.

“There exist very complex regulatory and legal barriers to normal work with underage FSWs, MSM...” (Service provider, social worker, Kyiv).

- Violation of the rights of underage persons during medical examination for HIV infection in institutions of temporary placement of adolescents. As a rule, personnel of these institutions are unaware of the rights of children.
 1. According to a scheme established by the Procedure of Health Service Provision to Children in the Shelters for Minors of the Service for Children and in the Centres for Social and Psychological Rehabilitation of Children, and Schemes of Medical Examination of Children in Treatment Facilities⁴⁹, blood tests for HIV infection was included in the list of mandatory examinations for children upon their placement in the social protection institutions or health facilities. Following such examinations its results should be communicated to the teaching staff.
 2. Guidelines on the provision of health and social assistance to HIV positive children⁵⁰ states that in the event of positive result of HIV testing in a child of 14 years and older, the decision on disclosure of information about his/her HIV status to parents or legal representatives shall be made by the patient. At the same time, if parents or legal representatives of an adolescent officially request information from a health facility regarding the child’s health status, they should be able to receive all necessary data. The same Guidelines instruct that such information may be disclosed by health workers only when it concerns a child of 14 years and older “in cases when it may damage personal

⁴⁹ Joint Order of MoFYS and MoH Ukraine No 3297/645 as of September 28, 2006 “On Approval of the Procedure of Health Service Provision to Children in the Shelters for Minors of the Service for Children and in the Centres for Social and Psychological Rehabilitation of Children, and Schemers of Medical Examination of Children in Treatment Facilities”

⁵⁰ Joint Order of MoH, MoES, MoFYS, the State Department for Enforcement of Sentences and the MoLSP No 740/1030/4154/321/614a as of November 23, 2007 “On Measures for Organization of Prevention of Mother-to-Child Transmission of HIV, Health Care and Social Follow-up of HIV Positive Children and their Families”.

interests, health and further treatment of a child. Appropriate decision of the multidisciplinary team shall be duly substantiated and included in the patient's health record".

3. Mechanisms of data sharing regarding HIV testing, results of subsequent medical examinations and treatment do not provide clear guidance on who, how, when, on what legal grounds and so on should submit such information (including incomplete or shortened data).
- Joint Order of MoH, MoES, MoFYS, the State Department for Enforcement of Sentences and the MoLSP No 740/1030/4154/321/614a as of November 23, 2007 "On Measures for Organization of Prevention of Mother-to-Child Transmission of HIV, Health Care and Social Follow-up of HIV Positive Children and their Families" needs to be reviewed, amended and supplemented with norms concerning VCT.

"Many regulatory and legal acts, especially sectoral, contradict each other. We need clarity; we need some additional analysis, because new legal acts were passed at the national level. At least, this concerns documents that regulate work with adolescents and underage children with chemical dependencies. We need to amend current documents. Let's consider this intersectoral Order No 740 – it was signed by four ministries and the Department for Enforcement of Sentences..." (Service provider, social worker, Kyiv).

- The lack of clear and functional mechanism of cooperation / referral between facilities, institutions and organizations of social sphere and health facilities in the area of VCT service provision.

Quite common are situations when it is necessary to involve services for children in order to observe all formalities (these primarily concern obtaining official permission to perform HIV testing for a child under 14 years of age) related to the presence of legal representatives of most-at-risk adolescents.

The procedure of maintaining and securing information provided by underage clients to social workers needs to be strengthened.

In view of this analysis, we would like to speak out in favour of the following statements, provided in the draft VCT Guidelines: ***"In the provision of counselling to adolescents it is necessary to consider their age peculiarities (aggravation of certain personality traits; specific behavioural reactions, such as avoidance and resistance to adult influence; underdevelopment of motivational and emotional-volitional sphere; frequent changes in the emotional state; limited ability to forecast consequences of one's behaviour), their social and psychological characteristics (the presence and the level of social and pedagogical neglect; limited perception of the value of one's own health; the lack of health-seeking skills; low awareness about health issues and behavioural risks), and the level of their intellectual development. Accordingly, it is recommended to use age-specific and easy-to-understand vocabulary and to avoid the use of unclear scientific terms, or to provide detailed explanation of such terms. Representatives of this age category may be present in all populations that seek VCT services, therefore in the process of counselling it is necessary to consider recommendations of relevant sections of these Guidelines, also taking into account the existing age peculiarities"***.

6.1.2. Staff Training and Staffing

“Children are personalities, but by virtue of their age they cannot fully comprehend the situation and make decisions. Therefore, they need a person beside them who will not make decisions instead of children, but rather help them choosing the right direction without harm and consequences” (Project manager, NGO, Odessa)

- Staff training

1. Current HCT Guidelines require that all counsellors complete specialized training, but neither the procedure nor institutions that can offer such trainings are defined by this document. According to information from the State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases of MoH Ukraine, they have approved and introduced a number of training programmes: advanced training course for doctors on counselling and testing for HIV, and a distance-learning course for paediatricians and family doctors “Provision of medical and social services to adolescents and youth” (the course dedicates 8 academic hours to VCT, which is about 20% of the entire training) at the National Medical Academy of Postgraduate Education after P. Shupyk. A course of thematic advanced training on the basics of counselling and testing for HIV was introduced in the curriculum of Lviv National Medical University after Danylo Halytskyi. In addition to courses within the postgraduate education system, health and social workers can opt to participate in VCT trainings organized by international organizations (ICF “International HIV/AIDS Alliance in Ukraine, UNICEF and PATH) and approved by the Ministry of Health.

Currently there is no formally approved procedure for receiving a certificate of VCT counsellor.

2. A significant share of specialists involved in this study have completed specialized and certified training courses on the peculiarities of the work with adolescents (including MARA), provided at the National Medical Academy of Postgraduate Education after P. Shupyk, as well as trainings, supported by International HIV/AIDS Alliance in Ukraine and PATH.
3. All experts are adequately trained and use provisions of VCT Guidelines and methodological recommendations of International HIV/AIDS Alliance in Ukraine and UNICEF in their everyday work. Nonetheless, almost half of interviewed experts defined the age of “children” and “adolescents” in their own way.
4. Each third national expert views NGO staff members as people who lack professionalism. Experts explain it by insufficient training and significant staff turnover (including trained staff) as a result of insecure and unstable funding. At the same time the survey results show that only two out of 12 interviewed NGO members were not aware of VCT Guidelines. 10 NGO specialists participated in trainings and received a certificate of VCT counsellor. 7 NGO members participated in trainings on adolescents and MARA, organized by ICF “International HIV/AIDS Alliance in Ukraine”, UNICEF and PATH. If specialists do not have the abovementioned certificate, they never directly provide VCT services but rather work in the area of project manage-

ment. At the same time, most managers have VCT certificates as they completed relevant training courses.

Only a few respondents mentioned the Alliance's manuals as additional reference materials for conducting VCT that are used in practice.

- Staffing of facilities and organizations that provide VCT services.

Understaffing – particularly the deficit of lawyers, nurses and social workers – is viewed by the experts as one of key barriers to ensuring accessibility of VCT services. Ongoing reformation of the health sector hinders distribution of functions between paediatricians and family doctors. Specialists believe that only after completion of said reform will it become possible to clearly divide functional duties between various health professionals, including in the area of HIV counselling.

Almost all experts mentioned the issue of understaffing. In the course of individual interviews and during focus group discussions experts complained about the shortage of specialists, which creates waiting lines. Moreover, many VCT specialists work on conditions of part-time employment: in other words, they do not work every day and their working hours are shorter. As a result, the clients have to make appointments in advance. Doctors' working hours are not always convenient for the clients.

Systemic staff turnover and the need to continuously train new staff members significantly affects the quality of work and the quality of services.

Experts articulated the need for additional positions of outreach workers in mobile outpatient units in order to scale up its network and to ensure maximum approximation of services to clients, which is particularly important for reaching MARA.

The majority of health professionals do not have relevant training to be able to become members of outreach teams targeting MARA, and to work in mobile outpatient units.

All interviewed NGO experts mentioned various staffing problems, the lack of specialists and their poor training, but expressed readiness to participate in different educational activities to improve their professional competence.

- Inadequate knowledge of specialists in regulatory and legal field, particularly in the area of VCT service provision to the target population.

"I think we lack legal knowledge" (Health worker, Kyiv);

"We do not have enough knowledge. For example, I do not know all regulatory documents well enough to be able to give the number and wording of this or that order" (Service provider, health worker, Odessa);

"We lack legislative information, legal, to be precise. We do not know all these articles" (Service provider, social worker, NGO, Kyiv);

"As for details regarding children and adolescents... of course, we need additional knowledge" (Service provider, health worker, Mykolayiv);

“My knowledge in this area is limited, as we do not work with adolescents, and I do not study relevant legislation. I do not work with this category, so I have no data of this kind” (VCT service provider, health worker, Mariupol).

VCT specialists also need instructions on the provision of services to a child under 14 years who has legal representatives but it is impossible to involve them in VCT process for various reasons.

“We are not legally protected. And we don’t have full information about working specifically with adolescents. Well, I don’t have this law, which clearly states that I can deal with adolescents only in the presence of his parents. I usually work with adolescents who come here alone” (Service provider, health worker, Mykolayiv);

“The fact that even ART protocol officially reads as “the protocol for adults and adolescents” means that approaches used in the work with adolescents are the same as for adults. This needs to be different” (national expert, health worker, Kyiv).

- The lack of coordination between specialists in the provision of VCT services.

For every second expert the lack of coordination between health and social services is another serious obstacle: as a result of reformation of the country’s social service, joint work of health facilities and CSSFCYs is not coordinated centrally, and their cooperation is limited to local level. Moreover, the absence of clear national policy in this area further complicates conclusion of cooperative agreements between CSSFCYs and health facilities that offer VCT services.

According to NGO representatives, the majority of non-governmental organizations offering VCT services work only with clients who are 18 years and older. This creates additional organizational barrier, as NGOs are closer to most-at-risk populations than any other organization.

While describing their experience of VCT, adolescents highly appreciated friendliness of staff: more than one-third of respondents (37.4%) estimated it as “good”, and 31.6% – as “excellent”.

Not a single expert suggested involving additional human resource – specialists in social work (beginning from July 2012 the Ministry of Social Policy of Ukraine secured additional human resources for regions – 12 thousand specialists in social work. Their responsibility is to work with families, children and youth in difficult life circumstances and with vulnerable children in local communities, and to carry out preventive activities). This may be the evidence of experts’ distrust towards this newly established social work institute, or experts were simply unaware of prospects of getting this powerful resource “on board”. Therefore, it would be expedient ***to engage this newly established domestic resource – social workers – in the provision of VCT services upon completion of relevant training.***

6.1.3. Insufficient Funding

First, there is no separate expenditure item on the work with MARA: *“I wish we could address the issue of financing services provided to most-at-risk adolescents... For example, we need to designate some special, separate budget item, because they often need both examination and treatment. In many cases these adolescents have no money to pay for services. Well, our services are free, including counselling, but what if this kid is referred to some other facility where services are paid? Some extra money wouldn’t hurt... Especially for this population...”* (Service provider, health worker, Odessa).

