



Review of the National Legislation and Current Practices on the Guidelines of HIV counselling and testing of Adolescents, including Most-at-Risk Adolescents

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This report presents an analysis of national legislation for counselling and testing for HIV in Ukraine, and of common practices for health and social service provision. The goal is to identify legal, policy and service gaps in access to existing VCT services for adolescents and most-at-risk adolescents.

The review offers an algorithm of service provision and actions for service providers within the framework of current legislation that can be used in practical work, as well as specific recommendations on legislative changes which are necessary to eliminate obstacles that hamper MARA’s access to VCT services.

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Glossary

Anonymous counselling and testing is counselling and testing which takes place without collecting information that identifies the individual being tested. (test results and personal details, e.g. full name, date of birth, home address, work/school address, etc. are not recorded).

Active prevention denotes prevention of further spread of HIV through the implementation of harm reduction strategies and the use of condoms.

HIV infection is a disease that develops as a result of contracting HIV and has several stages of development, from a carrier state to clinically apparent forms.

HIV status describes the presence or absence of HIV infection in an individual that is confirmed by laboratory testing.

Group counselling / informing (GC/I) means voluntary pre-test counselling for the group of individuals with shared purpose for counselling (e.g. persons undergoing examination to obtain a certificate; pregnant women, and the like) with a view to inform them on the ways of HIV transmission, risks for infection, testing procedures and prevention measures.

VCT stands for *voluntary counselling* (in the form of consultative support on medical, psychological, legal and other issues, and the provision of health, social and other types of assistance at government or municipal health facilities and in other institutions, organisations and facilities, in other health facilities, and in citizen associations), and *testing* for HIV infection at government or municipal health facilities with adequately equipped laboratories that received accreditation according to procedure established by the Cabinet of Ministers of Ukraine.

Voluntary consent is a decision to have a HIV test made by a patient in an environment that rules out any possibility of coercion.

Informed consent means a patient has agreed to undergo testing and has made his/her choice after he/she was provided with clear and easy-to-understand information on the goals and procedures of testing, ways of HIV transmission, prevention measures and consequences of HIV.

Counsellor is an employee of a public or municipal health facility or other public / municipal institution, organisation or facility, or a health facility of other forms of ownership, or a representative of citizen association trained to perform pre- and post-test counselling on HIV.

Non-governmental organisations are organisations – including international – registered in Ukraine according to the Laws of Ukraine “On Charity and Charitable Organisations” (531/97-VR), and “On Citizens’ Associations” (2460-12) that work in the field of HIV/AIDS prevention, care and support to people living with HIV.

Patient is an individual (regardless of the gender) who came to receive VCT services in health facilities (or a client receiving such services in non-medical institutions, organisations, facilities and citizen associations).

Most-at-risk adolescents (10–19 years old) denote children and young people who are most at risk of HIV infection as a result of their behaviour, namely:

- injecting drug users (IDUs) who use non-sterile injecting equipment;
- Adolescents who practice unprotected sex because of sexual exploitation, including victims of human trafficking who have unprotected (often forced) sex for profit;
- Male adolescents who have unprotected anal sex with males, including sex for profit.

Pre-test counselling means counselling prior to test for HIV.

Post-test counselling means counselling after receiving HIV test results.

HCT services¹ denote voluntary counselling (in the form of consultative support on medical, psychological, legal and other issues, and the provision of health, social and other types of assistance at government or municipal health facilities and in other institutions, organisations and facilities, in health facilities of other forms of ownership, and in citizen associations) and testing for HIV infection at the government or municipal health facilities with adequately equipped laboratories that received accreditation according to procedure established by the Cabinet of Ministers of Ukraine.

Supervision stands for guidance, observation and control over the work of a counsellor, and provision of necessary support to ensure adequate quality of counselling.

Testing means laboratory analysis to detect the presence of antibodies/antigens to HIV (HIV test) using conventional (IFA) and rapid tests in special HIV diagnostics laboratories at the government or municipal health facilities, accredited according to procedure established by the Cabinet of Ministers of Ukraine.

¹ Terms “VCT” and “HCT” are interchangeable; the only difference between them is that VCT is exceptionally voluntary process of counselling and testing, while HCT may be initiated either by a patient or by a health worker.

Abbreviations

HIV	Human Immunodeficiency Virus
WHO	World Health Organisation
STI	Sexually transmitted infections
IFA	Indirect Fluorescent Antibody test for HIV
VCT	Voluntary Counselling and Testing for HIV Infection
YFC	Youth Friendly Clinic
HCT	HIV Counselling and Testing
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 organisations
MARA	Most-at-risk adolescents
FSWs	Female sex workers
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/Regional) department of health
CSSFCY	Centre of social services for family, children and youth
CSPR	Centre for social and psychological rehabilitation
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
PATH	International Organisation “Program for Appropriate Technology in Health”
OKHMATDYT	National Hospital for Children and Mothers

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1. Introduction

Responding adequately to the HIV/AIDS epidemic in Ukraine is one of country's top policy priorities as entrenched in relevant normative documents – the Law of Ukraine “On Prevention of Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Security of People Living with HIV” [1] and the National Programme to Ensure Prevention of HIV Infection, Treatment, Care and Support to HIV Positive People and Patients with AIDS for 2009–2013 (National AIDS Programme) [3].

The results expected from the National AIDS Programme, include: covering 60% of key populations at higher risk of HIV exposure with HIV prevention services, improving mechanisms for HIV prevention among young people aged 15-24 years (to increase their awareness of safer sexual behaviour) to increase the number of people capable of ensuring self-protection against sexual transmission of HIV to 60% of the respective group of youths, and to ensure the development of a network of specialised services and institutions providing health and social services to people living with HIV.

Until now, age-specific characteristics of most-at-risk populations and their associated behavioural patterns were have not been taken into account during the development and implementation of various HIV/AIDS response measures neither at the level of the National AIDS Programme, nor at the level of ministries responsible for its realisation, or the action plans of various national and international organisations working in the area of HIV/AIDS response. Furthermore, high risk behaviours and the overlapping of several types of similar conduct are particularly widespread among children and young people, especially among those who inject drugs, sell sex for profit or become victims of sexual exploitation, among adolescent boys who have sex with men, imprisoned adolescents, neglected and homeless children and youth [20].

At the same time, most-at-risk adolescents face numerous barriers before receiving necessary assistance, both medical and social. On the one hand, these obstacles arise from imperfect legislation and the limited availability of services, and on the other hand they are the product of adolescent psychological barriers and stigmatisation.

Statistics show that, of all newly reported cases of HIV in recent years, prevalence in the 15–24 year-old age group has reduced from 2007 through to 2011 (from 15%; 13%; 12%; 11% and to 9% respectively). This may be evidence of a general stabilisation of the epidemiological situation as young people shift to less risky behaviours [17]. But the question is, whether this trend also concerns most-at-risk adolescents?

The estimated number of adolescents who inject drugs is 50,000; the number of adolescent FSWs is 15,000; and the estimated number of adolescent boys who have sex with men is 20,000 [20].

Findings of a 2009 study “Most-at-risk adolescents: the evidence base for strengthening the HIV response in Ukraine”, conducted by IUSR after O. Yaremenko upon request of UNICEF, show that the prevalence of HIV infections by specific risk groups is 11% among adolescent FSWs; 5% among young MSM; 40% among girls and 30% among boys who inject drugs [19].

The goal of this Review is to assess current HIV counselling and testing practices in Ukraine in order to develop specific and detailed recommendations for service providers, to design an algorithm of service provision and actions within the framework of current Ukrainian legislation that can be used

in practical work, and to suggest necessary legislative changes for eliminating obstacles that hamper most-at-risk adolescents' access to HCT services.

The study covered a cohort of adolescents aged 10–19 years by age groups: 10–13 years, 14–17 years, and 18–19 years. The selected age limits (10-19 years) are in line with the WHO's definition of an "adolescent", and the further distribution of adolescents into three age subgroups is linked to distinctive legal statuses of adolescents within each group, which entail different opportunities for children and young people to receive health services, including HCT.

Specialists from institutions and organisations providing HIV counselling and testing, as well as regional and national experts participated in this study. As a result, the researchers had an opportunity to communicate with specialists who directly work with the clients on the one hand, and on the other – to hear from decision makers who shape HIV/AIDS policy (including HCT) at the national and regional level.

Overall, 49 experts from Odessa, Mykolayiv, Donetsk, Kyiv, Zhytomyr, Sumy and Mariupol were interviewed, including one social pedagogue of the vocational school; 3 specialists in adolescent paediatrics in polyclinics; 10 staff members of YFCs; 8 workers of drop-in centres (including those operating in AIDS centres); 2 specialists of CSSFCY; 12 NGO representatives; 3 experts from oblast departments of health, and 10 national experts (including two representatives of the Ministry of Health of Ukraine).

2. Summary of Findings

Analysis of national legislation has shown that the chance for adolescents to receive HCT services largely depends on their age. Today any adolescent who has reached his/her 14th birthday can receive such services independently (that is, without the involvement of parents or legal representatives) and even anonymously. At the same time, an adolescent under 14 years needs to obtain his/her parents' or legal representatives' consent to undergo HIV testing and counselling. Our analysis also revealed a number of inconsistencies between normative documents, which require further changes at a ministerial level to make necessary amendments.