Second, financing of this activity area is insufficient at all levels. For example, there are no budget items to cover travel expenses of social workers and adolescents during their transportation to a specific facility.

And third, there are no guarantees that adolescents will continue receiving these services after discontinuation of international donor support.

Another important issue identified by the experts is the deficit of rapid tests.

“Something needs to be done as this category of the population needs specific services that should be backed with relevant funding” (health worker, national expert, international organization, Kyiv).

“To improve funding”.

“I wish we received rapid tests to perform comprehensive VCT in line with the Protocol, including pre-test counselling, testing and post-test counselling... Considering our limited resources we provide counselling only... Collected blood samples need to be taken to the lab, and this means additional expenditures... It is easier for an adolescent to go to a place where they offer a full range of services. We only refer them to our AIDS centre” (service provider, NGO, Mykolayiv).

“In general, our health facilities work well. The main thing is to bring an adolescent there. There is shortage of transportation”.

“...or their location fully discourages people from coming to them” (national expert, representative of the international organization, Kyiv).

6.1.4. Organizational Barriers

Most of social work specialists involved in the study (representing NGOs and CSSFCY) pointed at the existence of organizational barriers.

First and foremost, experts pointed at inadequate development of infrastructure of facilities offering VCT services, because current system of VCT service provision fails to meet all needs.

“Barriers in this regard should be viewed as underdeveloped infrastructure of services for this age category” (National expert, health worker).

The majority of experts talked about the absence of a comprehensive approach to VCT service provision and “interruptions” in the process of counselling and testing of adolescents (or the lack of “one-stop shop” methodology in the VCT system).

Not many organizations in the country are willing to provide services to adolescents.

Experts also mentioned the shortage of premises for individual counselling during VCT.

Another important barrier is inconvenient working hours of health facilities: testing is usually provided in the morning hours, when most adolescents are in school. Maybe an adolescent would like to receive VCT services confidentially and even anonymously, but if he or she skips classes for these purposes, the parents and environment may learn about it and start asking uneasy questions. Respondents also mentioned the lack of gender-sensitive approaches in counselling.

6.1.5. Informational and Methodological Support

“In order to communicate information you need to have such opportunities. You can prepare plenty of information; obtain it from some sources, collect. But it turns out that it is very difficult to get your message across. If we talk about advertisement, it is too expensive. If these are booklets – again, you need to print them and disseminate. Therefore, the main barriers in this area are the lack of funding provided by health facilities on public information” (Health worker, national expert, Kyiv)

Analysis of experts’ responses made it possible to identify a number of issues of informational and methodological support of activities aimed at informing children and young people about VCT services and their availability.

1. In addition to health, psychological, social and legal services, facilities offering VCT also provide informational services.

In particular, experts emphasized that health workers conduct education and prevention work on a pro-bono basis, as an additional workload, and in educational establishments. As a result, such activities are fragmented and sporadic.

According to experts, adolescents are largely unfamiliar with activities of YFCs, even though these are facilities that are most accessible for adolescents, even without documents:

“I think that a key barrier is limited knowledge of most-at-risk adolescents about Youth Friendly Clinics, which actually offer a variety of services, including informational”;

“The main barrier for us is informational. If adolescents had more information, they would be more active in seeking YFC services; “We need to give more information to adolescents – including MARA boys and girls – about Youth Friendly Clinics in the city of Kyiv and about their locations” (Service provider, health worker, YFC, Kyiv);

“Informational barrier. I mean, availability of quality, useful information. It is the quality of information and the way it is presented that influences an adolescent’s readiness to

come (or not to come) to a YFC and undergo examination” (Service provider, infectious diseases specialist, Sumy).

The situation could have been improved by means of adequate coordination, but it is not in place.

“There exist no organizations that offer information capable of reaching the majority of this population – I mean adolescents and youth” (Service provider, health worker, YFC, Kyiv);

2. Modern information technologies (including Internet, social networks, online counselling) are not used to their full capacity in the context of disseminating information for adolescents; despite the fact that adolescents are active Internet users, this resource is not widely used to spread information about VCT. Experts believe that nowadays this is the optimal channel for delivering information to the target audience, as even MARA boys and girls use Internet because they often spend nights in Internet cafes and clubs.

In addition, one of service providers came up with an idea of Internet outreach and counselling via Skype.

“Information is available online, on different sites. People talk about various opportunities for testing and suggest various locations. The main thing is one’s willingness to do so” (Psychologist, VCT service provider, Odessa);

“They often visit Internet clubs, so everything that we discussed here can be transferred online, like Internet outreach. This will allow a social worker who discusses these issues in social networks to invite clients to the centres, and even to provide counselling via Skype. These are our plans for the future, because Internet nowadays is everything (Service provider, project manager, NGO, Odessa).

3. Capacities of the state media is severely underutilized, especially television. The resource of local radio and TV channels is not used at all.

“Information means television; I doubt that they read newspapers nowadays, but they definitely watch TV” (Psychologist, VCT service provider, Odessa);

“We should use different resources – television, and social work, and even word of mouth from one adolescent to another. Maybe somebody heard something and advised the other one” (VCT service provider, Odessa);

“More information on television is needed so they know what VCT is, how it is done and that there is nothing scary about it. They need to know that this it will benefit their health, and that the sooner they learn about their status, the better. They have to have clear understanding” (Service provider, psychologist, Odessa).

4. Experts mentioned an ongoing need for handout materials that are actively distributed among adolescents during educational and information activities, and also expressed concern with declining amount of social advertisement on billboards.

5. Many experts complained about the lack of information campaigns at the national level that would specifically target adolescents. Instead they implement a public awareness campaign on HIV prevention for broad strata of young people. This campaign incorporates various events entitled “Do not Give AIDS a Chance”, including concerts and performances, dissemination of thematic brochures, Internet activities and social advertising.

“Of course, clinics disseminate information themselves. They all have a stock of leaflets. They have information – someone writes tests, someone appears on TV and in media. Moreover, they have this standard concerning prevention activities which envisages mandatory development and dissemination of information materials, visibility in mass media and so on...”;

“There exist no organizations that offer information capable of reaching the majority of this population – I mean adolescents and youth” (Service provider, health worker, YFC, Kyiv);

“I cannot even imagine what else we need. We have posters hanging all over the place. Our specialists always inform them about opportunities, and provide details on where and how this can be done. We have plenty of information. Where else should we put it? How about sticking it on the specialists’ foreheads” (Service provider, psychologist, Kyiv).

Among other things, adolescents recommended using some age-specific and acceptable resources. For example, in order to motivate peers to take HIV testing, 36.7% of all respondents noted that online resources should provide clear and adolescent-friendly information about opportunities and locations of HIV testing; 23.6% suggested developing a mobile app with similar content.

In addition, adolescents who participated in focus groups suggested that besides Internet it was possible to use social networks and online counselling; street-based events for youth should employ colourful, friendly and easily perceivable social advertisement and flash mobs suitable for different age categories of adolescents. Also information can be presented in motivating and adolescent-friendly format, e.g. educative life stories in the form of comic books.

It should be added that 91.8% of surveyed respondents have Internet access, and each second adolescent uses the Web for more than two hours a day (53.6%). 94.8% of adolescents have cell phones (56.8% – regular mobile phones, and 43.2% – smartphones).

As the majority of respondents in the sample was represented by adolescents and young people from big cities and oblast centres (78.8% during the first wave, and 93.8% – during the second wave), respondents’ answers on scaling up access to information about HIV through Internet communication commonly represented interests of urban adolescents rather than those living in rural areas. **Therefore, inaccessibility of information and methodological resources for rural children and youth creates additional barrier, which limits their knowledge and prevents them from seeking VCT services.**

6.2. Subjective Barriers

6.2.1. Inadequate Knowledge

“...adolescents who have minimum, almost no knowledge; of them only about 0.1% know what to look for and where, and what are their rights” (Health worker, national expert, Kyiv)

Section III dwelled on issues of poor knowledge of adolescents and MARA boys and girls about various issues of HIV infection and AIDS and the ways of HIV transmission.

All interviewed experts confirm the presence of specific information barriers that prevent adolescents from accessing VCT services: *“We talk about simple absence of any information about the need to get tested for HIV. Most of them believe that this has nothing to do with them”* (health worker, national expert, Kyiv).

According to experts, information barriers to VCT do exist, but they are not crucial. If requested, any adolescent can obtain all necessary information. An adolescent willing to undergo testing for HIV can find relevant information in the Internet, ask friends, or receive it from health workers who regularly conduct prevention measures (classes) in educational establishments. The problem lies in adolescent’s understanding of his/her own risks and the need in testing – it is rather a question of motivation of target group representatives to undergo HIV testing.

More specifically, experts identified information barriers for adolescents, including MARA, particularly for those living in rural areas. Representatives of the organization that specifically focuses on the work with most-at-risk adolescents reported that many MARA clients simply couldn’t read; therefore useful information needs to be presented in pictures. Adolescents who can read are also more likely to perceive information in the form of comic strips.

“There exist no organizations that offer information capable of reaching the majority of this population – I mean adolescents and youth” (Service provider, health worker, YFC, Kyiv);

“The other question is accessibility of this service and availability of information – how much information this adolescent can have, where he can find it” (National expert, international organization, Kyiv).

It is worthy to note (Table 6.1) that more than half of all respondents never thought about the need of taking tests for HIV (59.1%). This is particularly true of the youngest respondents, while adolescents of older age gradually change their attitudes towards this issue: never thought about HIV testing 70.4% of those aged 13; 68.3% of adolescents of 14–15 years; 54.1% of adolescents aged 16–17; 53.7% of those aged 18–19 years, and 48.5% – of young people aged 20–24.

About one-third of respondents believe that risk of their exposure to HIV is insignificant (36.0%).

Each fifth respondent (17.2%) does not know where one can get tested for HIV. Moreover, the proportion of girls who are not aware of any testing sites is twice as higher than that of boys

(22.5% and 12.0% respectively), while the highest percentage falls on respondents of the oldest age group of 20–24 years (25.8%).

Additionally, 3.7% of adolescents did not know that they could receive testing without parental consent, including 5.6% of adolescents aged 13 years; 7.0% of those aged 14–15; 2.7% of adolescents of 16–17 years of age, and 1.5% of those who reached 18–19 years.

48% of adolescents believe that MARA boys and girls need to be aware of their own HIV status and its consequences.

Focus group participants also noted that they could be afraid that “parents will find out”, afraid of status itself and its consequences, of blood sampling procedure and the need to pay for services.