An assessment of current practices shows that most (but not all) specialists have sufficient knowledge of the legal framework to conduct work with adolescents, but there are still many obstacles that hamper adolescents' access to HCT services. These include:

1. Lack of awareness about HIV issues and opportunities to receive relevant services among adolescents (this primarily concerns rural teenagers and MARA)
2. Psychological barriers which prevent them from seeking HCT services
3. Inconvenient working hours at health facilities and the lack of financial resources among rural adolescents to pay for transportation to service provision sites
4. An absence of professional training and skills amongst many specialists, with regards to the peculiarities of working with adolescents, including MARA
5. Deficient staffing and high staff turnover
6. Limited skills and inadequate use of outreach practices by health professionals in their work with adolescents, particularly through mobile outpatient clinics
7. It is impossible to obtain a comprehensive package of HCT services, including test results, in the majority of health facilities and CSSFCYs during a single visit
8. A limited number of NGOs offer adolescent-centred services
9. Dependence on the content of services that are offered by NGOs on donor priorities, which rarely target adolescents
10. The necessity to involve child services, in order to observe all formalities concerning the presence of legal representatives of MARA
11. The absence of a clearly formulated national policy on HIV/AIDS response in adolescent's social environment and among MARA, which results in uncoordinated actions of the local specialists.

Analysis of current legislation and existing HTC practices served as a basis for recommendations and algorithms of the work of health and social workers in this area.

Expert interviews helped to determine the list of recommendations. Some of them, particularly those concerning a normative and legal framework, were presented to, discussed and agreed upon with working groups involved in the development of a new version of HCT Guidelines and amendments to the Law on HIV when the study was still underway.

In addition to proposals of normative and legal nature, the experts also provided the following recommendations on the organisation of HCT service provision:

2.1 For donors

To disseminate the practice of active use of mobile outpatient clinics for providing HCT services to adolescents, including MARA; to prioritise service provision to adolescents in the implementation of

various NGO projects; to introduce a practice of organising roundtables, follow-up workshops and work group meetings to share experience and to regularly update the knowledge base of professionals trained in HCT, and to organise training sessions in this area for all specialists involved in the provision of social and medical services to adolescents

2.2 For local authorities

To ensure the comprehensiveness of HCT services (both counselling and testing) in YFCs and CSSFCYs, particularly through the use of rapid tests; to ensure compensation of travel expenses for all adolescents, including most-at-risk adolescents, within the framework of HCT service provision; to strengthen the coordination of activities of health and social workers; to make the working hours of facilities offering HCT survives more convenient for young people;

2.3 For organisations that conduct training sessions for HCT counsellors and fund projects focused on service provision to adolescents

Ensure the maximum possible dissemination of UNICEF's training and methodological manual "Adolescents Most at Risk for HIV" (Participant's Book and Trainer's Book) among HCT counsellors, thus helping them to provide HCT with appropriate consideration of both legal and psychological peculiarities of adolescent clients (www.unicef.org/ukraine/ukr/Trainer.pdf and www.unicef.org/ukraine/ukr/Participant.pdf)

2.4 On informing the target population

Use modern information technologies for spreading information for adolescents (Internet, including social networks; online counselling).

Present information in motivating and adolescent-friendly format, e.g. educative stories in the form of comic books and the like.

3. Analysis of the National Legislation and Guidelines on HCT Provision to Adolescents, Including MARA, in the Context of General Approaches to HCT: Definition of HCT Services and Peculiarities of Provision to Adolescents, Including MARA

Ukraine's national legislation on HCT is based on several fundamental documents. These are the Law of Ukraine "On Fundamental Principles of Health Care Legislation of Ukraine" [2], the Law of Ukraine "On Prevention of Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Security of People Living with HIV" [1] 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" [3]. At the same time, the provision of health services to individuals who have not reached 18 requires special attention to the peculiarities of their legal status, as this category of the population is divided into two age groups – under 14 and under 18 years of age. These peculiarities are described in the Civil [4] and Family [5] Codes.

The main normative and legal act that regulates HIV counselling and testing in Ukraine is the Order of the Ministry of Health "On Improvement of Voluntary Counselling and Testing for HIV Infection" [6], which determine the procedure (protocol) for voluntary counselling and testing for HIV infection. This document defines basic principles of HCT (voluntariness, confidentiality, anonymity, accessibility and non-discrimination, reliability and sufficiency of information, professional and technical excellence, mobilisation of resources), its procedure, content, general requirements for counselling and testing, list of organisations that may provide HCT services, and the procedure of supervision.

In some cases the observance of the voluntary principle may be an issue as the guidelines envisage an option for the medical examination of minors under 18 upon request of their parents or legal representatives who have the right to be present at such examinations. At the same time it does not take into consideration an adolescent's possible dissent to undergo such examination. A situation when an adolescent has turned 14 and has a full legal right to receive HCT independently, but he/she is forced to take HIV tests against his/her own will is particularly unacceptable. In such cases it is very important to provide an adolescent with clear and sound information on the need for testing or any other examination, and to motivate him/her to agree to such testing. Parents should remember that Article 150 of the Family Code entrusts them a duty "to care for the child's health, his/her physical, spiritual and moral development". Therefore, health workers may support parents' initiatives regarding testing, but it is equally important for the counsellor to observe the voluntary principle.

HCT Guidelines (protocol) also provide 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). Yet it does not describe the peculiarities of counselling for adolescents who practice high risk behaviours similar to those prevalent among adult representatives of MARPs, even though the combination of age specifics, social status and behavioural practices of most-at-risk adolescents requires rather peculiar approach to counselling.

In 2011 the State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases has published methodological recommendations for health workers on the provision of HIV counselling and testing services [16]. In this publication, however, most-at-risk adolescents were also overlooked. The only positive development here was the inclusion of street children in the list of persons who are most at risk for HIV infection.

Apart from the MoH, another government ministry responsible for policy development and organisation of measures on working with adolescents, including MARA, was the Ministry of Family, Youth and Sports of Ukraine (MoFYS). In 2010 specialists from the State Social Service for Family, Children and Youth have developed 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” [15], which was subsequently approved by the protocol resolution of the National Council on HIV/AIDS and Tuberculosis. All measures and actions in this document, including those on HCV, focused on adolescents. But after reorganisation – or, rather, liquidation – of the ministry and its State Social Service the fate of this document remains vague, as there is no clarity regarding any legal successor and executing agency for the said measures.

Counselling and testing for HIV may be provided in any health facility, but HCT remains one of key activity areas of drop-in centres “Dovira” (*Trust*) [7]. Additionally these services are available for adolescents in Youth Friendly Clinics [9]. Joint Order of MoFYS and MoH also defines pre- and post-test counselling for HIV as one of functions of CSSFCYs within provision of social services covering various aspects of HIV/AIDS prevention [10].

Taking into account age-specific differences in adolescents’ statuses, it is expedient to analyse normative and legal bases separately for each of three previously defined age categories:

3.1 18–19 years

According to the Civil Code of Ukraine [4], adolescents of this age category are individuals of full legal age, or legally capable citizens who have the right to receive HCT services without any restrictions or the need to involve any third party in HCT process.

3.2 14–17 years

Certain inconsistencies exist in the requirements regarding this age category, as specified in the Law of Ukraine on HIV [1] and in HCT Guidelines [6]. For example, Part 2 of Article 6 of the Law reads that *“The testing of individuals aged 14 and older is provided on a voluntary basis, conditional on the availability of well-informed consent from the individual received after pre-test HIV counselling, which informs them about the 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”*. This means that provision of HCT services to adolescents aged 14 and older does not have any additional requirements, for example, the presence of an adolescents’ legal representative or their request to perform HCT.

At the same time, current HCT Guidelines are still not in line with the abovementioned Law. They state that *“a specific feature of counselling for adolescents is... 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; if HIV infection is discovered in a minor under 18 years of age, a staff member of the health facility performing medical examination shall notify thereof the minor’s parents or other legal representatives”*.

Therefore, current HCT Guidelines limit the adolescents’ access to HIV counselling and testing, if compared to the Law. Since any Law prevails over any Order, all activities of HCT counsellors shall be governed by provisions of the Law on HIV until HCT Guidelines are brought in full compliance with this Law.

It should be added that 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 HCT Guidelines, which, as expected, will be fully in line with Ukraine's Law on HIV.

3.3 10–13 years

All normative and legal acts consistently require the involvement of legal representatives of adolescents aged 10-13 years in the process of HCT service provision. Such involvement may include request, written consent, or physical presence. In particular, Article 43 of the Law of Ukraine "Fundamental Principles of Health Care Legislation of Ukraine" states the following: "Medical interventions for a patient under 14 years of age (underage patient), and for a patient who was officially recognised as legally incapable shall be carried out upon consent of such patient's legal representatives"; likewise Part 3 of Article 6 of Ukraine's Law on HIV states that "Testing of individuals under 14 and individuals officially recognised as legally incapable, is provided upon request and well-informed consent of their parents or legal representatives who have the right to be present at such testing and be made familiar with its results...".

Current HCT Guidelines establish the same limitations for children under 14 years as the Laws (see previous age category of adolescents).

A joint Order from the MoH and MoFYS on medical services for children in shelters and centres for social and psychological rehabilitation (CSPRs) [13] approved the Scheme of examination of children in social protection institutions and in treatment facilities. A 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 legal 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), whereas administrators of shelters or CSPRs are not granted the status of legal representatives of children who currently stay in their institutions.

As a result, this Order contradicts legal norms that require official consent of legal representatives of a child under 14 to conduct medical examination. In addition, this Order arranges that results of children's health check-ups in treatment facilities to be communicated to the teaching staff. Such disclosure of a child's health status is absolutely unacceptable from the viewpoint of HIV legislation. Moreover, this document does not establish the procedure of further communication of such data in compliance with confidentiality principles.