Information about future plans of taking test for HIV (N=188) is quite controversial, as adolescents do not have firm motivation: 28.5% have no plans of this kind, while 42.1% are still undecided.

Therefore, poor knowledge of principles of VCT services provision among adolescents in general and MARA in particular does not motivate representatives of this target population to undergo testing for HIV and creates additional problems, especially those linked with fear of stigma and discrimination.

Consequently, service providers need to intensify their efforts aimed at broader dissemination of information among adolescents and MARA boys and girls about opportunities for VCT and mandatory observance of its principles.

6.2.2. Psychological barriers

Analysis of responses of both adolescents and experts shows that psychological barriers among children and young people remain one of more powerful factors that prevent them from receiving the full range of VCT services.

Fear of possible disclosure of HIV status. In general, adolescents are reluctant to seek testing services in health facilities, as they are afraid to learn their HIV status and anxious about possible disclosure of testing results and the content of testing procedure (this primarily concerns adolescents who practice sex with men and tend to conceal the fact of such relations).

First, 8.1% of surveyed adolescents refused from testing as they were afraid of possible results. Such fears are more widespread among girls, as compared to the boys: 17.5% and 8.5% correspondingly. Similar trends can be observed in proportions of adolescents of different age groups – the fear increases with age: 2.8% (13 years); 3.2% (14–15 years); 9.1% (16–17 years); 14.9% (18–19 years); and 14.4% (20–24 years).

Second, 6.7% of adolescents who did not take HIV tests assumed that they could get infected during the testing procedure (6.8% of boys and 10.6% of girl). This is another evidence of their poor knowledge of how facilities offering VCT really work. 74.4% of such adolescents live in the apartment or a house, 16.3% – in the dormitory, and 9.3% – in the boarding school. 79.1%

of such adolescents live with parents. 7.5% of them belong to risk groups, and 6.6% are not exposed to infection.

And third, 6.1% of adolescents who did not undergo testing are afraid of negative attitudes of their environment, and the proportion of girls sharing this concern (9.4%) is three times higher than that of boys (3.4%). 53.8% of such adolescents live without parents; more than half of them (56.4%) live in the apartment or a house, 23.1% are inmates of boarding schools, 17.9% live in dormitories, and 2.6% – in the shelters. 56.4% of these adolescents are residents of big cities; 41.0% live in oblast centres, and 2.6% – in small towns. Similar proportion among MARA boys and girls reaches 14.9%.

In addition, respondents have some concerns associated with enrolment in medical care (3.6%) and with the fact that health workers may notify parents (2.8%). 5.1% do not want to know whether they are positive or not (table 6.1).

Concerns about the need to pay for testing. As mentioned in Subsection 5.4, which deals with non-observance of the patients' right to free testing for HIV, adolescents additionally mention this problem among barriers to HIV testing.

In particular, 3.9% of respondents refused to take an HIV test because they had to pay for it (Table 6.1). The boys (4.3%) mentioned this barrier less frequently than girls (8.8%). Respondents' answers, disaggregated by age, show that this barrier was more relevant for older adolescents (for 2.8% of respondents aged 13 years; for 1.1% of those aged 14–15 years; for 1.8% for adolescents of 16–17 years; for 9.0% of those aged 18–19 years, and for 11.3% of young people aged 20–24 years).

Therefore, statements about requests for payment for HIV tests are common both among those who eventually got tested (data in Subsection 5.4 also point at the increased frequency of payment requests depending on the client's age), and among adolescents who refused to take such tests.

Barriers to VCT services mentioned by adolescents are associated with children and young people's limited knowledge about opportunities to receive anonymous and free comprehensive health and social services in connection with HIV, as well as with fear of learning their own diagnosis and possible disclosure of one's HIV status among their immediate environment.

The absence of documents. Problems related to the absence of documents were the least cited in respondents' answers – 2% (mentioned primarily by adolescents of older age).

Therefore, adolescents are inadequately informed about opportunities for anonymous testing for HIV.

Experts point to this barrier when it comes to registration and prescription of ART. *“Formalization of documents, for example. If child's documents are elsewhere, sending a child to pick them up requires some money, but it is usually unavailable. What I mean is that budgets should include social worker's expenditures on transportation of a child, for example, to buy round-trip tickets for a social worker and a child”* (health worker, VCT counsellor, Kyiv).

VII. MOTIVES FOR HIV TESTING

“The key point is to have motivated clients. And this is a big problem with adolescents, as they are different a priori” (health worker, service provider, Kyiv)

Survey data demonstrate that only about half (46.9%) of surveyed adolescents and young people (44.7% of boys and 52% of girls) had themselves tested for HIV because they wanted to know their status. At the same time, 23.5% of respondents were “motivated” by the experience of unprotected sex and/or injecting drug use. 15.3% of respondents learned about the importance of testing at a lesson or during a lecture, while some had to undergo HIV testing because its results were necessary for submitting documents to university, or to get visa.

Virtually identical groups can be seen in responses of MARA boys and girls: 29.9% had test because they practiced unprotected sex and/or injected drugs, and 25.3% wanted to clarify their HIV status. Those who made a tattoo or piercing (2.6%), or needed testing results for documents (2.6%), or those planning marriage (1.3%) or pregnancy (0.6%) constitute the lowest proportions of MARA who took testing for HIV for various reasons (Table 7.1).

It should be noted that personal contacts are quite a convincing factor of motivating adolescents, as 15.3% of them learned about the importance of HIV testing at a lesson or lecture, while 11.7% listened to friends’ advice (this method is more productive in case of adolescents of older age).

While 11.7% of respondents were motivated by the advice of their friends (Table 7.1), a great deal of encouragement is shown by adolescents and young people who would recommend all their friends and acquaintances to take HIV testing – 62.8%. In general, girls are more likely to recommend testing to their friends than boys (Diagram 11).

In addition, adolescents’ willingness to recommend their friends testing for HIV increases with age: for example, about 37.8% of those aged 13 years would suggest VCT to their friends, while proportion of such adolescents increases to 55.9% among those of 14–15 years. Further age distribution is as follows: 62.2% (16–17 years), 69.8% (18–19 years), and 79.4% (20–24 years).

Therefore, adolescents’ readiness to recommend HIV testing to their friends and acquaintances depends on how they assess services of counselling and testing for HIV (Table 7.2).

Table 7.1.

Motives to HIV testing
(distribution of respondents' answers to the question "Why did you decide to take test for HIV?"), by gender, age and belonging to the risk group, %

	All respondents	By gender		By age					Among most-at-risk adolescents ⁵¹
		Boys	Girls	13 years	14–15 years	16–17 years	18–19 years	20–24 years	
Wanted to know my HIV status	46.9	44.7	52.0	80.0	23.8	54.1	40.0	50.5	25.3
Had unprotected sex and / or injected drugs	23.5	31.9	26.5	0.0	14.3	21.6	30.0	24.7	29.9
Learned about importance of testing at a lesson / lecture	15.3	8.5	16.3	40.0	0.0	32.4	15.0	10.8	7.1
Need it to submit documents to university, to get visa	15.3	17.0	11.2	20.0	23.8	16.2	25.0	8.6	2.6
Advised by friends	11.7	23.4	6.1	0.0	23.8	18.9	10.0	7.5	9.1
After receiving information from mass media	9.7	6.4	10.2	20.0	4.8	13.5	10.0	8.6	5.2
It was my partner's suggestion	5.1	14.9	1.0	0.0	9.5	8.1	2.5	4.3	4.5
Before conception	5.1	0.0	8.2	0.0	0.0	0.0	5.0	8.6	0.6
Before marriage	3.1	2.1	5.1	0.0	4.8	0.0	0.0	5.4	1.3
Made tattoo, piercing	2.0	2.1	3.1	0.0	0.0	0.0	0.0	4.3	2.6

Table 7.2

Assessment of VCT services by adolescents and youth, average scores,
(based on the results of online survey)

Characteristics of testing for HIV	Average scores*		All respondents
	1 st wave	2 nd wave	
Confidentiality of testing results	3.26	3.16	3.21
Blood sampling	3.03	2.86	2.95
Friendly attitudes of staff	3.07	2.84	2.95
Conversation after testing	2.60	2.49	2.75
Isolation of premises	2.80	2.70	2.75
Promptness of providing results	2.79	2.63	2.71
Conversation before testing	2.69	2.50	2.59

* Four-point scale, where "2 – unsatisfactory", "3 – satisfactory", "4 – good", and "5 – excellent". The higher is the score, the higher is the value of a particular characteristic of testing.

⁵¹ Integrated indicator calculated on the basis of answers to the following questions: #25 "How many sexual partners did you have in the past 12 months?" (answer "more than 6 partners"), or #26 "Did you ever practice the following – unprotected sex between males" (answer "yes"), or #26 "Did you ever practice the following – providing sex services in exchange for money or reward (food, clothes, housing, alcohol, drugs)?" (answer "yes"), or #28 "Have you ever injected drugs (with syringe)?" (answers "yes, several times", and "yes, many times"), or #33 "Why did you decide to take test for HIV?" (answer "because I had unprotected sex and / or injected drugs").

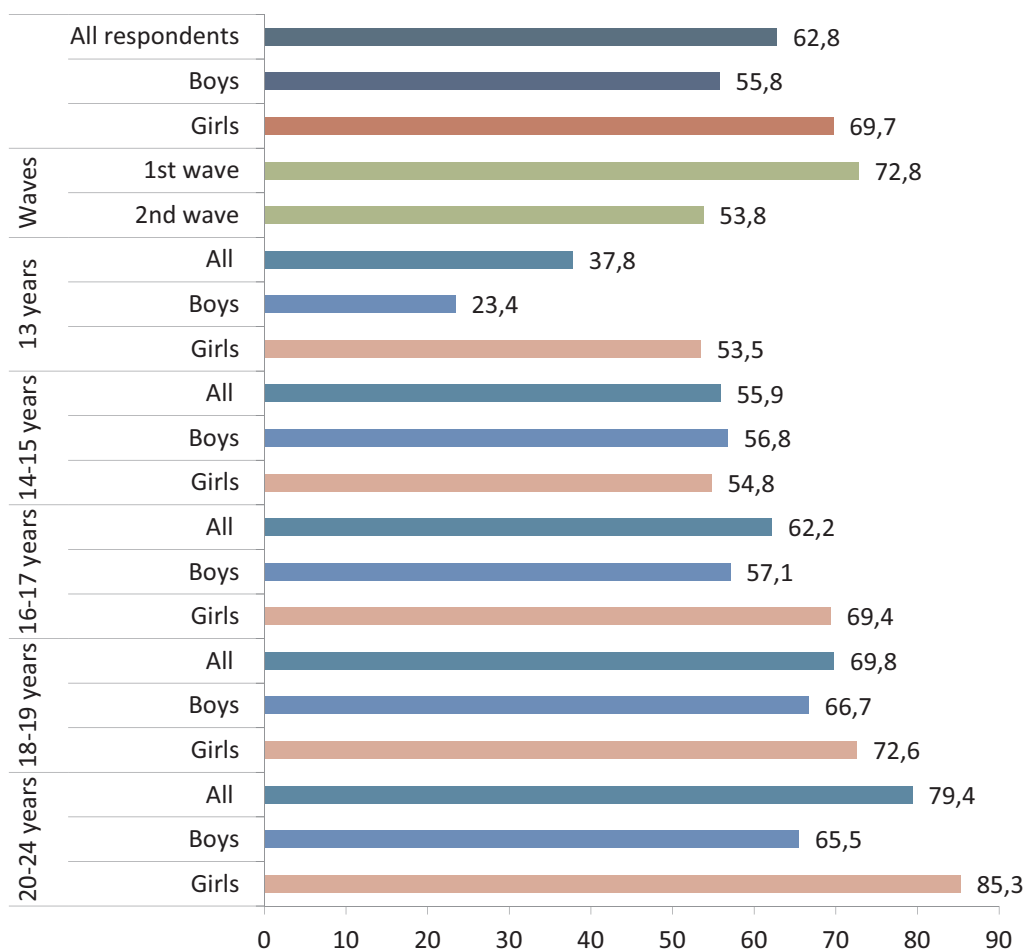


Diagram 11. Percentage of adolescents who would recommend their friends and acquaintances to undergo testing for HIV, by gender, age and wave of the study, %

Each fourth respondent (26.9%) was simply unaware of the best places for HIV testing, even though the proportion of adolescents who consider NGOs as the best place for adolescents to take HIV test (14.1%) is quite important indicator. Other sites mentioned by respondents include AIDS centre (41.7%), drop-in centre “Dovira” (25.3%), and YFCs (21.9%).

Venues, identified by adolescents and young people as the best sites for HIV testing (these are different from sites of the most recent testing – see Subsection 5.3), may also become additional incentives for the target population to receive VCT services.

In addition, analysis of survey results makes it possible to single out motives that could potentially encourage testing for HIV (by rating, Table 7.3):

As we can see, the most powerful incentive to take testing for HIV can be the information that preservation of one’s own health and health of person’s friends and family may depend on such test – 44.8%. Almost one-third of respondents note that learning about sexual partner’s drug use may also motivate an individual to HIV testing – 27.9%. 24.0% of respondents also mention casual sexual contacts without condoms in this regard.

In addition, the following factors could also improve conditions of testing (by rating, Table 7.4):

Table 7.3.

Motives that could encourage testing for HIV, by gender and age, %

	All respondents	By gender		By age									
		M	F	13 years		14–15 years		16–17 years		18–19 years		20–24 years	
				M	F	M	F	M	F	M	F	M	F
Information that my own health and possibly the health of my friends and family will depend on HIV test	44.8	41.1	48.4	34.0	32.6	44.7	52.4	36.8	42.6	33.3	60.0	60.4	50.4
If I learn that my sexual partner used (or uses) injecting drugs	27.9	20.4	35.4	4.3	4.7	12.1	27.2	24.1	40.2	15.7	43.3	47.2	43.6
Casual unprotected sex	24.0	20.4	27.5	10.6	4.7	13.6	15.5	24.7	32.0	15.7	28.3	35.8	39.8
Overcoming fear of possible testing results	22.2	19.0	25.4	14.9	16.3	14.4	21.4	23.6	28.7	13.7	25.0	24.5	28.6
If I learn that my sexual partner cheated on me	22.0	15.5	28.4	4.3	2.3	8.3	15.5	17.2	26.2	9.8	28.3	43.4	48.9
Incentive package, presents	16.1	19.9	12.4	40.4	23.3	24.2	21.4	13.8	10.7	13.7	8.3	17.0	5.3
If I start relationships with a new sexual partner	15.6	13.6	17.6	6.4	2.3	9.8	8.7	12.6	22.1	11.8	18.3	34.0	24.8

Table 7.4.

Motives that could improve conditions of testing, by gender and age, %

	All respondents	By gender		By age									
		M	F	13 years		14–15 years		16–17 years		18–19 years		20–24 years	
				M	F	M	F	M	F	M	F	M	F
To guarantee that none of my friends knows about it	43.6	39.2	47.9	29.8	20.9	39.4	41.7	40.2	48.4	21.6	41.7	60.4	63.9
Not to request identification documents	39.4	35.7	43.2	17.0	20.9	32.8	31.1	39.1	54.1	35.3	46.7	50.9	48.1
To offer HIV tests to all adolescents	37.4	30.6	44.0	25.5	34.9	31.8	35.9	26.4	38.5	25.5	26.7	50.9	57.1
To perform testing for HIV in convenient hours	33.9	29.8	38.0	17.0	30.2	25.8	28.2	32.2	35.2	17.6	36.7	54.7	51.1
To notify parents about testing results only upon the adolescents' consent	26.4	21.4	31.2	6.4	16.3	16.7	21.4	25.9	40.2	15.7	28.3	37.7	39.8

Even this aspect highlights adolescents' fear that VCT principles may be violated: 43.6% of respondents note that guarantees that no one knows about testing is a strong motivator,

while 26.4% of adolescents (the number of girls exceeds that of boys in each of surveyed age categories) point at the importance of notifying parents about testing results only upon the adolescent's consent.

According to surveyed adolescents, if no one requests identification documents (39.4%), if HIV tests are offered to all adolescents (37.4%), and if testing is provided in convenient hours (33.9%), then this can also increase their motivation.

In their responses adolescents also recommend such characteristics of HIV test that can encourage future testing for HIV (by rating) as a free-of-charge HIV service provision. In addition, simplification of testing procedure can also increase its popularity among adolescents, as 33.6% mention the need to notify about testing results no later than in two hours after testing (older adolescents are more likely to support this position than the younger ones); 29.2% suggested to base testing for HIV on saliva samples, while 20.6% would prefer their fingertip blood taken for testing instead of venous blood (more girls than boys supported the last two statements) (Table 7.5).

Table 7.5.

Characteristics of HIV test that could encourage HIV testing in the future, by gender and age, %

	All respondents	By gender		By age									
		M	F	13 years		14–15 years		16–17 years		18–19 years		20–24 years	
				M	F	M	F	M	F	M	F	M	F
If HIV testing is free	42.6	38.1	47.1	29.8	25.6	36.4	35.0	36.8	44.3	33.3	51.7	58.5	63.9
If results are provided no later than in two hours after testing	33.6	27.8	39.3	12.8	14.0	18.2	29.1	30.5	39.3	31.4	45.0	52.8	52.6
If HIV test is based on saliva sample	29.2	26.7	31.7	29.8	34.9	32.6	37.9	22.4	33.6	21.6	30.0	28.3	24.8
If HIV test is based on fingertip blood	20.6	18.6	22.6	14.9	20.9	18.9	15.5	15.5	24.6	15.7	10.0	34.0	32.3

Therefore, the following factors may motivate adolescents to get tested for HIV: almost half of respondents (47.7%) believe that adolescents practicing high risk behaviour should realize its importance and were not afraid of testing. This indicator tends to increase among older adolescents – in other words, understanding of importance of such test grows with age. About one-third of surveyed adolescents believe that offering HIV tests to all adolescents by health (35.8%) and social (29.1%) workers may also serve as powerful motivator (Table 7.6).

Respondents expressed different views regarding distance/proximity of the testing site from their places of residence. Almost one-third of surveyed adolescents (24.5%) believe that it would be expedient to have a place where one can get tested for HIV not far from their place of residence, while 8.0% believe that such site should be far away.

Table 7.6.

Motivating adolescents to undergo testing for HIV, by gender and age, %

	All respondents	By gender		By age									
		M	F	13 years		14–15 years		16–17 years		18–19 years		20–24 years	
				M	F	M	F	M	F	M	F	M	F
For adolescents practicing high risk behaviour to know that it is important, and not be afraid of testing	47.7	35.4	59.9	14.9	32.6	33.3	49.5	32.2	53.3	37.3	68.3	67.9	78.9
To have online resource with clear and adolescent-friendly information about HIV testing and testing sites	36.7	30.4	43.0	27.7	14.0	30.3	30.1	25.3	36.9	31.4	46.7	49.1	66.2
For health workers to offer testing for HIV to all adolescents	35.8	28.4	43.2	21.3	23.3	25.8	36.9	28.7	41.0	19.6	40.0	49.1	57.9
For social workers to offer testing for HIV to all adolescents that they work with	29.1	20.1	38.0	10.6	18.6	15.2	30.1	19.0	28.7	19.6	43.3	45.3	56.4
For facilities where one can get tested for HIV to be located not far from one's place of residence	24.5	23.0	26.0	6.4	20.9	19.7	18.4	25.3	30.3	29.4	23.3	32.1	30.8
To have phone apps with information about HIV testing and testing sites	23.6	21.2	26.0	27.7	18.6	20.5	25.2	15.5	15.6	11.8	33.3	45.3	35.3
For facilities where one can get tested for HIV to be located away from one's place of residence	8.0	5.5	10.4	6.4	7.0	6.8	11.7	1.7	9.8	5.9	8.3	13.2	12.0

Motivation of adolescents to undergo testing for HIV among those at risk and those not exposed to HIV infection:

Table 7.7

**Motivating adolescents to undergo testing for HIV,
among those at risk and those not at risk for HIV infection, %**

	Among those not at risk for HIV (84.1%, N=817)	Among those at risk for HIV⁵² (15.9%, N=154)
For adolescents practicing high risk behaviour to know that it is important, and not be afraid of testing	47.5	49.0
For health workers to offer testing for HIV to all adolescents	36.6	32.0
To have online resource with clear and adolescent-friendly information about HIV testing and testing sites	36.6	37.4
For social workers to offer testing for HIV to all adolescents that they work with	28.1	34.0
For facilities where one can get tested for HIV to be located not far from one's place of residence	25.6	19.0
To have a phone app with information about HIV testing and testing sites	23.3	25.9
For facilities where one can get tested for HIV to be located away from one's place of residence	7.5	10.2

Therefore, respondents' answers show that it is important for adolescents to have a place where one can get tested for HIV in the vicinity of their place of residence, while MARA boys and girls believe that it should be far away.

In seeking VCT services adolescents generally rely on health workers, while representatives of MARA population are more likely to trust social workers.

As for the sources of information, respondents' preferences also differ: if adolescents in general point to the importance of introducing relevant online resource, then MARA boys and girls would like to have mobile apps.

In the context of work aimed at strengthening motivation of adolescents, including MARA, to HIV testing, it is necessary to take into account relevant preferences of the target population.

Specialists of health facilities of all forms of ownership need to intensify their efforts in motivating adolescents to undergo testing for HIV.

Specialists of the social sphere, including members of outreach teams and counsellors of mobile outpatient units, need to carry out systemic efforts in motivating MARA to undergo testing for HIV.