When the legal representatives of a child cannot be determined, and the child has not reached 14 years of age, HCT may be carried out upon the authorisation of child welfare authorities following the request of services for children. This procedure is established by Article 65 of the Civil Code of Ukraine [4]: "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".

The national legislation does not provide clear guidance in cases when a child under 14 years does have legal representatives, but it is impossible to involve them in HCT for various reasons (e.g. they are unresponsive to the child's health needs or openly oppose testing for HIV). Article 170 of the Family Code of Ukraine [5] deals with "separating a child from parents without depriving them of their parental rights", particularly in cases when "leaving a child with parents presents the danger for his/her life and health". The Code does not describe specific situations that may be present the

danger for child's life or health. Yet services for children, such as government authorities that undertake measures to protect rights, freedoms and legal interests of children and maintain records of children in difficult life circumstances (according to the Law of Ukraine "On Bodies and Services for Children and Special Child Care Institutions") may initiate the testing of HIV for a child upon receiving an official 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.

Then Part 2 of Article 170 of the Family Code of Ukraine may be used, which states the following: "In exceptional cases, when a child's life or health is in jeopardy, a child welfare authority or a prosecutor may render the decision on immediate removal; of a child from his/her parents".

In this case the child welfare authority shall inform the prosecutor thereon without any delay and, within seven days after the decision has been made, take legal action for depriving either or both parents of their parental rights or for removing of a child from his/her mother or father without depriving them of parental rights. Therefore, in such situations it is expected that the service for children, health facility and child welfare authority take relevant joint actions.

Separate guidelines for the provision of health and social services to HIV positive children, is an integral component of the inter-sector Order of five ministries: "On Measures for Organisation of Prevention of Mother-to-Child Transmission of HIV, Health Care and Social Follow-up of HIV Positive Children and their Families" [14]. This Order also endorses Standard Provisions for a multidisciplinary team providing health and social assistance to HIV positive children and their families. The goals of such a multidisciplinary team and the functions of its members, described in Standard Provisions, concern only children with confirmed HIV positive status, and the diagnosis stage it not detailed.

These Standard Provisions state the following: "Medical care for patients under 14 years of age, or legally incapable individuals, shall be provided upon request/written consent of their legal representatives. Provision for medical assistance to an individual who has reached 14 years shall be provided upon his/her consent according to Article 284 of the Civil Code of Ukraine. Parents (adoptive parents), guardians or care-givers have the right to information about the health status of a child/person under care in accordance with Article 285 of the Civil Code of Ukraine. Shall the parents or legal representatives refuse medical examination of a child in health-threatening condition and with clinical signs of HIV infection; a doctor may initiate relevant examination and further medical supervision in line with the established procedure".

Therefore health professionals, guided by the abovementioned Order and Guidelines, 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 object. The Guidelines also state 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 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. Appropriate decision of the multidisciplinary team shall be duly substantiated and included in the patient's health record"*.

According to HCT Guidelines (protocol) [6], “...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 certificates on HIV test results”. These health facilities can also perform testing in mobile units and outpatient clinics [11]. In addition, the MoH Order, issued in 2012 [12], enables HIV testing with rapid tests “by all organisations/facilities (laboratories) on the territory of Ukraine regardless of their sector subordination and from of ownership that carry out free-of-charge testing for serological markers of human immunodeficiency virus”.

Therefore, in addition to health facilities, HCT services (using rapid tests) can also be provided by non-governmental organisations, including on the basis of mobile units and clinics, and in the centres of social services for family, children and youth. However, service provision in NGO’s mobile clinics or in the centres of social services for family, children and youth, raises questions about the disposal of expendables used in testing. Such expendable materials are the property of the implementing organisation, so health facilities cannot dispose of them at their own cost. The latter have the right to dispose only own expendables. This is a very serious issue for organisations that run projects with mobile HCT units.

3.4 Staff training

Current HCT Guidelines require that all counsellors complete specialised 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, the National Medical Academy of Postgraduate Education after P. Shupyk offers advanced training course for doctors on HIV counselling and testing. This unified training block is approved as an academic course for schools of higher education. In other words, a system of education on HCT was integrated in the official postgraduate education of doctors.

In addition, from this year on a new 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. Currently there is no formally approved procedure of receiving a certificate as a HCT counsellor. In 2010 the Department of Child and Adolescent Diseases at the National Medical Academy of Postgraduate Education after P. Shupyk has introduced a distance-learning course for paediatricians and family doctors “Provision of medical and social services to adolescents and youth”. This advanced training consists of 10 sessions, with three of them (two partially and one – fully) covering the issues of HCT. In general, the course dedicates eight academic hours to HCT, which is about 20% of the entire training. According to an expert who actually teaches this course, his students are not ready yet to perform counselling and testing for HIV, but at least they accumulate necessary information about HIV and begin to understand the importance of motivating adolescents.

In addition to courses within the postgraduate education system, health professionals can opt to participate in HCT training sessions organised by international organisations – ICF “International HIV/AIDS Alliance in Ukraine, UNICEF and PATH. In order to conduct these trainings, said organisations have concluded memorandums with MoH and agreed training agendas with the MoH management. Additionally, back in 2007-2008 training sessions on HIV counselling and testing were organised by the State Institute for the Family and Youth Development at MoFYS within the framework of the Global Fund’s Round 6 programme. These courses were indented for CSSFCYs and NGO representatives.

4. Analysis of Methodological Recommendations for the Procedure for providing HCT to Adolescents, Including MARA. Developed by International and National NGOs.

Aside from legislative documents, Ukrainian and international organisations have published a number of methodological recommendations that address the issues of HCT. In particular, HCT recommendations were developed by the USAID-funded “Health Policy Project”; by PATH, and by ICF “International HIV/AIDS Alliance in Ukraine” [24; 25; 28]. However, neither USAID nor PATH’s publications included recommendations on HCT for adolescents, including most-at-risk adolescents. The main goal of the said publications was to emphasise specific sections of HCT Guidelines, and in some cases – to enhance understanding of concepts and processes described in the Guidelines. Alliance’s methodological recommendations deal with the use of rapid tests in work with clients receiving HCT services in non-governmental organisations, including mobile units.

These recommendations do mention street children, but the list of most-at-risk populations, targeted by NGOs within the framework of Global Fund’s projects, implemented by the Alliance, omits street children and focuses on IDUs, FSWs, MSM, prisoners, and on individuals who have sexual contacts with representatives of listed categories.

At the time of writing of this Review, UNICEF has published the training and methodological manual “Adolescents Most at Risk for HIV” consisting of two parts – a Participant’s Book and a Trainer’s Book [29]. Unlike previous publications, this manual focuses on adolescents and on specifics of work with them, while one of its sections is dedicated to HCT. It describes legal base for HCT provision to adolescents, provides content and algorithm of HCT service, and explains peculiarities of counselling for adolescents.

Therefore, the majority of existing methodological recommendations and manuals neither provide information on peculiarities of counselling for adolescents (including MARA), nor analyse normative and legal framework to be used in the work with this category of clients. This is why UNICEF’s recent training and methodological manual, which absorbed all necessary information on the work with adolescents, needs to be disseminated to a maximum extent possible among all specialists working with adolescents in general, and among those who provide HCT services in particular.

5. Practical Experience of HCT Service Provision for Most-at-Risk Adolescents (medical component)

5.1 YFC

One of facilities that specifically focus on adolescents and young people, including those who are most at risk for HIV, are Youth Friendly Clinics (YFCs). According to YFC statutory provisions, the age limits of YFC clients range from 10 to 24 years [9]. In addition to health services, YFCs offer information, and psychological, social and legal services. The package of services depends on the staffing arrangements, which are approved by the local department of health, and on the amount of funding (YFCs are financed from the local budgets).

Staff members at the YFCs receive training sufficient for working with adolescents and for providing HCT services. As a rule, relevant trainings for YCF staff are organised and held by international and national NGOs. Specialists who complete training courses receive certificates as HCT counsellors.

In addition to this, specialists at YFCs have been participating in annual workshops at OKHMATDYT hospital since 2006. Also, considering the significant need of these specialists for education, similar training sessions were organised in oblast and city AIDS centres.

Primarily, the supervision of the HCT process is internal. In some occasions, supervision is carried out by specialists from AIDS centres, and representatives of NGOs and international organisations. Overall, every YFC undergoes certification once every three years. The provision of HCT services and prevention work with adolescents is also subject to certification.

Every Youth Friendly Clinic participating in the study routinely offers HCT services. National experts confirmed that HCT is one of the mandatory activity areas for all YFCs in Ukraine. About half of all YFCs have own medical procedure rooms and relevant specialists, who enable the provision of HCT services in comprehensive manner. About 40% of YFCs use procedure rooms at 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. And only 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.

Health workers and psychologists provide both pre- and post-test counselling services after having received adolescent's test results, including directly from the lab. As a rule, HCT is recommended when an adolescent is found to have an STI, or when a counsellor learns that an adolescent practices high-risk behaviour. Information about opportunities to receive free and confidential HCT services is displayed on the posters on the clinic's walls.

HCT for adolescents in residential institutions (shelters, boarding schools, and the like) may be initiated by the director of such an institution, usually with counsellor's visit on site.

In case of a positive result, the counsellor in the course of post-test counselling tries to motivate an adolescent who attained 14 years to informing his/her parents or other significant adults about testing results.

YFC specialists pointed out the need for more detailed explanation of specifics of the work with MARA in the HCT Guidelines (protocol) and during trainings.