In addition, it is recommended to design, develop, introduce and disseminate special mobile apps for MARA boys and girls with information about the importance of HIV testing and locations of testing sites.

⁵² Integrated indicator calculated on the basis of answers to the following questions: "How many sexual partners did you have in the past 12 months?" (answer "more than 6 partners"), or "Did you ever practice the following – unprotected sex between males" (answer "yes"), or "Did you ever practice the following – providing sex services in exchange for money or reward (food, clothes, housing, alcohol, drugs)?" (answer "yes"), or "Have you ever injected drugs (with syringe)?" (answers "yes, several times", and "yes, many times"), or "Why did you decide to take test for HIV?" (answer "because I had unprotected sex and / or injected drugs").

VIII. KEY ASPECTS OF IMPROVEMENT OF ADOLESCENTS' ACCESS TO VCT SERVICES

Results of the survey suggest that Ukraine has an extensive system that focuses on individual needs of recipients of VCT services, including children and youth. The current network of organizations that offer VCT services brings together governmental and non-governmental facilities, including AIDS centres, Youth Friendly Clinics, drop-in centres “Dovira”, children’s polyclinics, CSSFCYs, HIV service NGOs, mobile outpatient units, and the like.

Progress of the system of service provision to target populations in recent years was accompanied by a number of positive developments, which have resulted in improved access of different categories of children and youth, vulnerable to HIV infection, to friendly and high-quality health and social services.

It is possible to conclude that medical procedures aimed at detecting HIV infection in minors are properly formalized in the national legislation and comply with European standards. At the same time, the network of facilities and organizations involved in VCT service provision continues to expand, thus contributing to better meeting the demands for these services. Currently in Ukraine there exist over 700 drop-in centres and 104 YFCs. In order to bring services closer to a client and to ensure appropriate quality of informational, educational and consultative work with risk groups, a system of mobile outpatient units and outreach teams was established to reach most-at-risk adolescents and youth, as these categories are the most vulnerable to HIV (according to research findings, 68.6% of surveyed adolescents practiced unprotected sex; 7.2% injected drugs; 6.8% provided sex services for money or reward; 9.9% of boys had sex with men, and 5.7% fell victim to sexual violence and abuse).

At the same time, surveyed adolescents emphasize a number of positive trends in the provision of VCT services, such as friendly and benevolent attitude of staff, appropriate attention to every client, and relatively high quality of services.

A number of professional training programmes were developed and approved in the country to ensure systemic training of specialists – providers of VCT services. VCT staff is trained at different levels – both in the state educational facilities within advanced training courses, and in the framework of projects supported by international donors.

Nevertheless, the current system of VCT service provision fails to meet all needs.

Limited access of the target group representatives to VCT services, coupled with inadequate knowledge about HIV/AIDS and about opportunities to receive comprehensive HIV counselling and testing may contribute to further spread of HIV infection in children’s environment and hinder normal and full-fledged development of young people. For example, re-

spondents have relatively limited knowledge of the ways of HIV transmission; 33.9% of adolescents are not sure whether HIV positive person may look healthy; 23.8% of respondents are unsure or reject the statement that the only way to find out one's HIV status is to take testing; almost half of those surveyed (43.6%) do not know that testing results of sexual partners can be different or the same. The majority of service providers acknowledge that the amount of information and visual materials that inform about HIV and ways of HIV transmission, and encourage the use of VCT services is sufficient. Now it is time to introduce innovative technologies that are particularly popular among adolescents – Internet, flash mobs, mobile apps, and the like.

Regulatory inconsistencies and non-compliance of several regulatory and legal acts with the sectoral Law on HIV still present a problem in the area of VCT service provision to adolescents without consent of their parents / legal representatives. This collision contributes to various violations on the part of service providers, who, for example, demand parental consent from adolescents of older age. Still problematic is the question of HIV testing of adolescents in institutions of temporary placement (shelters, centres for social and psychological rehabilitation, and the like).

Quite common are cases of non-observance of voluntariness associated with HIV testing. In particular, 16.8% of respondents were not asked their permission for HIV testing, while 22.5% were not informed about their right to refuse testing.

Collected evidence revealed a number of objective and subjective reasons why adolescents refrain from VCT services. Objective reasons include inconvenient working hours and the need to wait in lines.

According to experts, subjective reasons also include adolescents' reckless attitudes towards their own health, unwillingness to know their own HIV status, the absence of documents, and the like.

Another important issue concerns accessibility of comprehensive VCT services for adolescents from remote areas and villages, as attitudes of local communities remain intolerant and even discriminatory, thus creating a number of psychological barriers. Therefore, public information activities aimed at formation of more tolerant attitudes to representatives of the target group are particularly relevant.

These reasons demonstrate that limited access of adolescents to VCT is preconditioned by both psychological and financial problems. A significant barrier to receiving the whole range of social services is associated with fear, including concerns about own HIV status (8.1% of respondents), disclosure of status, and negative attitudes of the environment (6.1%). Financial problems include inconvenient location of testing sites and inability to cover travel expenses to institutions and facilities offering VCT services (especially for rural adolescents), as well as demanding money for HIV testing (17.3% of adolescents with the experience of HIV testing had to pay for this procedure).

Amidst the lack of the national financing, the sector's dependence on international funding sources remains significant as the majority of social services provided by NGOs, as well as functioning of mobile outpatient units are only possible thanks to the programme "Support for HIV and AIDS Prevention, Treatment and Care for Most Vulnerable Populations in

Ukraine”, financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Their future sustainability remains unclear.

The study found that the system and procedure of referrals of VCT services and social follow-up remain untested, which limits performance and efficiency of these services.

Analysis of current normative and legal regulations and practical experience of VCT service providers working with adolescents and MARA boys and girls made it possible to formulate:

- step-by-step actions of health and social workers in this area (Table 8.1);
- algorithm of VCT service provision (Diagram 12).⁵³

Of similar relevance for the development of VCT service provision is the problem of staffing. Interviewed experts unanimously point to the shortage of qualified personnel, the lack of training and unpreparedness to work with the target population (with adolescents in general, and with MARA in particular), significant staff turnover and the need to continuously train new staff members, as well as a significant number of specialists in VCT service provision working part-time: all these create waiting lines and limit the time necessary to work with a client.

This is why we believe that it would be beneficial to consider recruitment of additional staff in VCT services, namely experts in social work, who will be responsible for detection and prevention of negative phenomena in children’s environments. Cooperation with newly established institute of social work may become extremely efficient in reaching adolescents vulnerable to HIV, and in providing them timely assistance in the context of VCT. Functioning of such large teams of social workers will be more effective upon completion of specialized educational courses with involvement of HIV service practitioners, including staff members of organizations and institutions working in the system of VCT service provision.

It is essential to strengthen cooperation between social (including NGOs) and health facilities and organizations, when joint efforts of these structures lead to creation of a single model of comprehensive VCT services for adolescents. The survey has identified some sporadic examples of such efforts.

Uncertainty about outcomes of ongoing health sector reform and the lack of coordination at the central level further complicates the development and strengthening of health and social services at the local level, particularly those aimed at supporting children and youth vulnerable to HIV.

The survey also discovered a number of opportunities that need to be strengthened and developed, e.g. introduction of online counselling, dissemination of information via Internet technologies and mobile phones, and so on.

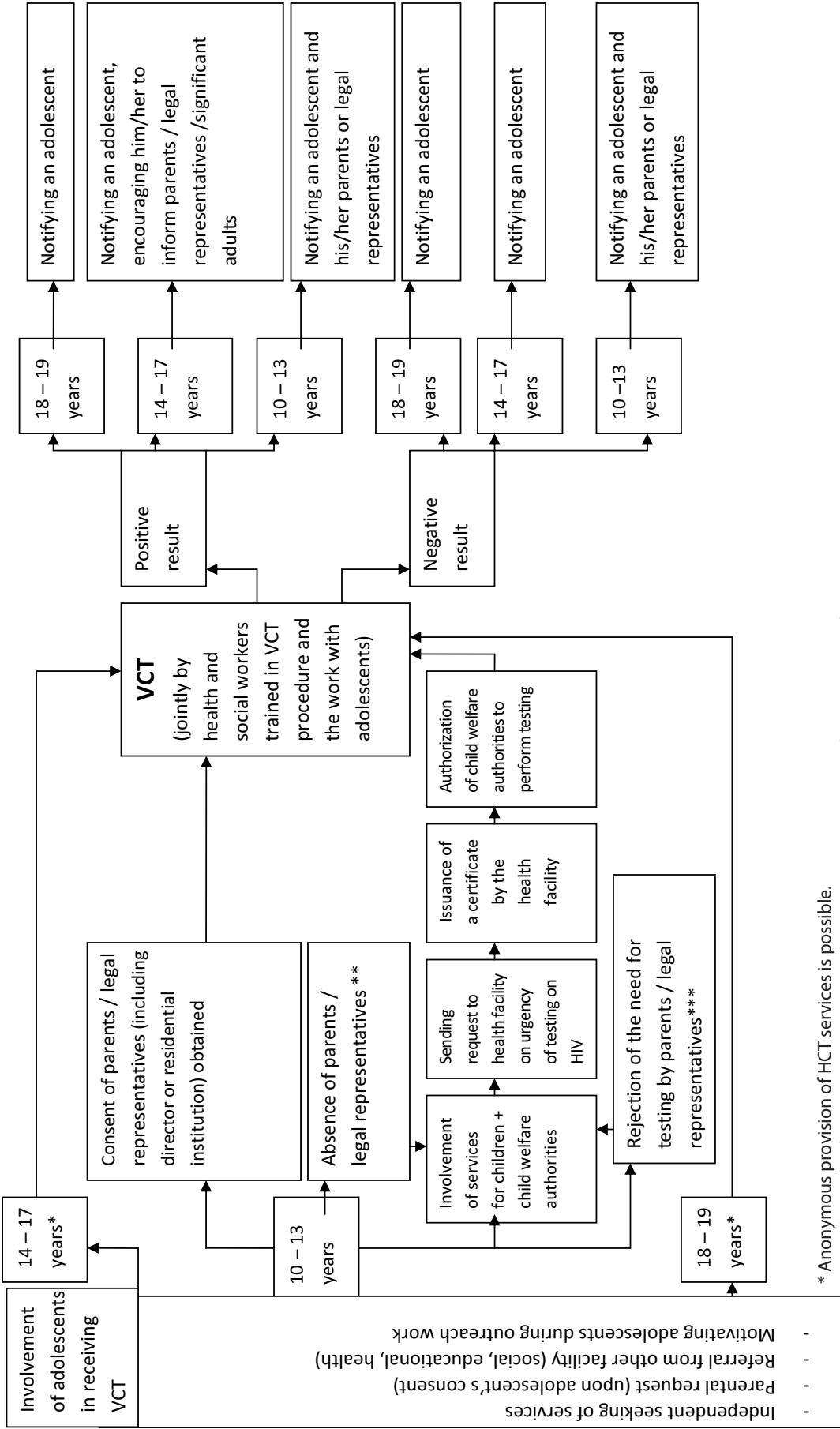
Development of new version of VCT Guidelines is underway. It is essential that peculiarities of VCT service provision to adolescents and MARA is duly included in this document.

⁵³ Two documents were used for analysis within this study: “Legal and regulatory review on HIV prevention and access of adolescents, including most-at-risk adolescents, to medical and social services” and “Review of the National Legislation and Current Practices on the Guidelines of HIV Counselling and Testing of Adolescents, including Most-at-Risk Adolescents”, prepared within UNICEF project (currently being printed).

Table 8.1

Step-by-step actions within VCT provision to adolescents

	Forms of involvement	VCT service provision (pre-test counselling and testing) depends on an adolescent's age	Post-test counselling, including notification about testing results
For health workers	<ul style="list-style-type: none"> Independent seeking of VCT or other services in a health facility (in this case internal referral is possible); Request of adolescent's parents or other legal representatives; Referral of an adolescent from other (health, social, educational) facility; in this case an adolescent may be accompanied by the representative of this facility, but the presence of the latter during counselling and testing is unacceptable unless an adolescent expresses such will; Encouraging adolescents to receiving VCT services in the course of outreach work (reaching adolescents through mobile outpatient clinics, visiting places frequented by young people, e.g. in educational establishments). 	<ul style="list-style-type: none"> adolescents aged 14–19 years have the right to receive VCT services independently and anonymously; involvement of legal representatives of an adolescent aged 10–13 years is mandatory and may include a request, written consent, or physical presence. 	<ul style="list-style-type: none"> 18–19 years – testing results are not disclosed to anyone except for an adolescent; 14–17 years – in case of confirmation of HIV positive status an adolescent should be encouraged to disclose his/her status to parents, legal representatives or significant adults, but these cannot be involved without adolescent's consent; 10–13 years – testing results are subject to mandatory disclosure to adolescent's parents or legal representatives.
For workers of social sphere	<ul style="list-style-type: none"> Encouraging adolescents to receiving VCT services in the course of outreach work (reaching adolescents through mobile outpatient clinics, visiting places frequented by young people, e.g. in educational establishments). 	<ul style="list-style-type: none"> adolescents aged 14–19 years have the right to receive VCT services independently and anonymously; involvement of legal representatives of an adolescent aged 10–13 years is mandatory and may include a request, written consent, or physical presence. 	<ul style="list-style-type: none"> 18–19 years – testing results are not disclosed to anyone except for an adolescent; 14–17 years – in case of confirmation of HIV positive status an adolescent should be encouraged to disclose his/her status to parents, legal representatives or significant adults, but these cannot be involved without adolescent's consent; 10–13 years – testing results are subject to mandatory disclosure to adolescent's parents or legal representatives.
Notes:	<p>a) if legal representatives of a child cannot be determined, VCT service provision to an adolescent may be carried out upon authorization of child welfare authorities following the request of services for children as temporary legal representatives of a child; at the same time, social service or an organization (NGO or CSSFCY), in cooperation with service for children try to find the child's legal representatives, restore his/her documents, place a child in shelter, and so on.</p> <p>b) if a child under 14 years has legal representatives, but it is impossible to involve them in VCT for various reasons (e.g. they are unresponsive in child's health needs or openly oppose testing for HIV), one should once again seek assistance of services for children, which, with support from child welfare authorities, may initiate testing of a child for HIV. To do so, services for children submit a request to the health facility on the need of such testing and that inaction may threaten the child's life and health. Upon reception of the official statement (certificate) from the health facility, services for children, in cooperation with law enforcement agencies, initiate removal of a child from his/her legal representatives and perform VCT upon request of the child welfare authority.</p>		



* Anonymous provision of HCT services is possible.

** Parallel search for adolescent's legal representatives, restoration of documents, referral to the shelter.

*** Service for children conducts targeted work with adolescent's parents / legal representatives (in case of confirmed threat to a child's life and health, service for children in cooperation with law enforcement agencies may initiate withdrawal of a child).

Diagram 12. Algorithm of VCT service provision to adolescents and MARA

IX. LESSONS LEARNED (METHODOLOGICAL GAPS)

Analysis of methodological and organizational gaps of the integrated study will be helpful for further research. Identified problematic areas contribute to understanding of the limitations of data interpretation and usage.

1. First of all, this study attempted to cover very broad target population – adolescents of 13 to 24 years of age, and an online survey among these respondents employed one and the same tool. Findings and conclusions of the study point to the expediency of applying other approaches, considering specifics of the respondents' age, e.g. suggesting shorter and easier variant of the questionnaire for younger age group, and offering a more complicated questionnaire with more questions regarding risky practices to those who attained 18 years of age. It would be reasonable to have “skips” for questions on risky behaviours for adolescents aged 13–14.
2. Secondly, the researchers believe that questions regarding same-sex relations should not be offered to the entire cohort of respondents. Unfortunately, research tools did not include separate questions regarding the boys' experience of sex with other boys or men as this answer was included into the list of risky practices; while answering current version of the question respondents could provide inadequate or underhanded responses.

Questions on same-sex relations should be included into a separate block for boys only. Design of the survey allows for female respondents to skip this block.

3. The need to carry out the second wave of the survey was preconditioned by lack of trust to the preliminary results from the researchers, medical and social workers.

For verification of the results focus groups with adolescents were conducted which confirmed the incompetency of respondents. First of all, it is confusion over general blood sampling and testing for HIV among some adolescents and young people. Secondly, a significant number of HIV positive adolescents also resulted from the lack of clear understanding of “positive” and “negative” results of testing, as adolescents often perceive “positive” as “good”, “successful”, and so on.

In order to receive competent answers from the respondents and to guarantee credible indicators on HIV testing and its positive results, the research team together with young people developed recommendations for social workers, NGO representatives, and youth activists who encouraged adolescents and young people to participate in the survey. These recommendations contain information on peculiarities of HIV testing and explanations on the meaning of “positive” and “negative” results, as well as way of informing respondents before answering the questions. These recommendations were used during the second wave of online survey.

5. The research tool did not envisage clarification questions. Therefore, it was not possible to determine:
 - whether testing was offered to adolescents aged 13 years without presence of their parents but in attendance of other adults who represent a child;
 - what are the reasons for some adolescents to conceal their age while seeking VCT services;
 - why pre-test counselling was not provided to almost one-third of surveyed adolescents, etc.
6. The design of possible answers to the question regarding pre-test counselling did not envisage selection of several response options.
9. In the course of individual and independent online surveys (unlike face-to-face interviews that present opportunities to ask clarification questions) adolescents are much more likely to use “I don’t know” or “Difficult to answer” options. Therefore, in designing new scales of on-line questionnaires the researchers should try to expand the selection of specific answers to the question, and avoid options without answer.
4. Valuable and positive experience in terms of organization of the study was the use of tablets during the second wave of online survey, which significantly broadened adolescent’s participation, especially participation of most-at-risk adolescents..
7. As the majority of respondents in the sample was represented by adolescents from big cities and oblast centres (78.8% during the first wave, and 93.8% – during the second wave), respondents’ answers on scaling up access to information about HIV through Internet communication commonly represent interests of urban adolescents rather than those living in rural areas.
9. Research tools provide insufficient information needed for identification of most-at-risk adolescents. For instance, there were no questions on being a client of HIV-service NGO, coverage by targeted prevention programmes, and way of being recruited into the survey. Methodology and research tools could not identify most-at-risk adolescents.
10. It is also expedient to develop standard indicators for assessing VCT services provided to the target group, and to include them in the future surveys.

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Questionnaire for the online survey of adolescents within the study “Voices, Values and Preferences of Adolescents on HIV Testing and Counselling”

Introduction

United Nations Children’s Fund (UNICEF) and its partner organizations conduct a research aimed at studying HIV testing practices among adolescents. Within this research we explore views, opinions and experience of adolescents in the area of HIV testing.

We invite you to participate in this study. If you agree to participate, it will take you about 10 minutes to fill in an anonymous questionnaire. This questionnaire includes questions about your views and possible personal experience of testing for HIV. We also ask you to provide some general information about yourself (e.g. gender, age, education, behavioural practices) for us to be able to accurately describe common features of adolescents participating in the survey. To ensure confidentiality, we do not collect the data that could disclose your identity (e.g. date of birth, name, address, and the like).

You can participate in the survey using your own computer with Internet access, or by using the researcher’s computer. Please note, that your answers will be entirely anonymous, and the researcher will not be able to identify your personality and your answers. We guarantee that your answers will be kept in strict confidence.

Your participation in this survey does not imply any risks or inconveniences. Your participation is voluntary. If questions become too uncomfortable for you, you can exit the study.

Your answers will contribute to better understanding of problems related to HIV testing among adolescents, and to the development of recommendations aimed at improving accessibility and quality of HIV testing services or adolescents.

We would be very grateful for your consent to participate in this study.

Adolescents’ informed consent to participate in the survey

- I was informed about the study “The Voices, Values and Preferences of Adolescents on HIV Testing and Counselling”.
- I understand that this study is confidential and anonymous.
- I understand that my views and experience will contribute to improving the procedure of HIV testing and counselling among adolescents.
- I understand that my participation in this survey is voluntary.
- I understand that I can refuse from participation in the study.
- I understand that I can refuse from answering any questions.

1. As a survey participant, do you agree with this statement?

- Yes
- No

Brief information about you

Your answers to the questions on this page will give us better idea of your personal characteristics

2. Please, indicate your age:

- | | | |
|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> 13 | <input type="checkbox"/> 17 | <input type="checkbox"/> 21 |
| <input type="checkbox"/> 14 | <input type="checkbox"/> 18 | <input type="checkbox"/> 22 |
| <input type="checkbox"/> 15 | <input type="checkbox"/> 19 | <input type="checkbox"/> 23 |
| <input type="checkbox"/> 16 | <input type="checkbox"/> 20 | <input type="checkbox"/> 24 |

***3. Please indicate your gender:**

- Male
- Female

4. Marital status:

- Married
- Unmarried
- In union, no official registration

5. What country are you living in?

Country _____

If other, please, specify _____

6. You live in:

- Oblast centre
- Big city (>100 thousand residents)
- Small town (<100 thousand residents)
- Township
- Village

7. What are your living arrangements?

- Apartment, house (rented, own, parents' or partner's)
- Dormitory
- Boarding school
- Shelter
- Spend most of the time on the streets (lofts, basements, etc.)
- No definite place of residence
- Please, specify where on the streets

8. Do you live together with parents?

- Yes
- No

9. Do you currently study (in school, vocational or technical school, university, college, etc.)?

- Yes
- No

10. What is the highest level of education that you reached?

- Incomplete primary (less than 4 classes of school)
- Basic secondary (4–7 classes of school)
- Incomplete secondary (diploma for 8–9 classes of school)
- VTS on the basis of incomplete secondary education
- Complete secondary education (diploma for 10–11 classes of school)
- VTS on the basis of complete secondary education
- Additional learning on the basis of complete secondary education (vocational training courses and the like)
- Secondary professional (VTS, college diploma)
- Basic higher (bachelor)
- Incomplete higher
- Complete higher (specialist, master)

11. Do you work?

- Yes, officially
- Yes, unofficially
- No

12. How do you spend your leisure time (you can select several options)

- Read books, do sports, music
- Watch TV
- Surf Internet
- Go to discos, parties, nightclubs
- There is almost no entertainment for adolescents in my locality
- Other

Please, specify _____

13. How often do you go to the parties, discos, nightclubs?

- Once a week or more frequently
- Once a month
- Several times a year
- Almost never
- Never

Please, specify, how often _____

14. Do you have Internet access?

- Yes
- No

15. How many hours a day do you use Internet?

- Less than one hour
- 1 – 2 hours
- More than two hours

16. Do you communicate with your friends and contacts via social networks (Facebook, VKontakte, Odnoklassniki, Twitter and the like)?