5.2 Drop-in centres "Dovira"

The drop-in centre specialists, including those operating in AIDS centres, offer HCT services to all clients, which may also include adolescents. Counselling is provided to all adolescents regardless of their age, while testing is only offered to those who turned 14. At the same time, two respondents admitted that if an adolescent under 14 years was the client of social services or non-governmental organisations and came over in the company of a social worker, then such adolescent would receive full package of HCT 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. Quite widespread is the practice of HCT provision to adolescents in residential facilities, shelters and reception centres on the basis of agreements with these institutions. In this case adolescents come for HCT services accompanied by the representative of such facility.

Adolescents under 14 years who are not in the custody of social authorities or institutions may only receive services in the presence of their parents or upon written consent of the latter. If counselling touches specific topics that an adolescent would prefer not share with his/her parents, they are

asked to leave the room. Parents or other legal representatives of an adolescent are notified about testing results. If adolescents have already reached their 14th birthday, counsellors simply encourage them to inform relatives about a positive result.

It should be noted that all drop-in centres participating in the study provide comprehensive HCT services offering 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 significant amount of time as a client can receive full package of HCT services during one visit.

The supervision of HCT process is primarily internal (within the facility), however on some occasions, activities are supervised by the representatives of NGOs and international organisations.

5.3 NGOS

A nurse, who works with NGO and carries out testing for HIV, has emphasised on several occasions that she is working only with clients of 18 years and older.

5.4 Child polyclinics

Specialists in adolescent paediatrics work with clients aged 14 years or over. Within the scope of their work they provide counselling on HIV infection, both during educational visits to schools, and during reception of patients. Two of three interviewed paediatricians refer their clients to YFC or to the drop-in centre to receive HCT services. The third paediatrician offers such services himself, and testing for HIV occurs in the same facility. One of paediatricians reported that their polyclinic previously provided HCT services, but after recent funding cuts the polyclinic stopped procuring test kits. In cases of referral, paediatricians always try to find out whether an adolescent eventually came to receive the service. One specialist noted that upon referral only about 20% of adolescents show up to receive HCT. In addition to information about HCT received in the course of paediatrician's consultation, adolescents may also learn about HCT and service provision sites from the posters on polyclinic walls. Two of three interviewed paediatricians mentioned the issue of insufficient coordination with other organisations, particularly with social services: they did not know anyone who to contact if adolescent's social problems, revealed during consultations, could not be addressed by a doctor.

5.5 Regional (Oblast) departments of health (DH)

Professionals responsible for paediatrics, maternity and child welfare at the oblast level are quite distant from the processes of HCT provision. Only one out of three interviewed DH representatives was familiar with HCT Guidelines. Their responsibility is usually limited to organisational work at the oblast level, covering activities of YFCs and specialists in adolescent paediatrics, as well as information and prevention-oriented work in the oblast, particularly in educational establishments. These specialists are aware of inconsistencies between normative and legal documents, and point to the need in comprehensive package of legislation with the analysis and recommendations on the use of specific provisions in an individual adolescent's case.

Oblasts do have a number of mobile outpatient clinics that offer broad range of services, including HCT. The problem is that they function within the projects of the Global Fund to Fight AIDS, Tuberculosis and Malaria, so it remains unclear whether this activity will be funded after conclusion of these projects, even though mobile outpatient unit is one of few feasible ways of reaching the most hard-to-reach populations, including MARA.

5.6 National experts

Experts have emphasised that MARA are one of the key population groups that need to be reached by the country's HIV/AIDS response. Until 2011 it was MoFYS that had a mandate for working with this social group at the ministerial level, and now this ministry is non-existent. Nowadays the Ministry of Social Policy should be a legal successor of activities aimed at MARA population, but interviewed experts still don't understand the content and details of such work and don't know persons / entities responsible for its implementation. The lack of proper attention to MARA can nullify positive trend towards reduction of the number of new infections among youth, particularly among young people aged 15–24 years. National medical experts believe that NGOs working in this area should focus on ensuring adequate access and increasing motivation of target population to receiving HCT services.

Experts describe drop-in centres and YFCs as the basic facilities where adolescents – including MARA – may receive HCT services. Currently in Ukraine more than 700 drop-in centres exist and 104 YFCs. Experts also mention telephone hotlines operated by AIDS centres and YFCs.

The State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases conducts ongoing monitoring of the implementation of relevant regulatory documents, including the HCT Guidelines. This primarily concerns the collection of statistical data, which also includes information about adolescents. Activities also include biennial monitoring visits. Should the need arise; additional visits are made to deal with the situation on site. The goal of monitoring visits is to verify the quality of services and fulfilment of regulating procedures.

6. Analysis of Key Obstacles to HCT Service Provision as Defined by Health Professionals: Adolescent status

6.1 Youth Friendly Clinics

The majority of professionals interviewed for this study, claim that they work only with adolescents who are 14 or older, even though, according to the provisions of the YFC Facility, their clients may include “children aged 10–18 years and young people of 18–24 years” [9]. In some cases services are provided to younger clients, but only with participation of their parents. If such adolescents do not have a legal representative, they will be denied the service. Two of 6 counsellors were unsure whether they can perform anonymous testing for unattended adolescents aged 14–15; one counsellor believed that it was possible to do after 15 years, and the other one – after 16 years of age. Considering the anonymous nature of services, the adolescent's status (orphan or a child deprived of parental care, a child with disability, etc.) has no effect on HCT service provision – the only obstacle here is the age under 14 years.

6.2 Drop-in Centres

According to reports from respondents, services are available in full measure to clients once they are 14. Moreover, these services may be anonymous. Positive testing results, however, create problems, as adolescents are required to present identification documents to be duly registered. As counsellors put it, if such documents are available, there is even no need to involve and to inform parents. If the documents are absent – e.g. in cases of street children – proper registration, further medical examination and treatment become impossible.

While speaking about adolescents under 14 years-old health professionals reported that the number of those seeking HCT services is very insignificant. If these adolescents are attended by social workers, they receive HCT with rapid tests, and this does not entail authorisation from

services for children or child welfare authorities. In other cases, the provision of HCT services requires the presence of the adolescent's parents or legal representatives. According to one of the consultants, if an adolescent under 14 years has no legal representatives, the appropriate medical examination is only possible upon the commission's decision. Another counsellor pointed to the fact that services to children who have been deprived of parental care and to children with disabilities can be provided only in the presence of their guardians or representatives of relevant authorities.

Describing the case of HCT provision to her 15-year old client, one of counsellors noted that the boy's parents were present, and added that all parents of adolescents under 18 with positive testing results are routinely notified thereof. At the same time she noted that HCT services could be provided anonymously to everyone who is older than 14 years. This respondent also insisted on the absence of any obstacles – including legal – for adolescents to receive HCT. Another counsellor, who provides HCT services to adolescents only upon parental consent up to the age of 18 years and routinely informs parents about testing results, also sees no legal barriers to HCT. In her case anonymous testing before the age of 18 is out of the question.

6.3 *Child polyclinics*

Children become clients of specialists in adolescent paediatrics from the age of 14. These Health Professionals work with adolescents who have no parents caring for them, and this also concerns HIV testing issues. However, as the representative of one polyclinic offering HCT puts it, orphans, children deprived of parental care and children with disabilities can get HIV testing independently (or without involvement of their legal representatives) only beginning from the age of 18. When it is necessary to test an adolescent from a shelter or a boarding school for HIV, this should be done with participation of this facility's official representative.

6.4 *Regional (Oblast) departments of health*

Specialists from oblast departments of health also point-out the need of involving parents or other legal representatives in HCT service provision to children who are under 14 years of age. One of the respondents noted that if a child had no legal representatives, the child's personal signature would be sufficient for service provision. This actually goes against the statements of counsellors who directly provide HCT services, and contradicts the current normative and legal base, which grants this right only to those who turned 14. Such dubious statement may be explained by inadequate attention of DH staff towards issues of HCT provision for adolescents. Two specialists believe that NGOs are capable of HCT provision if adequately trained; one expert notes that HCT is the domain of health professionals only. Specialists were at a loss when asked what to do if parents of an adolescent of 14 years and older insisted on the examination, while an adolescent opposed it.

6.5 *National experts*

Every second medical expert participating in the study mentioned the issue of HIV testing of adolescents who are under 14 years-old, and pointed at overall inconsistency of the national normative and legal base with adolescents' needs. More than half of the experts interviewed also mentioned the lack of specification and detail of HCT provision to adolescents in the national HCT Guidelines (protocol).

7. The accessibility of services (location of service provision site, information about the availability of services, and the readiness of HCT counsellors to work with the target population)

7.1 Youth Friendly Clinics

All respondents representing YFCs insist on full accessibility of HCT services for young people in their own youth friendly clinic, but at the same time they complain about poor accessibility of services in small towns and villages with no functional YFCs. The problem is that most adolescents have no money to travel to a service provision site, and are often unaware of such facilities and services. Another problem is the remoteness of YFC from downtown areas, especially in large cities where it takes a lot of time and effort to travel from one end of the city to another. Information about YFC services is disseminated by staff that come to educational establishments to teach adolescents about prevention and to inform them about YFCs. Respondents regretfully report that in some instances the administration of educational facilities interferes in such work: some school administrators are not ready to allow someone to lecture about safe sex in their school, while others believe that everyone knows everything about HIV/AIDS.

Another problem is the “interruption” of HCT service, as 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”.

All interviewed counsellors declared their readiness to work with MARA clients, yet one of counsellors noted that they do not work with drug users, while other respondent excluded adolescent boys who have sex with men from his YFC. In general, interviews show that most-at-risk adolescents rarely seek assistance in YFCs. Specialists link this to the fact that MARA do not value their health, so the need to look after own health and to seek medical assistance remains beyond their grasp. In most cases such adolescents are taken to YCFs by social workers from other organisations, or by their legal representatives.