- Yes
- No

17. Do you have a cell phone?

- Yes
- No

18. What type of the cell phone do you use?

- Smartphone (Samsung, HTC, iPhone, etc.)
- Regular mobile telephone

Basic knowledge about HIV/AIDS

19. HIV infection can be transmitted through... (please select answers that you consider correct)

- Unprotected sexual contacts
- Shared use of syringed during the use of injecting drugs
- From HIV positive mother to her baby
- Handshake
- Sharing food with someone who is infected
- Mosquito bites
- Sharing toilet, swimming pool and the like with someone who is infected
- Drinking from one glass in turns with someone who is infected

20. How do you think, can a healthy-looking person can have HIV?

- Yes
- No
- Not sure

21. Do you agree with the statement that the only way to find out one's HIV status is to take HIV testing?

- Yes
- No
- Not sure

22. HIV testing results of sexual partners can be:

- The same (both partners are either positive or negative)
- Different (one partner is positive and the other is negative)
- All of the above

23. The main ways to prevent HIV infection are... (please select answers that you consider correct)

- To use condoms consistently and correctly
- To avoid injecting drug use
- To remain faithful to your sexual partner
- To delay sexual debut
- To avoid tattooing and piercing in non-certified centres
- If a pregnant woman has HIV – to take appropriate medicines to prevent mother-to-child transmission

Main behavioural characteristics

24. Did you ever have sexual contacts (includes any type of sex – vaginal, oral, anal)?

- Yes
- No

25. How many sexual partners did you have in the past 12 months?

- 1
- 2
- 3–5
- 6–10
- 11 and more
- Did not have sexual partners in the past 12 months (during the previous year)

26. Did you ever practice the following?

- Unprotected sex with a person of opposite gender
- Unprotected sex between males
- Provided sex services in exchange for money or reward (food, clothes, housing, alcohol, drugs, etc.)
- Paid for sex
- Unprotected sex with HIV positive person
- None of the above

27. Have you ever fell victim to violence?

- Sexual
- Peer physical
- Domestic
- Psychological
- Never encountered violence

28. Have you ever injected drugs (with syringe)?

- Yes, several times
- Yes, many times
- No
- Refuse to answer

29. Did you have contacts / communication with the representatives of the following professions in the past 12 months (you can select several options)

- Health worker (doctor, nurse, midwife)
- Social worker of the social service or non-governmental organization
- Staff member of the youth organization
- Specialist of the service for children
- Police officer
- None of the above

Information about HIV testing

30. Have you ever had testing for HIV?

- Yes
- No
- Don't remember
- Don't know

Your testing experience

31. Why haven't you been tested for HIV in the past? (you can select several options)

- I never thought about it
- I was sure that the risk of infection is very insignificant
- I do not want to know my status even if infected
- I thought that no testing was available for minors without parental consent
- I was told that no testing was provided to minors without parental consent
- I did not have identification documents
- I was afraid of registration in the health facility
- I was afraid of possible infection during testing
- I did not know where one could get tested
- I had to pay money for testing
- I was afraid of possible positive HIV testing results
- I was afraid of negative attitudes of friends if they knew about my testing
- I was afraid that health workers would notify my parents about testing results
- Other

Please, specify _____

32. Are you planning to take test for HIV now or in the nearest future?

- Yes
- No
- Don't know

Your testing experience

The following questions concern your most recent testing for HIV

33. Why did you decide to take test for HIV?

- I had unprotected sex and / or injected drugs
- I wanted to know my HIV status
- I received information from mass media / Internet
- I learned about the importance of testing at the lesson / lecture
- It was my partner's suggestion
- It was my friend's advice
- I made a tattoo / piercing
- It was before marriage
- It was before conception
- I needed it to submit documents to university (job application, visa, etc.)
- Other

Please, specify _____

34. When did you have your most recent testing for HIV?

- Less than one year ago
- 1–3 years ago
- More than 3 years ago

35. What was your age at your most recent testing for HIV?

- Less than 15 years
- 15 – 18 years
- 19 – 24 years

36. Did they ask your age before testing?

- Yes
- No
- Don't remember

37. Did you have to conceal your true age to have testing for HIV?

- Yes
- No
- Don't remember

38. Did they request parental consent to perform testing for HIV?

- Yes
- No
- Don't remember

39. Prior to the most recent test, how often did you have HIV testing?

- Never
- Only once
- Annually
- Other

Please, specify _____

40. Who suggested you to take testing for HIV?

- Health worker
- Social worker / NGO staff member
- It was my own initiative
- Other _____

Description of the testing site

41. Where were you tested for HIV?

- Polyclinic / hospital
- Youth Friendly Clinic
- Antenatal clinic / maternity
- AIDS centre
- Drop-in centre “Dovira”
- Non-governmental organization
- Mobile testing unit
- Addiction treatment clinic / dispensary
- STI clinic / dispensary
- Military enlistment office
- Other

42. Was it easy for you to find the place where people can get tested for HIV?

Accessibility of testing site

Very difficult

Difficult

Easy

Very easy

43. Did you have to miss the entire day of studies / work to undergo testing?

- Yes
- No
- Don't remember

44. How much time did it take you to reach the testing site?

- Less than 20 minutes
- 21 – 40 minutes
- 41 – 60 minutes
- More than 60 minutes
- Don't remember

45. Did you have to pay for the test?

- Yes
- No
- Don't remember

46. Was the test anonymous (e.g. you were not asked to give your first and last name, address and the like)?

- Yes
- No
- Don't know
- Don't remember

47. Please, indicate the level of importance of testing anonymity (for your first and last name and address not to be registered)

The level of importance of testing anonymity

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Not important at all | Not really important | Important | Very important |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

48. Did they ask you consent to testing?

- Yes
- No
- Not sure
- Don't remember

49. Did they inform you about your right to refuse from testing?

- Yes
- No
- Not sure
- Don't remember

50. Were you given any verbal or written information prior to HIV testing?

- Yes
- No
- Don't remember

Information about test and testing methodology

51. What was the content of information?

- When to come to pick up the testing results
- How the testing will be performed
- How HIV can be transmitted
- How to get oneself protected from HIV
- What to do in case of positive result
- Where one can get condoms
- Where one can get sterile syringes
- Don't remember
- Other

Please, specify _____

52. How valuable / useful was this information for you?

The value of information

Useless

Nothing new

Partially useful

Very useful

53. What method was used during your most recent testing for HIV?

- Rapid test (fingertip blood)
- Rapid test (saliva)
- Venous blood sampling
- Don't remember
- Other

Please, specify _____

54. Did you receive results of this testing for HIV?

- Yes
- No
- Don't remember

Receiving results

55. What prevented you from receiving results of HIV testing?

- I was afraid of possible positive result
- I forgot / was too busy / not important for me
- Too far to travel
- I do not trust the facility where testing was performed
- Other

Please, specify _____

Term of waiting for testing results

56. How long did you have to wait for testing results?

- Less than 2 hours
- Less than 1 week
- Less than 2 weeks
- 2 weeks and more

Testing results

57. What was the result of your test?

- HIV positive
- HIV negative
- Do not want to discuss it

Post-test counselling

58. Did you have special conversation (counselling) after receiving positive testing result?

- Yes
- No
- Don't remember

Quality of post-test counselling

59. What did they talk with you about immediately after receiving positive testing result?

- I received psychological support
- About the importance of healthy lifestyle
- About treatment and possible psychological support
- How to live with HIV
- How to prevent further transmission of HIV to other people
- Where I can get condoms
- Where I can get sterile syringes
- Where I can get psychosocial support
- Other

Please, specify _____

60. How would you assess the quality of support provided to you immediately after receiving positive testing result?

Quality of support

Very poor

Satisfactory

Good

Very good

Notifying parents

61. Did they suggest you to inform your parents about positive results of HIV testing?

- Yes
- No
- Don't remember

Informing other people about the testing results

62. Did you share information about your testing results with someone else?

- Yes
- No

Information about people who were informed about testing results

63. Who did you tell about the results of your HIV testing (you can select several options)

- A friend
- A classmate
- Sexual partner
- Parents
- Siblings
- Other relatives
- A social worker
- Health workers (different from those who performed testing)
- Other

Please, specify _____

64. How much time has passed before you shared your testing results with someone else?

- Less than 1 month
- Less than 1 year
- More than 1 year

65. What prevented you from telling other people about you positive testing results? (you can select several options)

- Fear that my environment will learn about my positive status
- At first I want to deal with the situation myself
- There is no one to share with
- Other

Please, specify _____

66. Were you referred elsewhere to receive other types of support after receiving positive testing results?

- Don't remember
- Yes
- No

Referral to other types of support and evaluation of testing quality

67. Where were you referred to following notification about testing results? (you can select several options)

- AIDS centre
- Self-help group
- Telephone helpline
- Youth Friendly Clinic
- Addiction treatment facility
- STI clinic
- Antenatal clinic
- Other

Please, specify _____

68. How this referral to other facility occurred?

- They gave me address and telephone of this facility
- They arranged a meeting for me
- I was accompanied by the social worker
- Other

Please, describe _____

69. How would you assess the quality of testing for HIV? (Please select answers that match each of characteristics provided below)

	Poor	Satisfactory	Good	Excellent
Blood sampling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-test counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-test counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promptness of reporting results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observance of secrecy of testing results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Privacy of premises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendliness of staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

70. Would you recommend your friends and acquaintances to undergo testing for HIV?

- Yes
- No

Discouraging other people from taking the test for HIV

71. Why wouldn't you recommend your friends and acquaintance to undergo testing for HIV? (you can select several options)