According to experts, psychological barriers also prevent adolescents from seeking YFC services: they are afraid of the disclosure of testing results and the content of counselling. This primarily concerns adolescent boys who have sex with men. In most cases they try to conceal such contacts.

7.2 Drop-in centres

Specialists working in “Dovira” drop-in centres believe that HCT services are quite accessible. At the same time, one respondent mentioned the need to compensate adolescents’ travel expenses, as the lack of money for transportation to the service provision site is one of serious obstacles. Specialists also praised the effectiveness of mobile units in the provision of HCT to MARA, because these adolescents are less likely to come to the organisation themselves. Therefore, you either try to reach them via mobile clinic, or ask social workers to bring them over. The absence of follow-up leads to the loss of clients: an adolescent may come, have his/her blood sample collected, but then never returns to pick up the results. If HCT services were anonymous, especially for street children, then it would be virtually impossible to find these clients.

According to the majority of specialists, “informational” obstacles to services do exist, but they are not decisive, because one can get all necessary information if requested. An adolescent willing to undergo testing for HIV, can find such places on the Internet, or can learn about them from friends and during prevention activities organised in schools. An adolescent’s own understanding of his/her risk and the need in examination may be the problem.

All eight HCT counsellors stressed that they worked with all categories of adolescents, regardless of the type of high-risk behaviour. As one of respondents pointed out, the number of adolescent clients who have sex with men has increased notably in recent years.

Similar to YFC specialists, the staff of drop-in centres mentioned psychological barriers that prevent adolescents from seeking services. Most respondents articulated the word “fear” during interviews. Above all, adolescents are afraid of disclosure and of the fact that their parents may learn about testing and its results. The same fear concerns schools. Another obstacle to counselling and testing for HIV is the location of the drop-in centre in the premises of AIDS centre. Fear of AIDS and fear of the facility that personifies this disease are additional barriers to seeking assistance.

7.3 *Child polyclinics*

On the one hand, child polyclinics are one of the most easily accessible facilities – at least from the territorial standpoint, but on the other, not all polyclinics are capable of providing HCT services. Some refer their adolescent clients to other services. Information about where one can get such services is provided to an adolescent in full. Paediatricians work with adolescents of all age categories, but it is difficult to say how prepared are these specialists to deal with psychological aspects of work with MARA, because during interviews they primarily focused on physiological peculiarities of adolescence and on possible medical consequences.

7.4 *Regional (Oblast) departments of health*

All specialists representing departments of health confirmed the presence of various informational and psychological barriers to receiving HCT services. In particular, they emphasised that health workers conduct education and prevention work on a pro-bono basis, as an additional workload. As a result, such activities are fragmented and sporadic. The situation could have been improved by means of adequate coordination, but it is not in place. Specialists also mentioned territorial remoteness of health facilities from many rural communities, while the lack of money prevents many adolescents from travelling to such facilities. Another obstacle, mentioned by one respondent, was the shortage of test kits.

Another important barrier is the inconvenient working hours of the health facilities: testing is usually provided in the morning hours, when most adolescents are at school. If any adolescent wishes to receive HCT services confidentially and even anonymously, but he or she skips classes for these purposes, the parents may learn about it and start asking uneasy questions.

7.5 *National experts*

A majority of the experts interviewed agreed with the existence of informational and psychological barriers for adolescents to receiving HCT services, especially for MARA. 5 out of 9 experts who participated in the survey mentioned territorial and organisational barriers, particularly the inaccessibility of services for residents from remote communities. Also there are no 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, the dissemination of thematic brochures, Internet activities and social advertising. Experts expressed their concerns with limited knowledge of adolescents about YFCs – places where they can easily receive all necessary services, even without IDs.

One expert raised the question of the services' "commitment" to requirements of financing or controlling organisations, e.g. of supervision and auditing authorities. As a result, adolescent needs cease to be a priority in determining the content and form of service provision.

8. Staffing and staff training

It should be noted that almost all experts expressed their willingness to participate in training or other educational events dedicated to the specifics of work with adolescents, including MARA.

8.1 Youth Friendly Clinics

Different YFCs employ different number of specialists. Some clinics offer quite broad range of services, while others complain about the shortage of, for example, lawyers, nurses, and so on. In addition, doctors work in YFCs on conditions of part-time employment, in other words, they do not work every day and their working hours are shorter. In some YFCs this creates waiting lines, as the clients have to register up to two weeks in advance of the meeting.

Despite the fact that all YFC staff members were trained in the specifics of work with adolescents, some of them still define the terms "an adolescent" and "a child" in their own terms, instead of using WHO classification or the national normative and legal base. At the same time, all respondent agreed that an adolescent could independently seek services – including HCT – after attaining the age of 14. All respondents also recalled HCT Guidelines (protocol), but most of them forgot or misidentified the number of relevant MoH Order.

Only two respondents mentioned any methodological recommendations or manuals on HCT, telling that it was some publication by UNICEF. None of them could correctly name this publication.

8.2 Drop-in centres

The majority of staff members from drop-in centres participating in the study have completed specialised training on the specifics of work with adolescents (including MARA) and have received certificates of HCT counsellors. Almost all of them took part in HCT trainings organised by ICF "International HIV/AIDS Alliance in Ukraine", and one respondent additionally participated in PATH training. Some specialists also mentioned studying in the National Medical Academy of Postgraduate Education after P. Shupyk.

Despite such an extensive training experience, only about half of the specialists have correctly identified the age consistent with the term "a child", while the majority of them believes that adolescence is the age from 14 through 18 years. Probably, this is explained by the fact that the Order of the Ministry of Health "On Improving Organisation of Medical Care for Children of Adolescent Age", defines adolescence as the age from 15 to 18 years. Therefore, there exist certain inconsistencies between interpretation of "age of adolescence" by health workers of drop-in centres and the international practice of determining age limits.

All specialists who were surveyed are familiar with HCT Guidelines (MoH Order No 415); moreover, two experts confirmed their knowledge of recommendations issued by ICF "International HIV/AIDS Alliance in Ukraine" and by UNICEF. One expert also extensively uses a collection of normative and legal documents on the protection of children's rights, published with the support from UNICEF.

During interviews, these experts formulated a number of HR issues, e.g. shortage of specialists that often creates waiting lines, staff turnover, and the need to continuously train new staff members, which may lead to decline of the quality of education. One expert articulated the need in additional

positions of outreach workers in mobile outpatient units to ensure maximum approximation of services to clients, which is particularly important for reaching MARA.

8.3 *Child polyclinics*

All specialists in adolescent paediatrics have completed additional training courses on the work with adolescents, even though they focused mostly on medical aspects. One paediatrician from the polyclinic offering HCT services was aware of HCT Guidelines (protocol), but she did not mention any additional training or certificates of HCT counsellors.

8.4 *Regional (Oblast) departments of health:*

Understaffing is viewed by the specialists of oblast departments of health as one of key barriers to ensuring accessibility of HCT services. Ongoing reformation of the health sector hinders the distribution of functions between paediatricians and family doctors. Specialists believe that only after completion of said reform it will become possible to clearly divide the functional duties between various health professionals, including in the area of HIV counselling.

8.5 *National experts:*

Every expert interviewed within this study pointed at the existence of HR-related barriers, such as the lack of sufficient number of positions and limited roster of necessary specialists, as well as unpreparedness of staff to work with adolescents, and especially with MARA. Even though training modules for HCT counsellors – both the module included in the official postgraduate curriculum and the module developed by the International HIV/AIDS Alliance in Ukraine – have sections on adolescents, they are very superficial and short.

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

Having summarised the experts' answers, it is safe to say that the most common barriers that hinder adolescents' access to HCT services are:

1. The legal status of an adolescents aged under 14 years, which prevents them from receiving health services independently
2. A lack of awareness about HIV issues among adolescents, especially those living in rural areas and MARA, which results in their inability to objectively assess the risks of their own behaviour associated with HIV infection (lack of information about HCT service providers)
3. Psychological barrier to seeking HCT services as a result of low value of one's health and fear of "disclosure" by parents
4. A lack of finance that prevents rural teenagers from travelling to the service provision site
5. Inconvenient working hours at health facilities (testing is usually provided in the morning hours, when most adolescents are in school)
6. A misunderstanding amongst counsellors about possibility of providing HCT services without parental involvement starting from the age of 14 (it is also linked to the absence of clear definition of "an adolescent" in Ukrainian legislation and inconsistencies between the WHO's definition of adolescence (15–17 years) and changes in an individual's legal status after attainment of 14 years of age)

7. The lack of training on the peculiarities of work with adolescents in general and with MARA in particular (including psychological issues) for health professionals (with the exception of YFC staff)
8. A shortage of specialists. This often creates waiting lines, staff turnover, and the need to continuously train new staff members, which may lead to decline of the quality of education
9. Limited skills and inadequate use of outreach practices by health professionals in their work with adolescents, particularly through mobile outpatient clinics
10. Poor and sometimes non-existent coordination between health and social services
11. An inadequate follow-up of adolescents while referring them to HCT services
12. The widespread lack of full-package HCT services (including HIV testing results) during a single visit, as not all clients return to pick up their results, especially MARA
13. The absence of any clearly formulated national policy on HIV/AIDS response in adolescent's social environment and among MARA, which results in uncoordinated actions of the local specialists
14. A limited knowledge of, and as a result, lack of interest towards provision of HCT services to adolescents at the level of oblast departments of health.

9. Recommendations (Algorithm) for Service Providers on the Medical Component of HCT

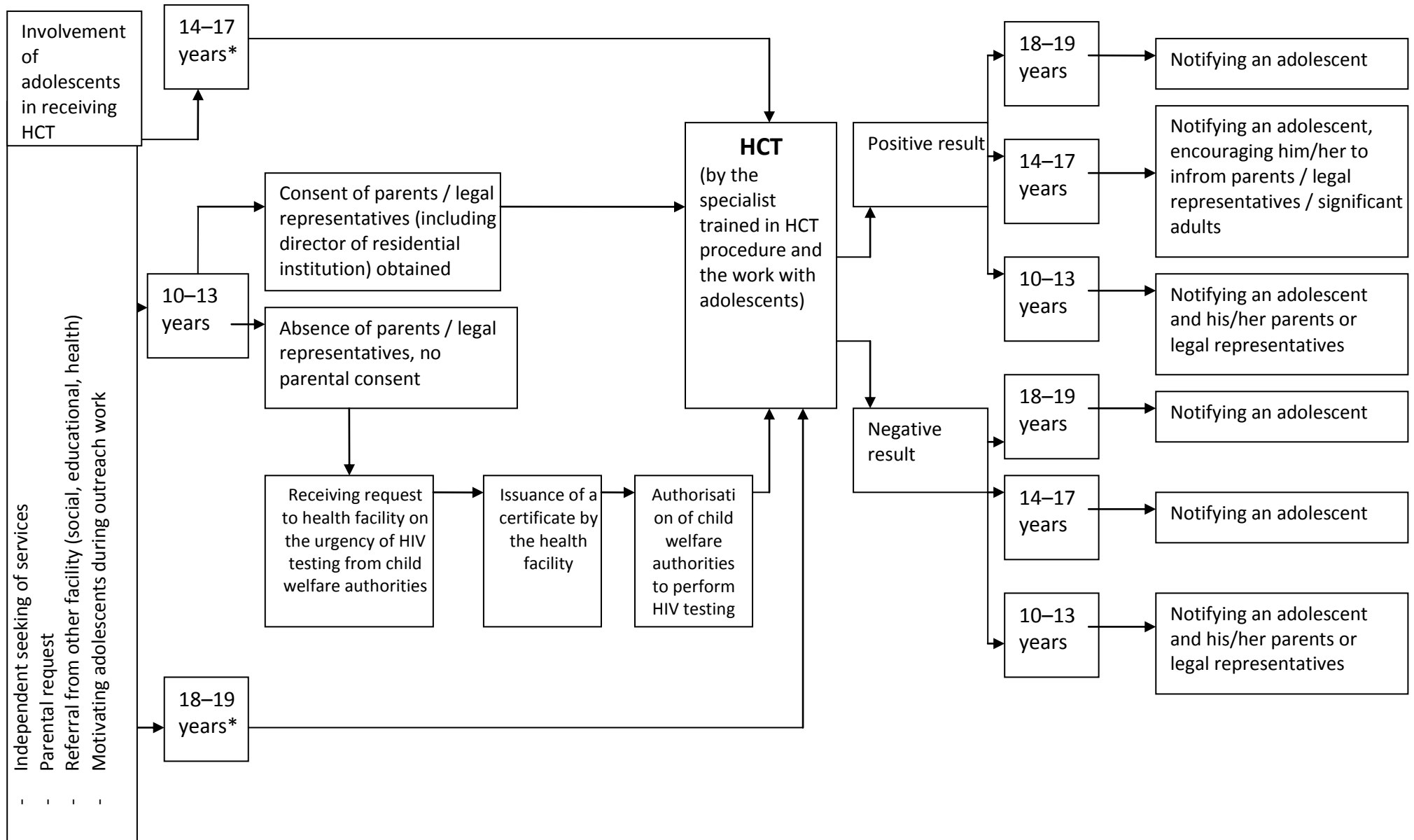
Analysis of the normative and legal base and current practices of HCT service provision suggests the following algorithm for health professionals providing such services:

1. Adolescents may be involved in the provision of HCT services in different ways, such as:
 - Independently seeking HCT or other services in a health facility (in this case internal referral is possible, for example, when a girl comes to see a gynaecologist and the doctor referred her to HCT)
 - The request of adolescent's parents or other legal representatives (including request from a director of residential institution)
 - 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 HCT services in the course of outreach work (reaching adolescents through mobile outpatient clinics, visiting places frequented by young people, e.g. in educational establishments).
2. Further provision of HCT services (pre-test counselling and testing) depends on an adolescent's age:
 - 14–19 years – adolescents have the right to receive HCT services independently and anonymously;
 - 10–13 years – involvement of legal representatives of an adolescent is mandatory and may include a request, written consent, or physical presence; if a legal representative of a child cannot be determined, HCT may be carried out upon authorisation of child welfare authorities following the request of services for children as temporary legal representatives of a child; if a child under 14 years has legal representatives, but it is impossible to involve them in HCT for various reasons (e.g. they are unresponsive in child's health needs or openly oppose testing for HIV), services for children, with support from child welfare authorities, may initiate testing of a child for HIV upon reception of official 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.

3. Post-test counselling, including the notification of test results, also depends on 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.

These recommendations are based on current legal framework and on the experience of HCT service providers. They are presented below in the form of algorithm.

Algorithm of service provision: medical component of HCT



*Anonymous provision of HCT services is possible.

10. Practical Experience of HCT Service Provision to Most-at-Risk Adolescents (social component)

The provision of HCT services in the social sphere is the responsibility of non-governmental organisations and centres of social services for families, children and youth.

Even before interviews it was clear that search for non-governmental organisations offering services to adolescents, including HCT, would be a very challenging task. The majority of NGOs work with clients aged 18 years and older. Organisations that do work with adolescents use very similar algorithms: pre-test (and sometimes post-test) counselling is the responsibility of a social worker who also motivates an adolescent to undergo examination; testing and post-test counselling (to preserve confidentiality of results) are performed by one and the same medical doctor involved in the project; all procedures are carried out by a nurse or a doctor. In most cases NGOs cooperate with infectious disease doctors and STI specialists. Therefore, NGOs are capable of providing a full range of HCT services. As a rule, service provision occurs in the mobile outpatient units / clinics; sometimes services are additionally available in NGO's community centre, or social workers take or accompany adolescents to AIDS centres. HIV testing is routinely performed with rapid tests, but sometimes a client may have his/her blood collected for verification of results. In this case results are communicated later, during the repeated visit.

Unlike non-governmental organisations, all centres of social services for family, children and youth are required to work with adolescents. Their resources in the area of HCT service provision, however, are much more limited than those of NGOs despite the fact that HCT Guidelines formally identify them as facilities capable of providing these services. As a rule, HCT services in CSSFCYs are limited to pre-test counselling with subsequent referral of clients to health facilities. The latter perform testing and provide post-test counselling. Sometimes an adolescent may return to CSSFCY for additional assistance and may as well receive post-test counselling. One CSSFCY representative described her brief experience of providing HIV testing that was available several years ago on the basis of mobile clinic. Another respondent from Kyiv-based CSSFCY also described very positive experience of working with adolescents via a mobile clinic, and added that this practice is one of key activities of their centre. Unfortunately such experience in Ukraine is the exception rather than the rule. Respondents also mentioned close cooperation between CSSFCYs and YFCs.

11. Analysis of Key Obstacles to HCT Service Provision as Defined by Representatives of Institutions and Organisations of Social Sphere

Adolescent status

11.1 CSSFCY

Considering the official name of such facilities and their statutory provisions, the adolescent's age is by no means a barrier to receiving services in the centres of social services for family, children and youth. Beginning from the age of 14, 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.

11.2 NGOs

Not many NGOs are ready to work with adolescents. It is explained by additional responsibilities, vagueness of normative and legal regulations of NGO activities, and the need in additional training

for NGO staff to be able to work with this age category of clients. Particularly challenging is the situation with non-governmental organisations that are ready to work with MARA fewer than 14, as typical issues associated with MARA-specific activities may even double in this age group. During interviews two NGO representatives noted that their projects targeted adult representatives of most-at-risk populations. One of them blankly denied any work with individuals younger than 18 years, while the other stated that their NGO would provide HCT services to anyone who was 14 and older – as it is permitted by the law – but not routinely, only upon request. Accordingly, the organisation 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 other specialist, their project works in the remand prison, including with adolescent detainees, but it does not specifically target this age category.

Almost all specialists interviewed both from CSSFCYs and NGOs agreed on the existence of normative and legal barriers to the provision of services to adolescents, particularly to MARA, as the latter often do not have identification documents and legal representatives. The absence of ID makes it impossible to confirm the diagnosis, to register and to begin appropriate treatment. The restoration of documents takes too much time, while an adolescent may require emergency medical intervention. Respondents even recalled several fatal consequences of such bureaucracy. Also specialists pointed at inconsistencies between different normative and legal documents.

12. Accessibility of services (location of service provision site, information about the availability of services, and the readiness of HCT counsellors to work with target population)

Specialists from the social sphere agree with their health sector counterparts regarding the existence of serious territorial barrier to services for adolescents who live in rural areas and small towns. As for the communities served by the respondents' organisations, their residents should not have any problems with territorial access to services.

The majority of specialists interviewed spoke about certain informational barriers for adolescents, including MARA, predominantly in rural areas. Representatives of the organisation 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. As adolescents are active Internet users, there is a need to intensify the use of online resources for disseminating information about HCT. Experts believe that nowadays this is the optimal channel for delivering information to target audience, as even MARA boys and girls use the internet because they often spend nights in Internet cafes and clubs.

A social pedagogue of the vocational school, interviewed during the study, also mentioned the problem of limited information. On the one hand, he personally informs adolescents about HCT services and encourages them to take tests, but on the other hand, he is not in position to directly refer them to a specific facility or to concrete specialists.