- This is not my business; everyone should be responsible for his or her own health.
- Let health workers deal with it.
- I think that my friends are healthy and are not at risk for HIV infection.
- I could be misunderstood as people in my environment do not typically discuss issues of HIV and AIDS.
- They may decide that I have HIV and start avoiding me.
- I do not want them to undergo similar stress that I had during testing.
- I encountered hostile attitude of staff in the facility where I had myself tested.
- Staff of the testing facility failed to preserve confidentiality and secrecy of testing results.
- I think that test is too expensive
- Other

Please, specify _____

What could make HIV testing better for you

72. What motivated or could encourage you to take testing for HIV? (you can select several options)

- Overcoming fear of possible testing results
- Information that my own health and possibly the health of my friends and family will depend on HIV test
- If I start relationships with a new sexual partner
- If I had casual unprotected sex
- If I learn that my sexual partner cheated on me
- If I learn that my sexual partner used (or uses) injecting drugs
- Incentive package, presents (food, redeem gift cards for cell phones, etc.)
- Don't know
- Other

Please, specify _____

73. What is the best venue for HIV testing? (you can select several options)

- AIDS centre
- Drop-in centre
- Youth Friends Clinic
- Family doctor's office
- Antenatal clinic
- Addiction treatment facility / dispensary
- STI clinic / dispensary
- NGO
- Don't know
- Other

Please, specify _____

74. What could improve conditions of testing?

- Not requiring identification documents
- Performing testing for HIV in convenient hours
- Guaranteeing that none of my friends know about it
- Notifying parents about testing results only upon my (adolescent's) consent
- Offering HIV tests to all adolescents
- Don't know
- Other

Please, specify _____

***75. What characteristics of HIV test itself could encourage your testing in the future? (you can select several options)**

- If HIV testing is free
- If results are provided no later than in two hours after testing
- If HIV test is based on saliva sample (instead of blood)
- If HIV test is based on fingertip blood (instead of venous blood)
- Don't know
- Other

Please, specify _____

76. What would you suggest to motivate other adolescents to undergo testing for HIV? (you can select several options)

- For facilities where one can get tested for HIV to be located not far from one's place of residence.
- For facilities where one can get tested for HIV to be located away from one's place of residence.
- For adolescents practicing high risk behaviour to know that it is important, and not be afraid of testing.
- For health workers to offer testing for HIV to all adolescents.
- For social workers to offer testing for HIV to all adolescents that they work with.
- To have online resource with clear and adolescent-friendly information about HIV testing and testing sites.
- To have phone app with information about HIV testing and testing sites
- Don't know
- Other

Please, specify _____

Your suggestions

77. Do you have any additional comments or suggestions that you would like to share with us?

Thank you very much for your participation! We will gladly share the results of this study and materials developed on the basis of collected information. Feel free to contact us by writing to stopaids.unicef@gmail.com and stating “adolescents-testing” in the topic of the letter. You may also find answers to some questions concerning HIV and the importance of HIV testing on the website www.stop-aids.net, which was developed by UNICEF experts for future parents.

Interviewer / social worker's statements prior to online survey "The Voices, Values and Preferences of Adolescents on HIV Testing and Counselling"

- *Mandatory immediately before the online survey – individual or in groups.*
- *Important: adolescents often confuse blood analyses and testing for HIV.*
- *If your organization has additional materials, e.g. leaflets, bulletins or other hand-outs on the topic – please distribute them among adolescents.*

- 1) **There exist many different types of blood tests:** full blood count, haemoglobin test, blood glucose test, tests for various infections (including sexually transmitted infections), hepatitis virus panels, food intolerance and allergy tests, and many others.

There also exists a test that determines the presence of human immunodeficiency virus – blood testing for HIV.

! We would like to talk to you about this particular HIV antibody test.

While answering the questions you need to remember that not every blood test is a HIV test. Various blood tests are common practice, but testing for HIV is performed only on the basis of relevant indications, or when you personally want to have your blood tested for HIV. When you will be answering the survey questions, remember this fact and try not to get confused. It is important for us to collect your thought specifically about testing for HIV.

- 2) **Do you know what HIV/AIDS is? Let me remind you:**

HIV stands for human immunodeficiency virus. When a person gets infected with HIV, the virus starts attacking human immune system, which is responsible for protection of human body from different diseases.

AIDS is acquired immune deficiency syndrome at the last stage. With weakened immune system an individual becomes vulnerable to different diseases, especially infectious ones.

HIV is not an ordinary virus. A person can get infected many years ago, but he or she may look and seem absolutely healthy and transfer the virus to other people. If the person is infected, it does not mean that he or she will immediately develop AIDS.

Therefore, we need to know that:

- One can get infected with HIV even without knowing it;
 - One can transfer HIV even without knowing it.
- 3) **Testing results can be “negative” or “positive”.** In our perception “positive” means “good”, but in this case HIV testing results marked with “+” mean that this virus is present in blood. “Negative” means that no antibodies to HIV were found in blood: a person is either not infected with HIV, or may be infected, but antibodies are insufficient to determine the virus.

Remember this while filling the questionnaire.

If you have any questions, you may ask me now; if you have any doubts during the survey, do not hesitate contacting me.

Interviewer, ask an adolescent if he or she has any questions. Get to the survey. Good luck and thank you!

Expert / Service Provider's Consent

Date: _____ 2012.

Greetings! I work on behalf of the Ukrainian Centre for Social Research after Olexander Yaremenko, which implements the United Nations Children's Fund (UNICEF) project "Regulatory and Legal Reviews on MARA and Barriers to Services, Collection of Strategic Information, and Scaling Up Analytical Work on Risks, Vulnerabilities and Factors that Influence the Spread and Prevalence of HIV Infection and Behavioural Practices among MARA". The goal of this research is to study adolescents' views and attitudes towards counselling and testing for HIV on the basis of the World Health Organization methodology. Within this project we plan to hold focus groups and online survey of adolescents. Similarly we would like to collect **views and opinions of experts and service providers**, involved in the provision and coordination of services used by adolescents.

We ask you to consider an opportunity to join this study in the form of face-to-face interviews that will take about one hour of your time. Interview will cover topics regarding your views and experience of VCT, current capacity to provide VCT services, and expected changes in health services necessary to improve adolescent's support in this area. All interviews will be carried out in separate premises.

All your statements will be **strictly confidential**. Your name shall not be used in any reports. Participation in the interview is not payable, and your participation is **voluntary**. If you choose to participate, you may change your mind at any time. You shall not be fined in case of refusal.

Results of interviews, focus group meetings with adolescents and online survey will serve as a basis for recommendations, aimed at further development of HIV testing services for adolescents.

This interview was approved by the Professional Ethics Commission of Sociological Association of Ukraine.

If you have any questions or doubts regarding interview, please, do not hesitate contacting us: NGO "Ukrainian Institute for Social Research after Olexander Yaremenko", Kyiv, 29 Panasa Myrnoho St., office 211, tel. (044) 501-50-75. Project manager – Anastasia Sudakova.

Service provider's consent. Yes, I would like to participate in this interview.

I, _____, was informed about the interview **The Voices, Values and Preferences of Adolescents on HVT Testing and Counselling**

- I was informed about goals and objectives of the interview, and I understand them.
- I was allowed to ask questions about the interview, and I received clear answers.
- I understand that my participation in this interview is voluntary.
- I understand that all my words will be kept in secret, and my name will not be used in any reports.
- I understand that if I have any questions or doubts about this interview, I can contact coordinator at any time.

I understand that if I have any questions or doubts regarding my rights as an interviewee, or if I am not sure about the interview or coordinators, I can address to:

Signature of a participant

Date

Signature of an interviewer

Date

Adolescent's Informed Consent

Date:

Greetings! I work on behalf of the Ukrainian Centre for Social Research after Olexander Yaremenko, which implements the United Nations Children's Fund (UNICEF) project "Regulatory and Legal Reviews on MARA and Barriers to Services, Collection of Strategic Information, and Scaling Up Analytical Work on Risks, Vulnerabilities and Factors that Influence the Spread and Prevalence of HIV Infection and Behavioural Practices among MARA". The goal of this research is to study adolescents' views and attitudes towards counselling and testing for HIV on the basis of the World Health Organization methodology. We would like to communicate with 20 adolescents aged 15 to 19 years.

We ask you to consider an opportunity to become a **focus group participant**. If you agree to participate, you will spend morning or afternoon with a group of **8–10 adolescents**. Focus group envisages a number of sessions and discussions in the premises of a non-governmental organization or youth centre. **Previous experience of testing for HIV is not required** – we would like to hear your thoughts about counselling and testing for HIV and relevant services.

Participation in this focus group is only up to you. If you choose to participate, you may change your mind at any time. You decide what information to share. No one would judge you for your refusal to participate, to continue, or to answer specific questions.

This focus group is strictly confidential. Your name shall not be used in any reports; you may even pick a pseudonym (code name) to introduce yourself. Nonetheless, if anyone reports something that raises concerns about your safety, for example, if someone physically harms you, we will probably have to do something about it, but we won't make any steps without discussing the entire situation with you personally.

You may know some adolescents in the group, but we are asking you to maintain their confidentiality, as they will be asked to protect yours. Unfortunately, we cannot guarantee this, therefore we kindly ask you **not to disclose your confidential or personal information**.

Results of interviews, focus group meetings with adolescents and online survey will serve as a basis for recommendations, aimed at further development of HIV testing services for adolescents. It should be added, however, that we are not responsible for possible changes in local services, but your participation in this focus group guarantees that your views and opinions will be heard.

Participation in the focus group is not payable, but you will be reimbursed all travel expenses. Some snacks and drinks will be available to participants.

This focus group was approved by the Professional Ethics Commission of Sociological Association of Ukraine.

If you have any questions or doubts regarding focus group, please, do not hesitate contacting us: NGO "Ukrainian Institute for Social Research after Olexander Yaremenko", Kyiv, 29 Panasa Myrnoho St., office 211, tel. (044) 501–50–75. Project manager – Anastasia Sudakova.

Adolescent's consent. Yes, I would like to participate in this focus group.

I, _____, was informed about the focus group meeting **The Voices, Values and Preferences of Adolescents on HVT Testing and Counselling**

- I was informed about goals and objectives of the focus group, and I understand them.
- I was allowed to ask questions about the focus group, and I received clear answers.
- I understand that my participation in this focus group is voluntary.
- I understand that I can change my decision regarding my participation without prejudice.
- I understand that I do not have to answer any questions if I don't want to.
- I understand that all my words will be kept in secret, and my name will not be used in any reports.
- I understand that if I have any questions or doubts about this focus group, I can contact coordinator at any time.
- I understand that if I have any questions or doubts regarding my rights as a focus group participant, or if I am not sure about focus group or coordinators, I can address to:

Signature of a participant

Date

Signature of a moderator or social worker

Date