More than half of all specialists representing NGOs and CSSFCYs have pointed at the existence of various organisational barriers. These included the shortage of premises for individual counselling during HCT, an insufficient number of organisations willing to provide services to adolescents, the lack of sustainable financing of this activity area at all levels, the lack of guarantees that adolescents

would continue receiving these services after discontinuation of donor support, and the unavailability of supplementary services for adolescents (housing, consumer services, social and pedagogical work, restoration of documents and the like).

As for the organisations that routinely provide services to adolescents (including MARA), their HCT counsellors expressed a readiness to work with all categories of adolescents. Among their clients there are many adolescents who have unprotected sex with multiple partners (including sex for profit), and drug users (both injecting and non-injecting). The proportion of adolescent boys who have sex with men among the clients is miniscule, and many specialists could not remember a single client of such kind. Social workers who did meet such MARA – like their health sector counterparts – report the absolute seclusion of this group.

13. Staffing and staff training

13.1 CSSFCY:

Only two representatives of CSSFCYs participated in the study. Both took part in HCT training sessions, organised by PATH and ICF “International HIV/AIDS Alliance in Ukraine”. One of them remembered the number of the MoH Order that approved HCT Guidelines (protocol), while the other did not mention this protocol as a document that governed his professional activity.

CSSFCY specialists that were interviewed identified the age categories as follows: children are individuals of 0-9 years and of 0-18 years and adolescents are people aged 10–18 years and 10–19 years. One of the specialists mentioned the existence of staffing problems.

According to the experts interviewed, there is no supervision over HCT service provision.

13.2 NGOS

It is interesting to note that 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 twelve NGO members interviewed were not aware of HCT Guidelines, while 6 of them remembered the number of relevant MoH Order. Ten NGO specialists participated in training sessions and received a certificate as a HIV counsellor. In most cases these events were organised by ICF “International HIV/AIDS Alliance in Ukraine”, while some staff members attended UNICEF and PATH trainings. If specialists do not have the abovementioned certificate, they never directly provide HCT services but rather work in the area of project management. At the same time, most managers have an HCT certificate as they completed relevant training courses.

Seven specialists participated in training sessions for adolescents and MARA also organised by the Alliance Ukraine and UNICEF.

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

The majority of the specialists defined the term “a child” as an individual below the age of 18 years, according to Ukraine’s national legislation. Some specialists limited the age of a “child” to 14 or 16 years. As for the age of adolescence, the researchers collected many variants of answers: 12–18 years, 16–18 years, 10–19 years, 14–18 years and 14–16 years. While answering this question, specialists used a variety of arguments in support.

During interviews only 4 experts mentioned any staffing issues, pointing out the shortage of staff rather than at the level of their training. At the same time, all interviewed specialists expressed their willingness to participate in different educational activities to improve their professional competence.

HCT supervision in non-governmental organisations is carried out by the specialists of AIDS centres, by representatives of donors (Alliance Ukraine), and through the clients' feedback. Considering the fact that even in NGOs this service remains the domain of health workers, we should also mention supervision in the workplace.

The interviewees' answers make it possible to conclude that the most common barriers that hinder adolescents' access to HCT services are:

13.4 For Health Workers

1. The Legal status of an adolescents aged under 14 years, which prevents them from receiving health services independently;
2. A lack of awareness about HIV issues among adolescents, especially those living in rural areas and MARA, which results in their inability to objectively assess risks of own behaviour associated with HIV infection; the lack of information about HCT service providers
3. Psychological barriers that prevent individuals from seeking HCT services as a result of low value of one's health and fear of "disclosure" by parents
4. Territorial barriers that prevent individuals from reaching services for adolescents, for those living in rural areas (remoteness of service provision sites)
5. A lack of staff;
6. Poor coordination between health and social services.

13.5 For Health Workers

1. A limited number of NGOs offering adolescent-centred services, particularly services for those under 14 years
2. The need to involve health workers in the process of HIV testing and to adjust working schedule accordingly, which may be inconvenient for the clients
3. Dependence of the content of services that are offered by NGOs on donor priorities, which rarely target adolescents
4. The necessity to involve services for children in order to observe all formalities concerning the presence of legal representatives of adolescents, and this takes a lot of time and effort
5. For CSSFCYs – inadequate follow-up for adolescents in the course of referral to HCT services
6. The impossibility of obtaining a comprehensive package of HCT services (including testing) in the majority of CSSFCYs as a result of limited resources
7. The problem of further examination for an adolescent (MARA in particular) to confirm diagnosis and to complete registration due to the lack of consistency of service provision by health and social workers, and due to underdeveloped referral and follow-up procedures
8. The absence of a gender-sensitive approach to the counselling of adolescents.

14. Recommendations (Algorithm) for Service Providers on the Social Service Provision

The components of the algorithm² for Social Services offering HCT services are much the same as those designed for health professionals. This is so because both health and social service providers operate within a single legal framework, but some components are still different. The following algorithm is for specialists working in the social sphere:

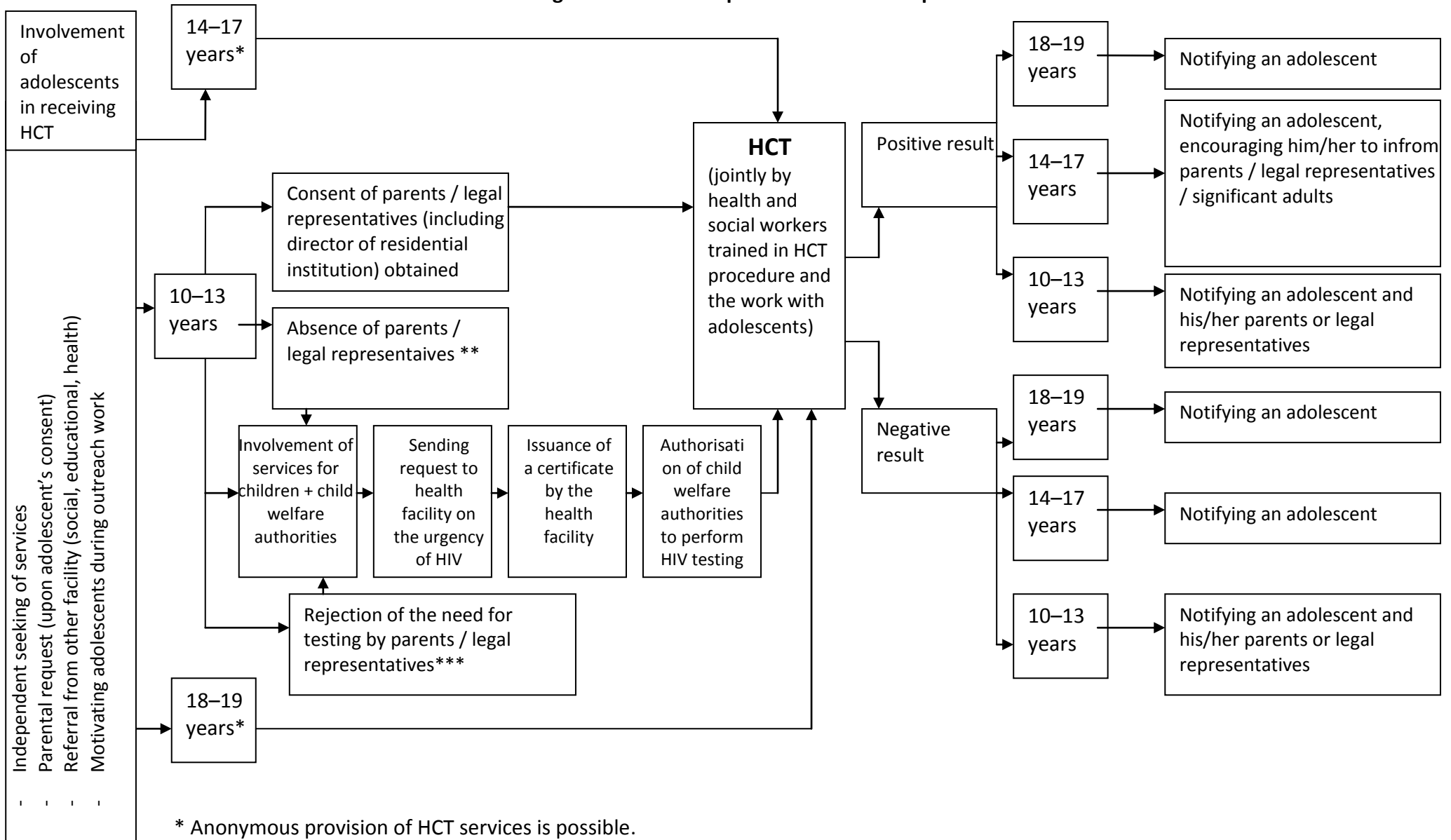
1. Adolescents may be involved in the provision of HCT services in different ways, such as:
 - Independently seeking HCT or other services in a facility or organisation providing social services (in this case internal referral is possible, or referral and preferably – follow-up to other facilities providing HCT services, for example, when a girl comes to see a psychologist and this specialist referred her to HCT)
 - Upon request of the adolescent's parents or other legal representatives (including request from a director of residential institution)
 - The referral of an adolescent from other (social, educational) facilities, 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.
 - Encouraging adolescents to receiving HCT services in the course of outreach work (reaching adolescents through mobile outpatient clinics, visiting places frequented by young people, e.g. in educational establishments).
2. Further provision of HCT services (pre-test counselling and testing) depends on an adolescent's age:
 - 14–19 years – adolescents have the right to receive HCT services independently and anonymously;
 - 10–13 years – requires the involvement of legal representatives of an adolescent is mandatory and may include a request, written consent, or physical presence.
if legal representatives of a child cannot be determined, HCT service provision to an adolescent may be carried out upon authorisation of child welfare authorities following the request of services for children as temporary legal representatives of a child, at the same time, social services or an organisation (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
If a child under 14 years has legal representatives, but it is impossible to involve them in HCT 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 HCT upon request of the child welfare authority.
3. Post-test counselling, including notification about testing results, also depends on the age:
 - 18–19 years – testing results are not disclosed to anyone except for an adolescent;

² To make it more user-friendly, authors provide the entire algorithm instead of describing differences.

- 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.

While using this algorithm, one should consider whether HCT service offered by the institution/organisation of the social sphere is provided in comprehensive manner (that is, includes testing). If testing for HIV is not provided, HCT service is usually limited to pre-test counselling, and adolescents are further referred to a health facility to receive testing and post-test counselling. If an adolescent returns to said institution/organisation after HIV testing, shows his/her readiness to disclose HIV status and seeks post-test counselling, specialists of this organisation will have to provide such service. These recommendations are presented below in the form of algorithm.

Algorithm of service provision: social component of HCT



* 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).

15. Concluding Recommendations

By summarising the survey results, the concrete ideas of the specialist interviews, together with their proposals has helped to outline a number of recommendations for improving various aspects of HCT service provision, primarily for enhancing the country's normative and legal base in this area.

15.1 Ministry of Health

The majority of recommendations are intended for the Ministry of Health:

15.1.1 On amendments to the laws:

- Initiate amendments to the Law of Ukraine on HIV that would clearly specify acceptable ways of examining and treating a child regardless of his/her age, if there existed a direct threat to the child's health and life even in cases when his/her legal representatives strongly opposed suggested procedures (relevant amendments were submitted to the working group involved in the development of changes to the Law on HIV);
- Amend the Law on HIV in a way to enable medical examination and further registration and if necessary – treatment of adolescents under 14 years of age who have no parents or guardians
- Introduce measures aimed at ensuring accessibility and adequate quality of HCT services for adolescents, primarily MARA and rural teenagers, in the upcoming National Programme to Ensure Prevention of HIV Infection, Treatment, Care and Support to HIV Positive People and Patients with AIDS for 2014–2018, particularly by means of scaling up the YFC network and involving NGOs through social commissioning mechanisms
- Ensure the coherence of the response to HIV for adolescents in different national programmes (e.g. the National Programme to Ensure Prevention of HIV Infection, Treatment, Care and Support to HIV Positive People and Patients with AIDS and the State Programme "Health of the Nation")

51.1.2 On amendments to Orders:

- List the staff of youth friendly clinics and include relevant YFC personnel responsible for HCT provision in the MoH Order on the staffing structure (Order No 33 "On Staffing Norms and Standard Personnel of Health Facilities")
- Expand Standard Provisions on a multidisciplinary team providing health and social assistance to HIV positive children and their families (Joint Order No 740/1030/4154/321/614a as of November 23, 2007) with specific objectives of a multidisciplinary team and its individual members to ensure HIV diagnostics in children, particularly those in need of both medical and social assistance. Accelerated implementation of the abovementioned inter-sector Order is also very important as only few respondents mentioned this document during interviews despite the fact that it provides clear instructions for health workers regarding legal peculiarities of HCT and further treatment of adolescents depending on their age.

It should be noted that MoH started implementing some of the measures suggested even before this Review was published. In particular, specialists of the Ministry of Health have:

- Analysed normative and legal base for inconsistencies and conflicts between the Law of Ukraine "On Prevention of Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Security of People Living with HIV" and relevant bylaws, including HCT Guidelines, which still contains provisions limiting opportunities for HIV testing for children of 14 years and older without consent of their legal representatives (a working group on counselling and testing for HIV with the State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases is currently developing a new version of HCT Guidelines

- (protocol), which, as expected, will be fully in line with the Law on HIV and allow adolescents of 14 years and older to receive HCY services independently)
- Include, in the new version of HCT Guidelines, provisions for improving the mechanism of cooperation between health and social services in the process of testing of adolescents for HIV, which would enable medical examination and further registration and if necessary – treatment of adolescents under 14 years of age who have no parents or guardians (relevant proposals were submitted to the working group on counselling and testing for HIV with the State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases, and agreed with its members. Relevant section of the new version of HCT Guidelines will read as follows: “Initiated by the health worker testing and counselling of children under 14 years and individuals officially recognised as legally incapable is provided upon request and well-informed consent of their parents or legal representatives. If legal representatives of a child are not determined, HCT shall be performed upon request of child welfare authorities with involvement of a representative of services for children”)
 - Introduced changes to HCT Guidelines that would specify acceptable ways of examining and treating a child regardless of his/her age, if a direct threat to the child’s health and life exists, even in cases when his/her legal representatives strongly opposed suggested procedures (new wording is based on recommendations of this study and reads as follows: “In cases when health workers have identified or suspect HIV infection, whereas non-testing and the absence of subsequent treatment put the life and health of a child at serious risk and the child’s parents, being aware of such danger, do not undertake any necessary steps towards diagnostics and treatment, HCT may be initiated by the representatives of services for children upon official request from the child welfare authorities. The health facility shall issue relevant certificate stating that HIV testing is vitally important, and that untimely testing puts the child’s life and health in jeopardy”)
 - Introduce a section in the HCT Guidelines on counselling and testing of adolescents, which also describes the peculiarities of HCT service provision to adolescents practicing various risky behaviours. As an option, it was suggested to include additional paragraphs on adolescents’ counselling in other sections covering various target populations (new wording is based on recommendations of this study and reads as follows: “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 HCT services, therefore in the process of counselling it is necessary to consider recommendations of relevant sections of these Guidelines, also talking into account the existing age peculiarities”).

An important recommendation was also developed for the Ministry of Social Policy of Ukraine: The national legislation should establish an official status of the heads (directors) of shelters for children and of centres for social and psychological rehabilitation as legal representatives should of children with legally established status of an orphan or a child deprived of parental care.

Special attention should be given to the proposals of specialists from the social sphere. In particular, these suggestions concern legislative changes that would grant a status of children's legal representatives to those social workers who accompany adolescents under 14 years in the process of HCT service provision. This issue has stirred up some heated discussions, including at the meeting of the working group: on the one hand, this status will significantly simplify and accelerate HCT procedures for children with unidentified legal representatives, but how it will work for a social worker, who may become responsible for the child's adherence to treatment in the future in case of prescription of ART? Diagnostics without further necessary treatment is unacceptable. Discussions ended with a decision of the members of the working group not to award such mandates to social workers. Instead they included provisions in the new version of HCT Guidelines on adequate participation of services for children and child welfare authorities in the process.

Speaking about options for prescribing treatment to adolescents who have already reached the age of 14, specialists generally lean toward the idea of involving their legal representatives. If the child's legal representatives do not approve treatment but the child's health is at risk, it is recommended to provide medical assistance without such consent. At the same time, specialists are required to provide information about the child's health status to parents upon their request.

In addition to proposals on the improvement of normative and legal base, the experts also provided specific recommendations to enhance practices of HCT service provision on sites:

15.2 For local authorities:

- Ensure the approximation of HCT services for rural residents: family doctors should undergo relevant HCT trainings at AIDS centres (local health facilities that offer HCT services need to allocate necessary funds for the procurement of rapid tests)
- Ensure the comprehensiveness of HCT services (both counselling and testing) in YFCs, particularly through the use of rapid tests
- Strengthen the coordination of activities of health and social workers with the goal to ensure education, motivation and follow-up of adolescents to receive testing for HIV
- Change the working hours of health facilities in order to enable HIV testing (blood sample collection) in afternoon hours and during weekends instead of time when adolescents are in schools
- Ensure prioritisation of service provision to adolescents and to shift priority of NGO activities from donor requirements and requests towards specific target populations

15.3 For donors that support functioning of mobile clinics and staff training

- Disseminate the practice of active use of mobile outpatient clinics for providing HCT services to adolescents, including MARA, going beyond the service provision to adult clients only. At the same time, it is necessary to increase the number of mobile units and to involve joint teams of health workers and CSSFCY specialists in their work
- Ensure involvement of counsellors of both genders in order to make counselling of adolescents gender-sensitive
- In addition to training, we recommend organising other events on the topic (adolescents, HCT), e.g. roundtables, follow-up workshops, self-help groups for specialists to contribute to knowledge sharing.
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15.5 For organisations that conduct trainings for HCT counsellors and fund projects focused on service provision to adolescents, including MARA

- Organise training sessions on HCT for all specialists working in the area of health and social service provision to adolescents
- Include a training module for HCT counsellors for practicing counselling skills in the work with adolescents who oppose medical examination, initiated by their parents/legal representatives. More specifically, counsellors need to be able to motivate adolescents to take such tests and to ensure observance of the principle of confidentiality.
- Ensure the maximum possible dissemination of UNICEF’s training and methodological manual **“Adolescents Most at Risk for HIV”** (Participant’s Book and Trainer’s Book) among HCT counsellors thus helping them to provide HCT with appropriate consideration of both legal and psychological peculiarities of adolescent clients (www.unicef.org/ukraine/ukr/Trainer.pdf and www.unicef.org/ukraine/ukr/Participant.pdf)

15.6 On informing the target population for social service providers

- Use modern information technologies for spreading information for adolescents (Internet, including social networks; online counselling)
- Present information that motivates in an adolescent-friendly format, e.g. educative stories in the form of comic books.

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